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PARAGUAY ASSESSMENT REPORT

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PARAGUAY ASSESSMENT REPORT

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ACRONYMS

APS	*Atención Primaria de Salud* (Primary Health Attention, remote health service units, smaller than health posts)
CDC	Centers for Disease Control and Prevention
CEPEP	*Centro Paraguayo de Estudios de Población* (Paraguayan Center for Population Studies), the IPPF affiliate
CIRD	*Centro de Información y Recursos para el Desarrollo* (Center for Development Information and Resources)
CPR	Contraceptive prevalence rate
CS	Contraceptive security
CTU	Contraceptive Technology Update
DAIA	*Disponibilidad Asegurada de Insumos Anticonceptivos* (contraceptive security)
DGEEC	General Directorate for Statistics, Surveys and Censuses (*Dirección General de Estadística, Encuesta, y Censos*)
DMPA	Depot medroxyprogesterone acetate
EC	Emergency contraceptive
EDL	Essential Drug List
ENDSSR	*Encuesta Nacional de Salud Sexual y Reproductiva* (Reproductive Health Survey)
FP	Family planning
FY	Fiscal Year
GDP	Gross domestic product
GOP	Government of Paraguay
IC	Injectable Contraceptive
IEC	Information, Education and Communication
INPPARES	*Instituto Peruano de Paternidad Responsable* (Peruvian Institute for Responsible Parenthood)
IPPF	International Planned Parenthood Federation
IPS	*Instituto de Previsión Social* (Paraguayan Social Security Institute)
LAC	Latin America and Caribbean
LAPM	Long-Acting and Permanent Methods
LMI	Lower middle income
LMIS	Logistics Management Information System

MOH	Ministry of Health (*Ministerio de Salud Pública)*
MOU	Memorandum of Understanding
MSPBS	*Ministerio de Salud Pública y Bienestar Social* (Ministry of Health)
MWRA	Married women of reproductive age
NGO	Nongovernmental organization
OB/GYN	Obstetrician/Gynecologist
OC	Oral contraceptive
PAC	*Profesional Afiliado a CEPEP* (CEPEP-affiliated Professional)
PHN	Population, health and nutrition
PNSSR	*Programa Nacional de Salud Sexual y Reproductiva* (National Sexual and Reproductive Health Program)
PPM	Public-private mix
PPP	Public-private partnership
PSI	Population Services International
R&D	Research and Development
RH	Reproductive health
RHS	Reproductive Health Survey
SDP	Service delivery point
SHOPS	Strengthening Health Outcomes through the Private Sector
SM	Social Marketing
SRH	Sexual and Reproductive Health
SSR	*Salud Sexual y Reproductiva* (Sexual and Reproductive Health)
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
US	United States
USAID	United States Agency for International Development
VSC	Voluntary surgical contraception
WIU	Women in union
WRA	Women of reproductive age

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EXECUTIVE SUMMARY

Paraguay's notable successes in improving the health of its people are best seen in its reproductive health indicators. In recent years the rate of contraceptive prevalence among women in union as well as all women of reproductive age has increased dramatically. This can be attributed to extensive support from the Government of Paraguay and USAID.

Although both the private and public sectors participated and contributed to these successes in reproductive health, unprecented growth in the public sector over the past decade caused some to question the long-term security of the overall contraceptive prevalence rate. To help inform policy makers and market leaders alike, this private sector assessment, requested by USAID/Paraguay, is meant to determine the current market segmentation and recent trends regarding FP products and services to get a better picture of the current public-private mix. Ultimately, the SHOPS project will derive from the findings a strategy, to be implemented by SHOPS, to help Paraguay achieve a healthy and balanced private-public mix that will be conducive to maintaining the successes achieved to date in reproductive health after graduating from donor support in family planning.

The project's analysis resulted in the following key findings:

CURRENT MARKET SEGMENTATION

The SHOPS project conducted a secondary analysis of the ENDSSRs 2004 and 2008 looking at recent trends relating to both FP consumers and suppliers. Important to acknowledge is the growth of consumer groups participating in the market, specifically those from the two lowest income quintiles, rural areas, and the Northern region, all of which are more likely to use the public sector. The current method mix for FP users shows an increase in the use of pills, condoms and injectables versus long-term and traditional methods, as well as a change in method mix among WIU from two predominant methods to three. Although not all actors in the private sector experienced growth during this time, the rapid growth of the public sector did not negatively impact the overall private sector, and in fact, improved market segmentation mostly by serving a previously under-served segment of the population from the lower two wealth quintiles.

POLICY & POLITICS INFLUENCING THE AVAILABILITY OF FP SERVICES AND PRODUCTS

The policy environment is receptive and supportive of FP, and does not act as a barrier in any of the three sectors (public, non-profit and commercial). What is missing is a more proactive policy environment encouraging these three groups to universally define goals and definitions (e.g. universal access). Ultimately what needs to be furthered is public-private dialogue amongst key players focusing on achieving shared goals in a collaborative and sustainable fashion.

FP MARKETPLACE: PRODUCTS AND SERVICES

Services

Service providers have not experienced the same gains as the commodities market during the period of growth. CEPEP (the Paraguayan IPPF-affiliate) has experienced a loss in market share and the Paraguayan Social Security Institute (IPS) has not made significant gains, and remains underutilized. In general, commercial clinical providers are not viewed as preferred sources of FP, as both cost and accessibility to private providers present obstacles for some, while others prefer to self-manage their contraceptive use without formal provider consultation.

Products

The commodities market overall is healthy and competitive. Pharmaceutical companies, both local and international, are enjoying success due to the increased use of pills, condoms and injectables, which are easily obtained at pharmacies. The market offers consumers in different wealth quintiles a variety of products, brands, and price points to choose from.

Conclusions

Taking into account the aforementioned findings, the SHOPS project offered the following conclusions:

- Paraguay enjoys a favorable public/private mix in the provision of FP methods. In general, the gains of the public sector in FP did not correlate to negative effects for private suppliers, but rather achieved the goal of increasing underserved populations' access to contraceptives. That being said, not all private sector suppliers experienced growth during 2004-2008, but some of this can be attributed to a shift towards resupply methods, away from long-term methods.
- Private sector clinical providers are not emerging as a preferred source of FP, as many Paraguayans are beginning to self-manage their contraceptive use. It is important to maintain the presence of private providers in the service industry, as they represent an opportunity to manage the balance between short-term and long-term methods and encourage the correct use of hormonal contraceptives in Paraguay. Additionally, re-supply methods are more expensive than long-acting and permanent methods over time.
- The policy factor is currently an impartial element in the FP marketplace, but it should not be neglected in the process of balancing the public-private mix in the FP market. Policies should encourage dialogue and collaboration at all levels of the market and work towards achieving goals set forth in a common agenda.

RECOMMENDATIONS

Based on the results of the private sector assessment in Paraguay, the SHOPS project offers policy makers and market leaders two overarching recommendations aimed at maintaining the favorable relationship between the public and private sectors in the FP market as well as ensuring a healthy and balanced FP method mix.

- Proposed leadership strengthening activities to include:

  Working with the DAIA to change its orientation and focus in order to better serve all sectors' interests in the FP market, more clearly define a universal vision for a sustainable private-public mix in FP, and to increase the institutional capacity and visibility of the DAIA as a policy mechanism in Paraguay.

- Proposed repositioning activities to include:

  Providing support to IPS in order to consolidate political support and commitment from IPS leadership for the re-launch of the Sexual/Reproductive Health program, assess client needs in FP counseling and services, strengthen capacity in service delivery, and "rebrand and market" IPS's FP services to clients.

  Conducting a series of diagnostic studies in order to determine CEPEP's current role in the FP market and productivity levels, assisting in the development and implementation of a repositioning strategy focusing on securing CEPEP a sustainable position in the marketplace which will allow it to be a self-sufficient organization.

1. INTRODUCTION

1.1 ANTECEDENTS

Paraguay has made significant progress in the past decade in improving the health of its people, specifically in those indicators related to reproductive health and family planning. Data from the newest Reproductive Health Survey (RHS) show an increase in the rate of contraceptive prevalence among women in union of reproductive age, from 72.8% in 2004 to 79.4% in 2008. This was mainly due to an increase in the use of modern family planning (FP) methods, which grew from 60.5% to 70.7%.

During the same time period, government support for family planning improved dramatically and USAID invested robustly in strengthening the family planning program at the Ministry of Health (*Ministerio de Salud Público y Bienestar*, or MSPBS). As a result, the public sector is now playing a greater role in providing FP services and products—from 36% of Women in Union of reproductive age (WIU) in 2004 to 42% in 2008. Several factors explain the dramatic expansion of the public sector's FP program, including ministry commitment to national coverage under the FP program, a protected line item in the national budget to procure contraceptives, and improvements in FP logistics.

Although the public sector has been expanding at a faster rate in the last four years, both sectors have experienced growth. However, the prospect of continued rapid growth in the public sector concerned program managers as they questioned sustainability and whether or not the public-private mix was becoming unbalanced. Rapid public sector growth could have consequences potentially affecting long-term contraceptive security by crowding out the private sector and/or placing an unsustainable burden on the public sector due to consumers shifting from private to public. This report analyzes current market segmentation and recent trends in order to assess whether these consequences are likely, and how rapid growth in the public sector has affected market segmentation in Paraguay.

1.2 PRIVATE SECTOR ASSESSMENT

To better understand the dynamics of the FP marketplace in Paraguay, USAID/Paraguay requested the Strengthening Health Objectives through the Private Sector (SHOPS) Project to conduct a private sector assessment. The SHOPS assessment and subsequent programming are seen as one of the final steps to Paraguay's successful graduation from donor support in FP. The findings and recommendations from the private sector assessment will be used to design a strategy that the SHOPS project will implement to help maintain an optimal market mix, so that the advances made in FP coverage will endure after USAID graduates FP assistance to Paraguay.

The assessment focused on:

- Describing the private family planning market in Paraguay (NGO and commercial).
- Analyzing current market segmentation and its recent trends.
- Identifying the interface between the public sector and private sector (including reviewing current public policy toward the private sector).

- Examining the normative issues and current barriers to optimizing private sector participation in the FP marketplace.
- Identifying areas of support required to ensure successful graduation, with particular focus on two key actors—*Centro Paraguayo de Estudios de Población* (CEPEP— the Paraguayan IPPF-affiliate) and *Instituto de Previsión Social* (IPS—Paraguayan Social Security Institute).

1.3 OVERVIEW OF REPORT

This report discusses the current market segmentation in Paraguay, as well as explores recent trends to provide some sense of where the market may be going. The assessment examines the private sector's role in light of rapid growth within the public sector and how this may affect the sustainability of contraceptive security going forward. Additionally, it studies the major actors from all three sectors—public, NGO and commercial—and analyzes their general positioning. The report examines changes in the method mix and how the current method mix affects the various suppliers.

In addition to reviewing and analyzing market trends, the report looks into the factors that may have led to these changes and how they could influence the overall family planning system in the future. The policy analysis explores to what extent certain legislative accomplishments have created an enabling environment for family planning in Paraguay, and how policy platforms can continue playing a positive role.

Because the contraceptive prevalence rate (CPR) is so high in Paraguay, the report does not focus on demand-side factors as much; demand appears to be strong and healthy in Paraguay. The assessment focuses more on the long-term capacity of the whole market to be able to meet demand, and on how contraceptive sourcing patterns affect the various suppliers from all three sectors.

Although the report is specific to SHOPS/Paraguay programming efforts, it presents information that may be of interest to a wider audience, given the remarkable progress made in Paraguay and the favorable market segmentation. Because Paraguay is one of the lead countries in USAID's current family planning graduation efforts, the Paraguay case could serve as a model to other USAID countries entering or approaching the graduation process—e.g., countries with 60% to 70% CPR (women in union, all methods).

1.4 WHOLE MARKET APPROACH AND MARKET SEGMENTATION

The assessment team used a "whole market"[1] orientation to analyze the sustainability of contraceptive security in Paraguay, and assess the appropriateness of the market segmentation and the role each sector is playing. A balanced or "appropriate" public-private mix is reached when the consumer needs from the various segments are served by the corresponding sector (public, NGO or commercial) in a manner that maximizes overall efficiency and is sustainable for all three sectors.

[1] A whole market approach, sometimes referred to as a total market approach, is a coordinated effort incorporating the public, private non-profit and private commercial sectors to respond to the varying needs for family planning in a given country

The assessment looks into segmentation by socio-economic or wealth quintile, as well as other factors such as differences by method, urban versus rural, and nuances within the three sectors. Figure 1 shows optimal segmentation by wealth quintile.

FIGURE 1. SIMPLE SEGMENTATION

Wealth quintile	Sector
Wealth quintile 5	Commercial Sector
Wealth quintile 4	Non-profit private sector (NGO, religious organizations, etc.) and Social Security
Wealth quintile 3	
Wealth quintile 2	Ministry of Health
Wealth quintile 1	

In addition to verifying that consumers from each socio-economic quintile are sourcing appropriately, sustainability also hinges on each sector having the appropriate incentives and resources to serve its corresponding segments. The public sector must have sufficient public funds and political support to serve its target population. The NGOs must be able to offer low-cost products and services and still cover their costs in order to be self-sufficient. The commercial sector needs to earn sufficient profit in order to justify continued investments in the marketplace. The whole market approach therefore looks at sustainability in terms of consumer sourcing and provider sustainability.

Because Paraguay is in the advanced stages of completing a USAID graduation plan, the findings are meant to analyze the current market segmentation, as well as identify ways to maintain and/or improve market segmentation and therefore the overall sustainability of contraceptive security in Paraguay.

2. FAMILY PLANNING TRENDS

Paraguay has made enviable progress related to reproductive health and family planning over the past 10 years. Paraguay's fertility rate is on par with the estimated world average of 2.5 live births per woman.[2] Paraguay's CPR is one of the highest in Latin America; by most sources Paraguay is in the "Top 20" highest CPRs in the world. Section Two provides the context in which to better understand the growth in FP use and evolution of the public-private mix over time.

TABLE 1. PARAGUAY'S FP INDICATORS AT A GLANCE

Indicator	Value
Total Fertility Rate	2.5
CPR for WIU, all methods, %	79.4
CPR for WIU, modern,%	70.7

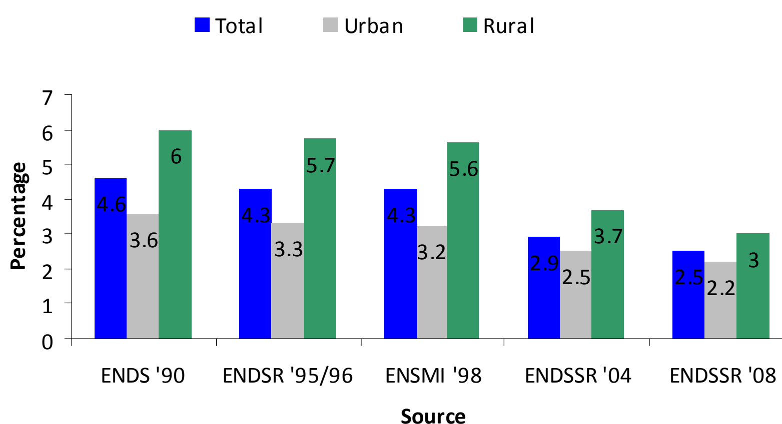
Sources: RHS, 2008

2.1 TRENDS IN TOTAL FERTILITY RATE

Paraguay experienced an important decline in the Total Fertility Rate (TFR) between 1990 and 2008. The Reproductive Health Surveys show that the TFR declined from 4.6 children per woman of reproductive age in 1990, to 4.3 from 1995-1998, to 2.9 from 2001-2004, to 2.5 in the most recent survey.

Graph 1 reveals that geographical differences in TFR have also closed during the last 20 years, with marked acceleration in the last 10 years. In 1990, the TFR in urban areas was 3.6 (see grey-colored bars in Graph 1) compared to a much-higher 6.0 (green-colored bars) in rural areas. However, by 2008 urban TFR was 2.2 while rural TFR was 3.0. This means that on average women in rural areas have only 0.8 more children than women in urban areas in Paraguay.

GRAPH 1. DECLINE IN TOTAL FERTILITY RATE



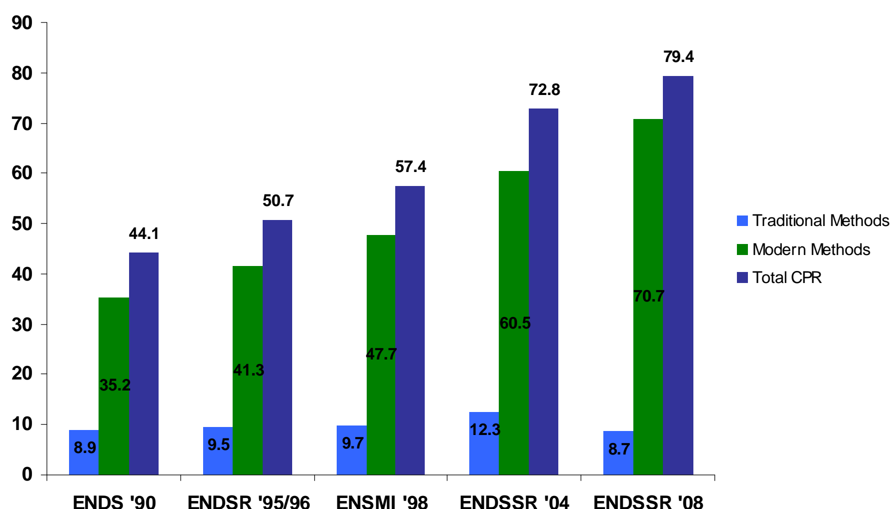
[2] The World Bank, World Development Indicators (2010).

2.2 TRENDS IN CONTRACEPTIVE PREVALENCE RATES

Use of family planning methods underwent equally dramatic changes during the same time period. As Graph 2 shows, contraceptive prevalence among Women in Union of reproductive age (WIU) rose from 44.1% in 1990 to 79.4% in the 2008 survey. The fastest growth period was experienced between 1998 and 2004 when CPR in Paraguay increased by over 15 percentage points from 57.4% to 72.8%. During that time period, CPR was growing on average 2.5 percentage points per year. Growth slowed a bit from 2004 to 2008, as it approached a saturation point, but was still impressive at 1.5 percentage points per year, from 72.8% to 79.4% in just four years.

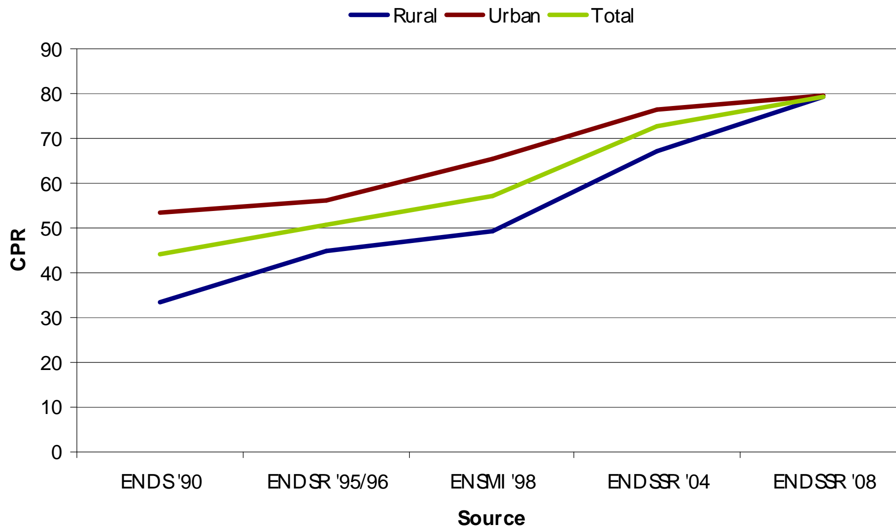
The rapid rise in contraceptive prevalence has been fueled by Paraguayan women choosing modern methods. Graph 2 shows that modern method use (green-colored bars in Graph 2) grew from 35% in 1990 to 70.7% in 2008. Additionally, the 2008 RHS shows that the prevalence of traditional methods decreased from 12.3% among women in union of reproductive age in 2004 to 8.7% in 2008.

GRAPH 2. EVOLUTION OF CPR IN PARAGUAY – WOMEN IN UNION



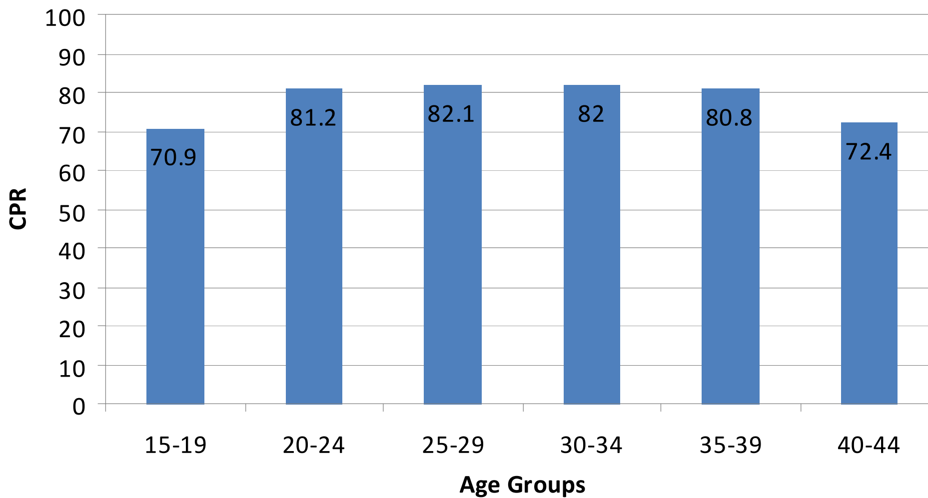
The gap in FP use between rural areas and urban areas has also closed. As shown in Graph 3, contraceptive use in 1990 in rural areas was 33.5% (blue-colored line) while it was 53.3% in urban areas (grey-colored line). In 2008, contraceptive use in rural areas was the same as in urban areas: rural CPR at 79.3%, compared to urban CPR at 79.5%. As shown in Graph 3, total CPR (green line) in 1990 was essentially halfway between urban and rural levels, but by 2008 all three lines merge, as the prevalence levels become equal between the urban and rural user. In Paraguay, where one is located does not seem to influence one's ability to access family planning.

GRAPH 3. EVOLUTION OF CPR (ALL METHODS) – WOMEN IN UNION – TOTAL AND BY REGION



Additionally, Graph 4 demonstrates how evenly spread CPR is across the age groups in Paraguay. CPR is at or above 80% from 20 to 39 years, the heart of the reproductive years, and above 70% in the two outside age groups.

GRAPH 4. CPR BY AGE GROUP, 2008

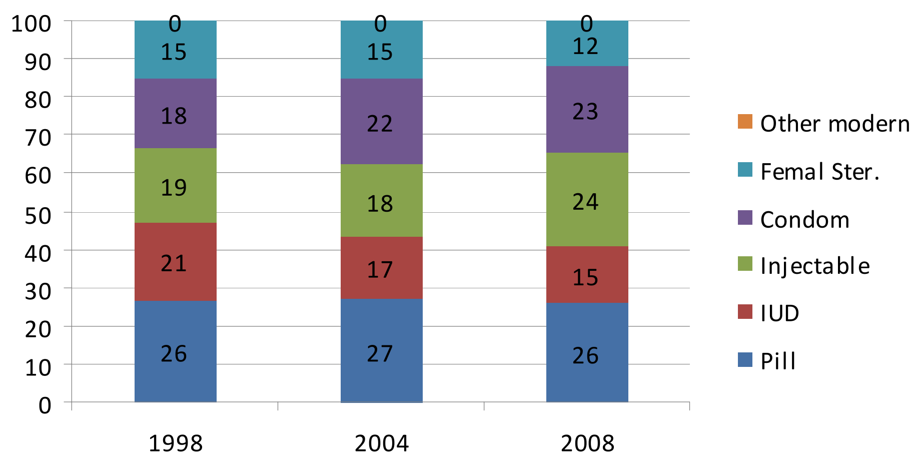


To achieve this landmark success, all sectors of society—rich and poor, rural and urban, young and old—will have had to embrace FP use as a social norm, and providers will have had to respond to consumers' demand across age groups, wealth quintiles and geographic locations.

2.3 TRENDS IN CONTRACEPTIVE METHOD MIX

Graph 5 shows that the method mix for modern methods has changed somewhat over time, notably a shift from long-acting and permanent methods (LAPM), IUDs and female sterilization, to short-term methods. LAPM made up 36% of method use in 1998, but only 27% in 2008.

GRAPH 5. MODERN METHOD USE AMONG ALL WRA

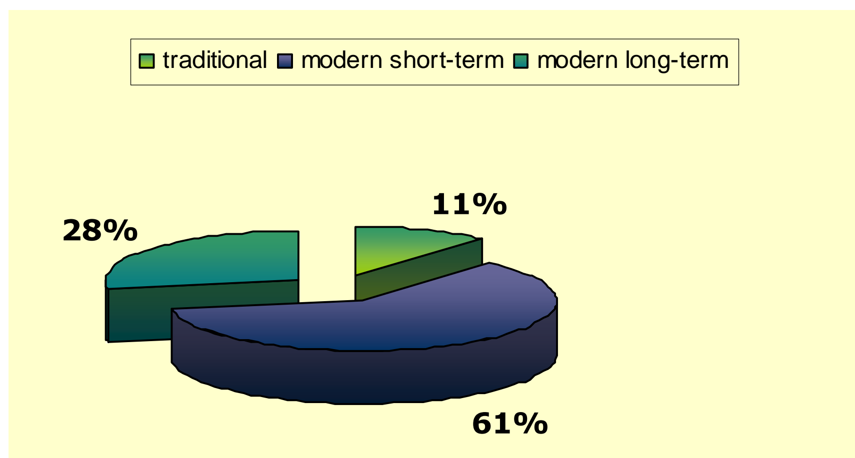


At a quick glance, one can observe that the mix includes many different methods and that no single method has much more than a quarter of the market. While there is no ideal method mix, this balanced pattern is rarely seen in other Latin American and Caribbean (LAC) countries. In Paraguay, five methods are at or above 10% prevalence, whereas typically only three or four methods predominate.

The modern methods that experienced the most growth in their use over the last 10 years were injectables and condoms. The proportion of the user population (all WRA) using injectables grew from 19% to 24%, while the proportion using condoms increased from 18% to 23%. The proportion using pills remained constant at 26%, meaning that pill use grew at the same rate as overall CPR. Looking at both the 10-year and four-year trends, injectables, pills and condoms have been the fastest-growing methods. IUD use has also grown, but at a slower rate than overall CPR, which explains the smaller portion of the overall user population seen in 2008. In 2004, 17% of the method mix was IUDs; this decreased to 15% in 2008. However, female sterilizations not only saw a decrease in their relative proportion of the method mix from 15% in 2004 to 12% in 2008, they also decreased in actual prevalence from 11.5% in 2004 to 9.9% in 2008.

Because the three predominant short-term methods have been growing at a faster rate than traditional methods (declining) or long-term methods (no growth, marginal decline), the overall method mix now slants towards resupply methods. In 2008, more women used the pill (26%), followed by injectables and condoms (24% and 23%, respectively). Graph 6 demonstrates the dominance of short-term methods (61%) over long-term methods (28%) and traditional methods (11%). Short-term method prevalence represented 51% of overall prevalence in 2004. Long-term methods have fairly consistently maintained at around a third of the method mix (33% in 1998, 32% in 2004 and 28% in 2008). The major movement in method mix over the last 10 years has been the decline of traditional methods (from 17% in 1998 and 2004 to 11% in 2008), and the growth of short-term modern methods (from 49% in 1998 to 61% in 2008).

GRAPH 6. 2008 METHOD MIX – TRADITIONAL, SHORT-TERM, LONG-TERM



A strong product-oriented market is generally viewed as favorable by the private sector because it allows for active commercial participation. Paraguay's configuration is beginning to mirror markets in the US and other developed countries. Based on 2002 data, resupply methods made up 56% of the US method mix, while long-acting and permanent methods (LAPM) comprised 38%, and traditional methods made up the remaining 6%.[3] However, vasectomies account for 9 percentage points of LAPM in the U.S. After removing vasectomies from the US method mix, the two markets look quite similar. Products become virtually the same at 61%, LAPM in the US becomes 32% compared to 28% in Paraguay, and traditional methods remain at 6% in the U.S. versus 11% in Paraguay.

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[3] Guttmacher Institute, "Facts on Contraceptive Use," January 2008.

3. ANALYSIS OF CURRENT MARKET SEGMENTATION

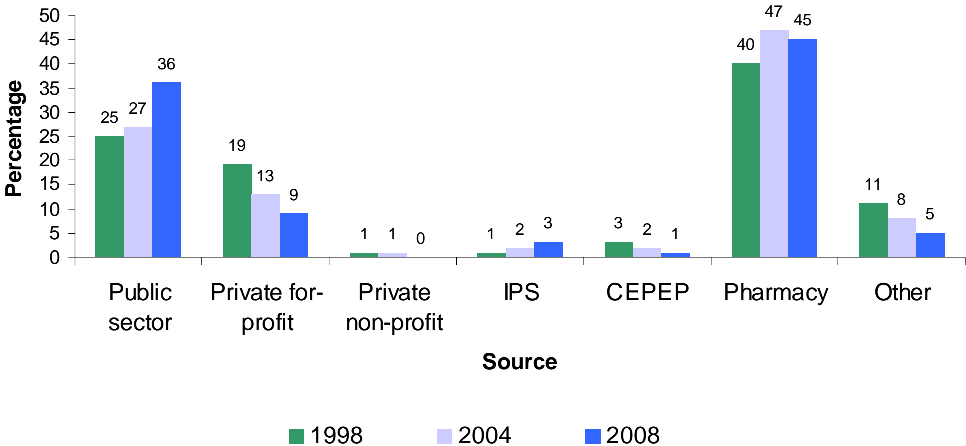
The rapid increase in CPR between 1998 and 2008 was accompanied by noticeable changes in contraceptive sourcing patterns in the same period. Use of public sector services increased relative to those offered in the private sector. This analysis examines the implications of shifts that occurred in the sourcing of methods towards publicly subsidized sources, as opposed to self-financed or insurance-covered sources, and whether current sourcing patterns are appropriate. For example, if a large percentage of middle and high income users avail themselves of services intended for the poor, incentives may be needed to encourage these people to use private sector outlets and services instead.

In order to answer questions around shifting and appropriate market segmentation, SHOPS analyzed the ENDSSR 2004 and 2008 data, looking at whether the changes in method sourcing were due to an influx of new adopters with a need for public sector services, or whether there was a shift among the existing user population from paying for services and products to obtaining them for free. Finally, we examine whether changes in method choice may have resulted in different sourcing patterns.

3.1 SOURCES OF CONTRACEPTIVE METHODS

The 2008 ENDSSR data continued to reflect a preference among Paraguayans for obtaining FP methods in the private sector, especially pharmacies. However, sourcing among all WRA from pharmacies fell from 47% to 45% between 2004 and 2008. Public sector use increased from 27% to 36%, use of IPS services increased from 2% to 3%, and use of CEPEP services decreased from 2% to 1% (Figure 2). There are similar patterns from the WIU population; public sector sourcing increased from 32% in 2004 to 42% in 2008, pharmacies decreased from 50% to 41%, and IPS increased from 2% to 3.5%.

FIGURE 2. SOURCE OF CONTRACEPTIVES AMONG CURRENT USERS (%)



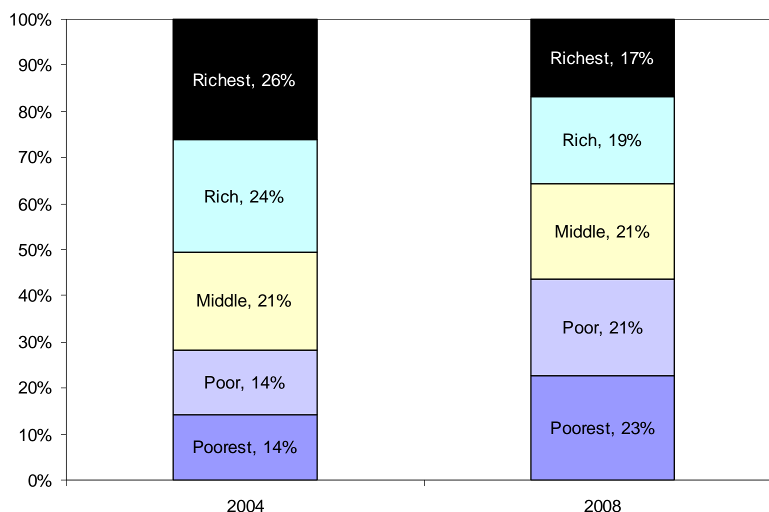
Even though the trend in sourcing is from the private sector toward the public sector, the private sector is still the larger provider of contraceptives in Paraguay. All private sector sources accounted for 55% of sourcing by all WRA in 2008 and the public sector accounted for 39%, with 5% going to "other" (other countries, neighbor or friend).

3.2 SOCIO-ECONOMIC (WEALTH QUINTILES) ANALYSIS

Increases in the use of modern contraceptive methods were experienced across all socio-economic groups. Increases in the poorest and poor income quintiles were greater relative to the middle and higher wealth quintiles. Graph 7 shows the change in the distribution by wealth quintiles of the user population based on faster relative growth in the lower quintiles. Smaller increases are seen in the upper quintiles, mostly likely because prevalence in these quintiles was already high. Rapid growth in the lower income groups demonstrates the program's success in capturing the "late adopter," which is a sign of an advanced market.

These changes are reflected in the socio-economic status (SES) composition of the overall user population. Graph 7 shows how the user population is more evenly spread in 2008 across income groups than in 2004. The two lowest quintiles accounted for 44% of all contraceptive users in 2008, whereas they represented only 28% in 2004. These two quintiles now account for 54% of the pill user population, 43% of the IUD user population, 32% of the injectable user population, 44% of the condom user group and 43% of the sterilization adopter group. These numbers are several percentage points higher than in 2004. It is clear that the overall user group is now "poorer" than it was in 2004 because CPR has increased faster among lower income groups

GRAPH 7. SES CHARACTERISTICS OF MODERN METHOD USERS (ALL WRA)



Method sources within quintiles

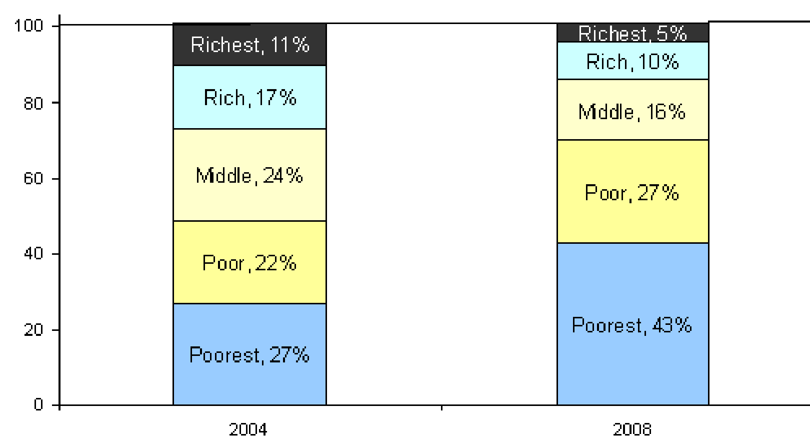
The percentage of users of modern methods obtaining their method from the public sector increased in 2008 relative to those using the private sector. It is important to know where (in which user segments) this change was most pronounced. The following table shows that people in the two poorest quintiles are more likely to obtain their method in the public sector, and it also indicates that they did so increasingly between 2004 and 2008. This tendency may have been intensified by the increased availability of contraceptive products and services at public health centers in the previous four years. On

the other hand, it cannot be argued that middle and higher income users switched to the public sector, because the percentage of people in this group obtaining methods from the public sector has remained constant or dropped. The use of pharmacies, while lower overall, actually increased in the middle and upper quintiles as indicated in Table 2 below.

TABLE 2. SOURCE OF TOP 5 MODERN CONTRACEPTIVES BY WEALTH QUINTILE (ALL WRA)

Source of current method	Poorest		Poorer		Middle		Richer		Richest	
	2004	2008	2004	2008	2004	2008	2004	2008	2004	2008
Public	45	68	40	46	30	27	20	19	12	12
Private for-profit	6	6	8	6	7	8	14	10	24	17
IPS	0	0	1	2	3	2	3	4	3	5
CEPEP	0	0	1	0	2	1	2	1	2	2
Pharmacy	29	22	41	39	49	54	54	60	55	59
Other	19	3	10	7	8	7	6	5	4	6
Total	100	100	100	100	100	100	100	100	100	100

GRAPH 8. SES COMPOSITION OF THE PUBLIC SECTOR USER GROUP (ALL WRA)

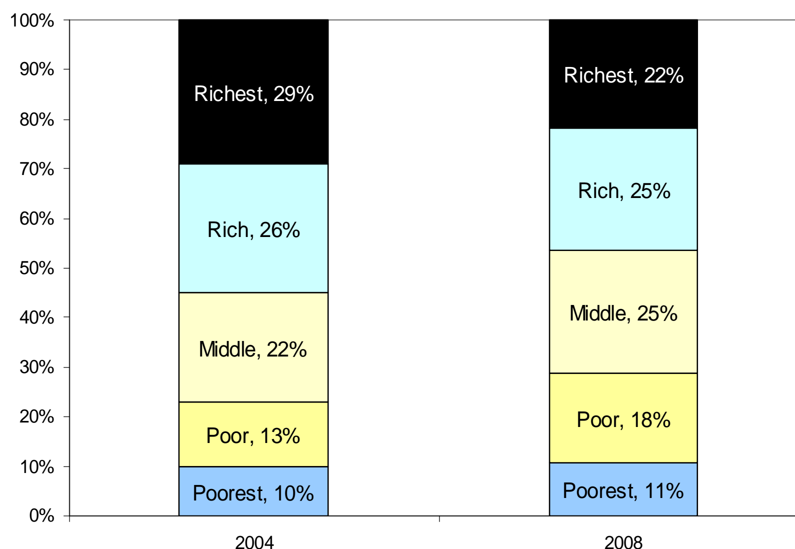


Socio-economic profiles by source

Another way to analyze sourcing patterns is to look at the user profile for each source. As evidenced by Graph 8, the public sector user profile changed dramatically from in a short four-year time period. In 2008, 70% of public sector FP clients came from the poorest two quintiles versus only 49% in 2004. Based on regression analysis conducted by Abt Associates, a poor woman in 2008 was 78% *more* likely to use the public sector than a poor woman in 2004.

The pharmacy user group also looks different in 2008 (Graph 9): it has a higher proportion of low income users (29% versus 23% in 2004), and more middle income users. This reflects the fact that the overall user group includes more low income people in 2008 (Graph 7). Some of the influx of new users from the two lower incomes quintiles did spill over into the pharmacy group. However, both in absolute numbers and relative to other sources, more users from the lower quintiles sourced from the public sector in 2008 than in 2004.

GRAPH 9. SES COMPOSITION OF THE PHARMACY USER GROUP (ALL WRA)



Choice of contraceptive methods within quintiles

The most noticeable changes in method choice between 2004 and 2008 included a *relative* increase in the proportion of the user population that use pills and injectables, and a *relative* decrease in the proportion of the overall user population that use IUDs, condoms and sterilization (although the use of both condoms and IUDs did increase between 2004 and 2008). The use of pills increased the most in the poorest and richest quintiles, likely reflecting the combination of increased availability of commodities in the public sector and intensive marketing investments in this class of product by pharmaceutical companies. Many pill adopters may have been previous users of traditional methods. Traditional methods experienced a significant decrease in popularity, falling from 22% to 10% in the poorest quintile and from 16% to 12% in the richest quintile. Interestingly, the richest quintile now has higher relative use of traditional methods than the poorest quintile, although only slightly higher. Use of injectables increased the most in the two lowest and the middle quintiles.

TABLE 3. CURRENT USE OF CONTRACEPTIVE METHODS BY WEALTH QUINTILE, 2004-2008 (%)

Current method	Poorest		Poorer		Middle		Richer		Richest	
	2004	2008	2004	2008	2004	2008	2004	2008	2004	2008
Modern	78	90	82	90	83	89	86	90	84	88
Pill	30	33	27	25	20	19	16	19	14	21
IUD	11	13	14	12	13	12	14	15	15	14
Condom	12	9	16	20	20	21	24	26	26	26
Injectable	12	23	13	21	16	26	18	22	13	14
Female Sterilization	12	10	12	11	13	10	14	9	15	12
Other *	1	2	0	1	1	0	0	0	0	1
Traditional **	22	10	18	10	17	11	14	10	16	12
Column total	100	100	100	100	100	100	100	100	100	100

*Other modern methods include: vasectomy, vaginal methods, patches and LAM.

**Traditional methods include withdrawal, rhythm method, and billings.

Where people obtain their contraceptive varies by method. Table 4 shows that the poorest and poor quintiles are much more likely to obtain pills in the public sector than other groups. Furthermore, between 2004 and 2008 their use of the public sector to obtain pills increased, and their use of pharmacies decreased. Oddly, the percentage of pill users in the richest quintile who obtained pills in the public sector also increased, though the vast majority still source from pharmacies. Pill users in the middle quintiles actually decreased sourcing from the public sector and increased their use of pharmacies.

TABLE 4. SOURCES OF ORAL CONTRACEPTIVE PILLS WITHIN EACH QUINTILE (ALL WRA)

Source of OCs	Poorest		Poor		Middle		Rich		Richest	
	2004	2008	2004	2008	2004	2008	2004	2008	2004	2008
Public	52.7	70.6	42.3	56.5	33.6	28.2	14.1	14.5	4.5	10.2
Private for-profit	0.2	5.8	3.3	7.8	0.2	6.8	1.3	3.3	5.1	4.8
Private non profit	0.0	0.0	0.0	0.5	0.0	0.0	0.6	0.0	0.0	0.0
IPS	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.7	1.2	0.0
CEPEP	0.0	0.0	0.6	0.0	1.6	1.3	4.4	0.0	1.3	0.8
Pharmacy	40.0	22.1	51.4	33.9	58.9	59.6	75.4	80.1	86.5	84.2
Other	7.1	1.4	2.4	1.3	5.8	4.1	3.6	1.4	1.5	0.0
Total	100	100	100	100	100	100	100	100	100	100

The following table tells a similar story for injectables. Users in the two poorest quintiles were much more likely to obtain this type of contraceptive in the public sector, and did so in greater numbers in 2008. In contrast, the vast majority of injectables users in the middle and upper two quintiles are still obtaining the product in pharmacies—though there was some minimal switching to the public sector, possibly because public health centers offer a three-month injectable, DMPA, that is not available in the private sector (with the exception of CEPEP). The same phenomenon may explain why fewer low-income injectables users than pill users are using the public sector, as monthly injectables are available only in the private sector.

TABLE 5. SOURCES OF INJECTABLES WITHIN EACH QUINTILE (ALL WRA)

Source of ICs	Poorest		Poor		Middle		Rich		Richest	
	2004	2008	2004	2008	2004	2008	2004	2008	2004	2008
Public sector	32.01	42.0	13.72	18.1	7.38	9.4	6.44	5.7	2.43	3.3
Private for-profit	0.47	0.9	0.98	0.0	0.55	1.2	0.85	1.6	0.35	1.3
Private non-profit	*	*	*	*	*	*	*	*	*	*
IPS	*	0.0	*	0.5	*	0.0	*	0.0	*	0.4
CEPEP	0	*	0	*	0	*	0.43	*	0	*
Pharmacy	61.35	44.7	84.27	59.7	86.81	76.0	86.54	79.2	92.37	78.2
Other	6.17	12.4	1.03	21.7	5.25	13.4	5.75	13.6	4.85	16.8
Total	100	100.0	100	100.0	100	100.0	100	100.0	100	100.0

Table 6 shows that most low-income users obtained IUDs from the public sector in 2004 and this preference remained in 2008. However, the middle income group was less likely to obtain IUDs in the public sector, and instead used the private for-profit sector, IPS and CEPEP in higher proportions in 2008 than in 2004. Surprisingly, more users from the rich and richest quintiles respectively obtained IUDs in the public sector, which seems to correspond to a decrease in their use of private for-profit providers. It should be noted that the purchase of IUDs in pharmacies seems to have stopped,

suggesting that this product has become difficult to find in the private sector. More users obtained the method from IPS across all wealth quintiles.

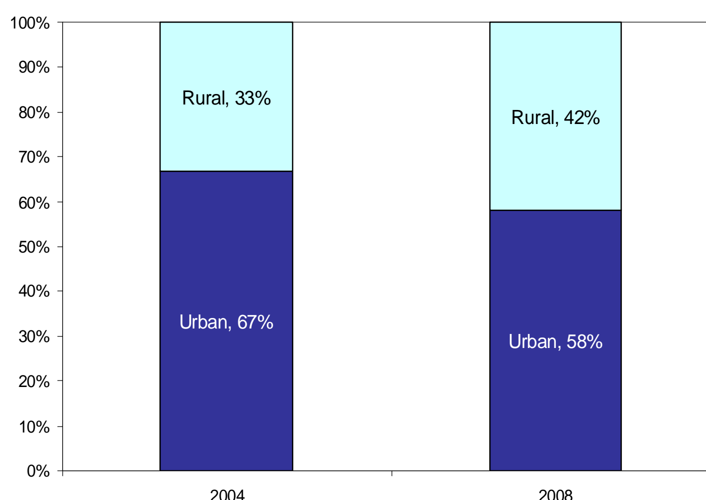
TABLE 6. SOURCES OF IUDS WITHIN EACH QUINTILE (ALL WRA)

	Wealth quintile									
	Poorest		Poor		Middle		Rich		Richest	
Source of IUDs	**2004**	**2008**	**2004**	**2008**	**2004**	**2008**	**2004**	**2008**	**2004**	**2008**
Public sector	92.48	91.05	86.98	86.1	74.42	61.9	29.15	47.07	29.15	32.24
Private for-profit	1.78	4.72	7.21	7.05	15.32	23.15	56.41	31.52	56.41	46.45
Private non-profit	*	0	*	0	*	1.99	*	1.96	*	1.3
IPS	2.54	0	0	3.45	0	4.13	2.35	13.67	2.35	10.83
CEPEP	0	2.44	0.47	1.63	2.47	6.68	2.32	5.78	2.32	7.43
Pharmacy	1.85	*	1.69	*	6.65	*	6.82	*	6.82	*
Other	1.34	1.79	3.65	1.78	1.14	2.15	2.95	0	2.95	1.74
Total	100	100	100	100	100	100	100	100	100	100

3.3 URBAN VERSUS RURAL USERS

Between 2004 and 2008, the number of people using modern methods who came from rural areas increased noticeably. The total user group now includes 42% rural users, versus 33% in 2004. This distribution better reflects the overall population distribution of Paraguay, which is approximately 60% urban and 40% rural, and explains why CPR is virtually the same among WIU from urban and rural areas: 79.5% and 79.3%, respectively. The change is felt across all contraceptive methods. The most significant difference is in the injectables user group: 42% of injectables users are now in rural areas, versus 29% in 2004.

GRAPH 10: URBAN/RURAL COMPOSITION OF THE MODERN METHOD USER GROUP (ALL WRA)



Rural users tend to prefer pills, whereas condoms are the most widely used method in urban areas (note that these data include all WRA, not just women who are in union). Changes in the method mix

between 2004 and 2008 were similar in urban and rural areas. The use of traditional methods dropped significantly, and this decrease may be reflected in increased use of pills and injectables in both groups. Both sterilization and IUD use declined in the urban segment.

TABLE 7. CURRENT USE OF MODERN CONTRACEPTIVES BY URBAN-RURAL RESIDENCE (ALL WRA)

Current method	Urban		Rural		Total	
	2004	2008	2004	2008	2004	2008
Modern method	83	89	82	89	83	89
Pill	16	18	29	31	20	24
*IUD	15	14	12	12	14	13
Condom	23	24	15	15	21	20
Injectable	15	22	13	21	15	22
Female sterilization	14	11	12	9	13	10
Other modern	0	1	1	1	0	1
Traditional method	17	11	18	11	17	11
Total	**100**	**100**	**100**	**100**	**100**	**100**

*Conversely, IUD use among WIU increased from 2004 to 2008.

The increase in users from rural areas relative to urban areas has implications for method sourcing. Table 8 shows that rural residents (who are already more likely than urban users to use the public sector) substantially increased their sourcing of contraceptives from the public sector between 2004 and 2008. Although the use of the public sector has also grown in urban areas, the increase is small relative to rural areas; 4.7 percentage points in urban versus 12.1 percentage points in rural areas. Interestingly, for-profit private providers experienced a decrease in urban areas, while experiencing an increase in rural areas.

TABLE 8. SOURCE OF FP METHODS AMONG RURAL AND URBAN RESIDENTS (ALL WRA)

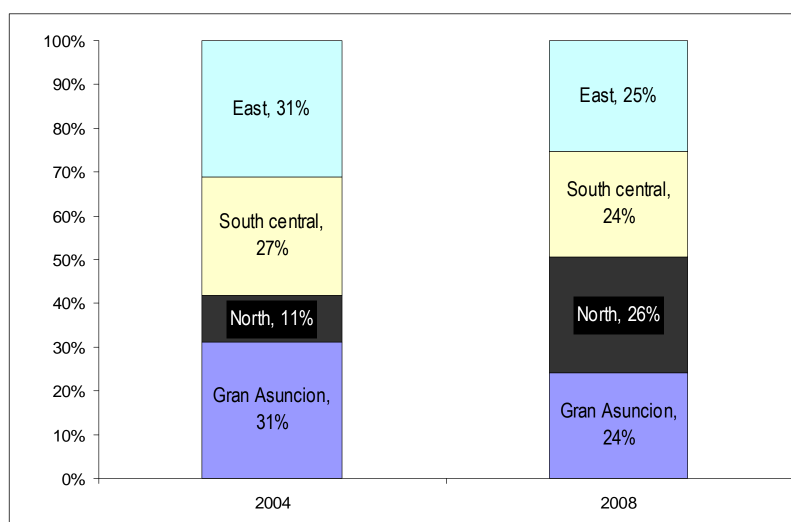
Source of modern methods	Urban			Rural			Total	
	1998	2004	2008	1998	2004	2008	2004	2008
Public sector	17.1	20.3	25.0	37.0	39.6	51.7	27	36
Private for-profit	19.5	16.3	9.8	13.6	5.8	7.9	13	9
Private non-profit	1.0	1.2	0.4	0.7	0.5	0.2	1	0
IPS	1.1	2.8	3.4	0.7	1.0	1.4	2	3
CEPEP	4.8	2.0	1.2	1.2	0.8	0.5	2	1
Pharmacy	48.9	53.2	54.9	27.2	36.0	32.5	47	45
Other	7.5	4.3	5.3	19.6	16.3	5.8	8	5
Total	100	100	100	100	100	100	100	100%

Finally, although the public sector received the biggest increase in rural users—60% of public sector users were from rural areas in 2008, versus only 51% in 2004—all sectors received an influx of rural users. The percentage of rural users went from 16% to 37% in the private for-profit sector, from 17% to 26% in the private non-profit sector, and from 26% to 30% in pharmacies. Even CEPEP and IPS received a higher percentage of rural clients in spite of their urban location and focus.

3.4 REGIONAL PATTERNS

The regional breakdown of the user population is much more balanced across geographies in 2008 than in 2004 (Graph 11). Users reside in Gran Asunción, the Northern, South Central and Eastern region in roughly equal proportions. In 2004, more than a third of all users lived in Gran Asunción and only 11% in the North. The largest subsequent influx of users came from the North. This change most likely reflects progress in making reproductive health services more widely available and affordable in previously underserved areas.

GRAPH 11. REGIONAL COMPOSITION OF THE MODERN METHODS USER GROUP



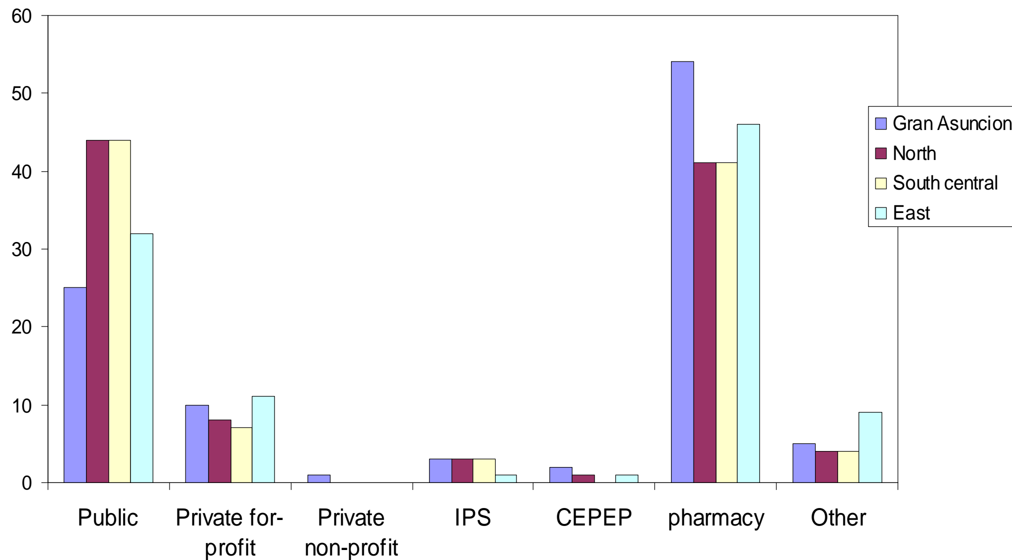
Which methods did new users from the North tend to choose? Table 9 indicates that users from the North generally favor the pill, but the percentage of injectables users in this group increased significantly in 2008 (from 16% to 27%). The use of pills increased most noticeably in the East. As noted before, most of these new users may have previously used traditional methods.

TABLE 9. CURRENT USE OF MODERN CONTRACEPTIVES BY REGION (ALL WRA)

Current method	Region									
	Gran Asuncion		North		South central		East		Total	
	2004	2008	2004	2008	2004	2008	2004	2008	2004	2008
Modern method	83	88	82	91	84	90	83	89	83	89
Pill	14	17	29	28	22	21	22	28	20	24
IUD	18	18	11	10	16	15	9	10	14	13
Condom	25	26	13	15	20	21	20	18	21	20
Injectable	13	18	16	27	14	21	17	21	15	22
Female Sterilization	12	9	12	10	12	11	16	11	13	10
Other modern	0	1	0	1	0	0	0	2	0	1
Column total	100	100	100	100	100	100	100	100	100	100

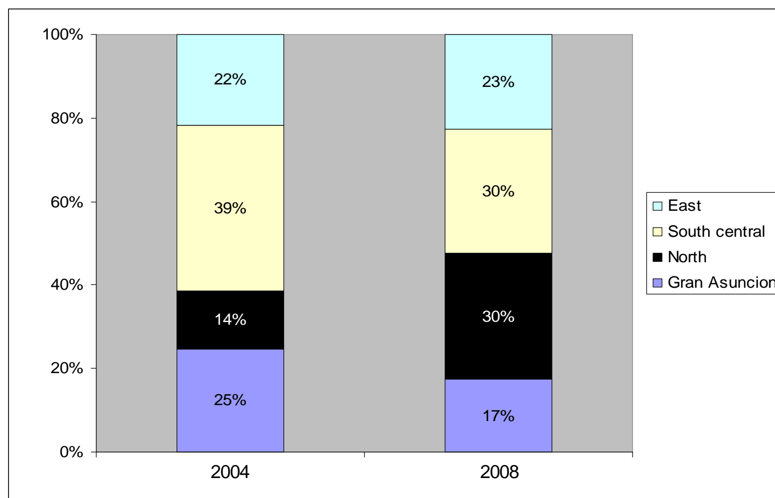
The influx of users from the North is likely to have brought an increase in the use of public sector services. In 2004, 14% of public sector users came from the North, compared to 25% from Gran Asunción and 22% from the East (Graph 13). Users in Gran Asunción are much more likely to obtain methods such as pills, condoms, and injectables in pharmacies.

GRAPH 12. SOURCE OF FP METHODS BY REGION (ALL WRA)

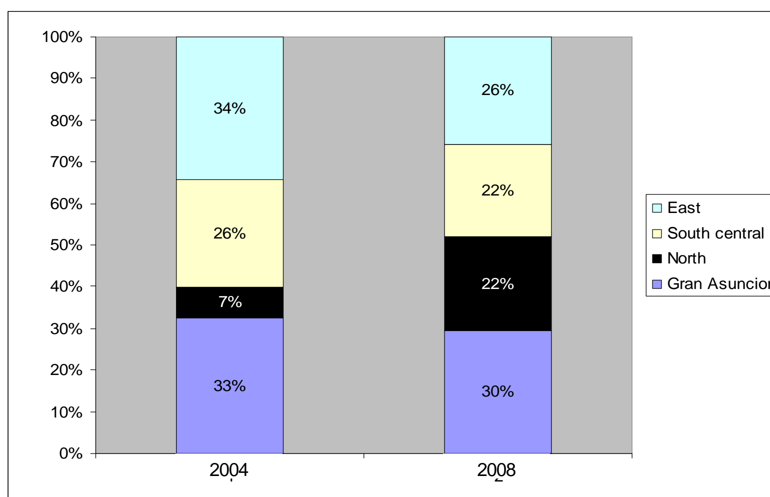


As demonstrated by Graph 12, sourcing patterns are fairly consistent across regions, although there is preference in Gran Asunción for pharmacies over the public sector relative to the other regions. All sources reflect the overall increase in users from the North region. In the public sector, the percentage of users from the North has doubled (Graph 13). In pharmacies, it has tripled (Graph 14), and it also tripled in the private for-profit sector. However, in both sectors the geographic distribution across the four regions is more evenly spread in 2008 than it was in 2004. This is especially seen in the public sector, where in 2004 only 14% of the public sector users came from the North and 39% came from South Central. In 2008 these two regions were the same, both at 30% of the overall public sector user population.

GRAPH 13. REGIONAL COMPOSITION OF THE PUBLIC SECTOR USER GROUP (ALL WRA)



GRAPH 14. REGIONAL COMPOSITION OF THE PHARMACIES USER GROUP (ALL WRA)



3.5 CONCLUSION

Overall, the data show a well-balanced market in terms of method mix, sourcing patterns, and regional distribution. Far from reflecting a trend toward shifting from private to public sources in the user population, the secondary analysis of the ENDSSR 2004 and 2008 suggests the following:

Growth in consumer groups:

- Between 2004 and 2008, Paraguay experienced *an influx of users from the lowest income quintiles, rural areas and the Northern region*. All three segments were *more likely to use the public sector* and may have been encouraged to do so by the increased availability of products and services in this sector.

- However, all sectors, including pharmacies, received more users from lower income quintiles, rural areas, and the North, suggesting that *the private sector has the capacity to serve new users originating from these segments*.

Changes in method mix:

- The *overall increase in the use of pills and injectables* in relation to longer-term methods and traditional methods is reflected in a sourcing pattern that *favors commodity sources* such as health centers, but also pharmacies, which continue to attract most of the users from the middle and upper income quintiles.

- *Method mix among all women of reproductive age improved* from only two methods at or above 10% prevalence in 2004 to three methods in 2008. Method mix among WIU of reproductive age slid marginally, but is still very strong, with five methods at or above 10% prevalence.

Impact on market segmentation:

- There is no indication that the strengthening of public sector provision has had a negative impact on the overall private sector, although some actors within the private sector, such as CEPEP, have lost market share. Additionally, *the growth of the public sector has not negatively affected the market's segmentation.*

- In fact, it could be argued that the segmentation in Paraguay experienced further refinement from 2004 to 2008. A larger proportion of users from the lower two wealth quintiles sourced from the public sector in 2008 than in 2004.

- Additionally, users from these quintiles represented a larger portion of the overall user population. This double effect—*a larger proportion of a larger user population from the lower two quintiles sourcing from the public sector*—explains how rapid growth in the public sector could happen without detrimental effects to the private sector. At the same time, a larger portion of the middle and upper two quintiles sourced from the private sector, specifically from pharmacies. Therefore, in terms of sourcing patterns, *segmentation improved*, not worsened, as the public sector grew.

Areas for improvement:

- As of 2008, the main opportunity visible for improving sourcing patterns in Paraguay is with IPS, since currently only 3.5% of users source methods from IPS, even though IPS covers 18%-20% of the Paraguayan population. This phenomenon creates a market inefficiency effect, because IPS represents a severely underutilized asset in the marketplace in terms of human capital, physical infrastructure and financing.

- IPS is the only significant remaining piece of the puzzle to improve market segmentation in Paraguay going forward. The rest of the strategies should focus on maintaining the current segmentation by assuring the sustainability of the various programs and actors so that Paraguayans continue to have a wide variety of methods, brands, price points and locations to source contraceptives.

4. POLICIES AND POLITICS INFLUENCING THE AVAILABILITY OF FP SERVICES AND PRODUCTS

4.1 POLITICAL COMMITMENT AND LEADERSHIP

The FP program in Paraguay, in its early years, had a checkered history of political support and leadership commitment (see Figure 3). The government of Paraguay (GOP) started its FP program in the **early 1970s.** Due to political opposition during the decade of the 1970s, the government's FP program was limited to promotion of the Billings Methods. The political opposition to FP culminated in 1979, when the GOP suspended all provision of FP services. The Paraguayan IPPF-affiliate, CEPEP (the Paraguayan Center for Population Studies), was the principal provider of modern FP methods during this period.

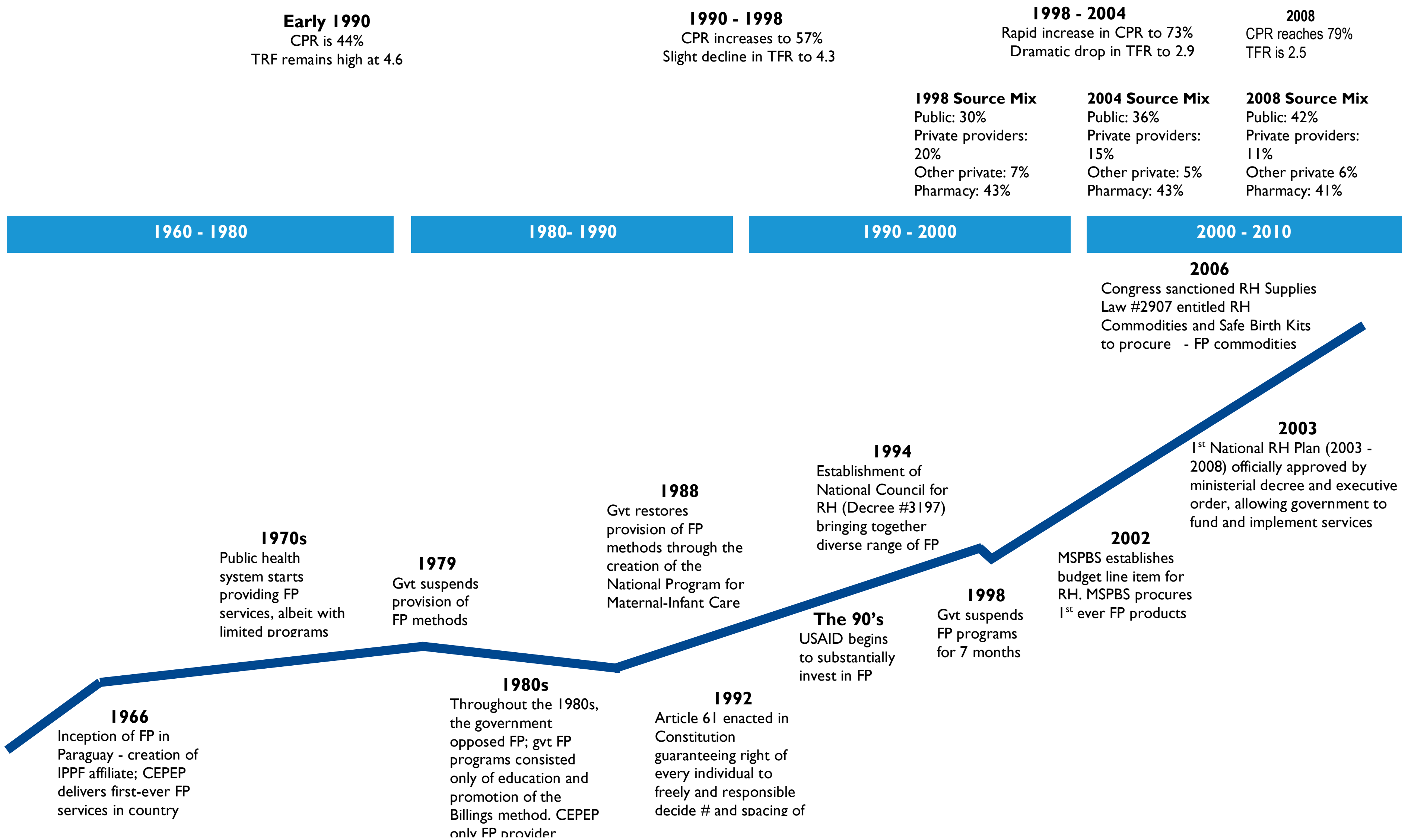
Government opposition to FP continued **until the late 1980s**. The tide in political support began to change when the MSPBS created the National Program for Maternal and Infant Care in 1998, re-establishing government FP services. At the same time, several international agencies, such as United Nations Population Fund (UNFPA), Pan American Health Organization (PAHO) and the United States Agency for International Development (USAID), began investing in reproductive health services including FP. UNFPA and USAID in particular also provided much-needed contraceptives to help build MSPBS FP programs.

The **decade of the 90s** created the policy and institutional framework for FP, supporting further growth in the FP program while creating safeguards to ensure its continuation. The promulgation of Article 61 in the Paraguayan constitution in 1992 was a watershed event. The Constitution recognizes the right of every citizen to freely and responsibly determine the number and spacing of children. The Constitution also guarantees the right to information and adequate services that respond to people's needs. It supports the establishment of a "special reproductive and maternal-child health plan" for low-income groups. The Constitution also provided the legal framework for the government to create, in 1994, the National Reproductive Health Council, through Decree #3197, with the mandate to draft the government's response to FP/RH in Paraguay. This Council brings together a wide range of health sector actors who have a vested stake in FP/RH. Despite the important policy milestones achieved, the steady increase in MSPBS FP services was temporarily suspended yet again following the inauguration of a conservative government in 1998. However, the hostile environment—along with the conservative government—lasted only seven months, and the FP program was restored and has remained in operation ever since.

Political support and leadership for FP continued on an upswing **during the 2000s,** with a series of important policy reforms that laid the foundation for country ownership of FP services and products by providing funding and programming. In 2002, MSPBS included a budget line for the sexual and

reproductive health program. Shortly thereafter, in 2003 the new Minister of Health approved the *National Plan for Sexual and Reproductive Health 2003 - 2008 (PNSSR)*, identifying FP as a priority. This plan also included use of modern contraceptives as a key indicator for measuring the SRH program's success and amount of national budget funds spent to purchase contraceptives as a measure of political and economic commitment.

FIGURE 3. POLICY TIMELINE



In 2006, the government of Paraguay promulgated new legislation entitled the *Law for Funding the RH Program and Provision of Safe Birth Kits,* which earmarks funds to procure RH commodities including contraceptives. This groundbreaking law guarantees full funding for RH and FP supplies based on future projections, thereby ensuring sufficient funding as demand grows. Also, in 2006 the MOH signed a MOU with the UNFPA that set up a procurement mechanism for contraceptives with GOP funds. In 2007, the GOP also signed a three-way MOU with USAID and UNFPA, committing the GOP to assume full financial responsibility for contraceptive procurement.

In 2008, a new political party took the reins of government for the first time in 61 years, ushering in changes in the health sector. The new Minister of MSPBS, Dr. Esperanza Martinez, removed user fees and declared free medical services and medication for all Paraguayans. Key informant interviews revealed that this new policy has had a dramatic impact on the MSPBS: the FP clinics are more crowded and there are longer waiting times. To date there have been no major stock out issues related to FP commodities, but the increased demand has strained supplies; some interviewee informants even mentioned the need to borrow from other MSPBS clinics to maintain stock levels. Others have expressed doubt about the public sector's ability to keep pace with dramatic increases in demand, fearing they will have to turn away clients who are most likely to be poor and underserved.

4.2 ADVANCES MADE THROUGH THE DAIA

The Contraceptive Security Committee—more commonly known in Spanish as the DAIA (*Disponibilidad Asegurada de Insumos Anticonceptivos)* — has played an instrumental role in consolidating political support for FP programs and securing public funds to procure FP commodities. The DAIA Committee was established in 2003. Like its parent, the National Council on RH, the DAIA is composed of representatives from the public, private, NGO sectors and the donor community. Although these legislators are not official members, the DAIA also has strong linkages with influential representatives from both the Senate and House of Representatives, further strengthening its advocacy role in contraceptive security policy. The chair of the committee rotates each meeting, sharing responsibility among all participating organizations.

DAIA

Brings together a diverse group of Paraguayan institutions dedicated to CS including:

- Government institutions related to RH
- NGO sector, CEPEP
- Commercial sector, PSI/Paraguay and the Chamber of Pharmacies in Paraguay
- International donor agencies, including USAID and UNFPA

The DAIA and its legislative allies have achieved several critical policy milestones: i) increasing amounts of public funds allocated to the FP budget line item, ii) additional resources to strengthen MSPBS logistical management capacity, and iii) National Council on RH approval of the Contraceptive Security Strategy and Implementation Plan. The DAIA also played a leadership role in the passage of the *Funding of RH Commodities and Safe Birth Kits Law*. The Paraguayan DAIA's policy achievements surpass any other LAC country efforts to ensure contraceptive security (DELIVER, 2006).

The DAIA remains an active coordinating committee—a major accomplishment when compared to other coordinating bodies in health that have become dormant. With technical assistance from the DELIVER Project, the DAIA developed a CS Strategic Plan (2006-2010) that focuses on advocacy, financing, logistics and access to FP products and services. The DAIA has a small group of active and committed members who continue to meet on a regular basis to address both short-term and long-term CS issues.

The DAIA, however, is at a crossroads and faces two significant challenges in order to fulfill its role of ensuring long-term access to FP services and products. First, the committee is composed largely of and focuses on public sector representatives and issues. Issues that are important to NGOs and the commercial sector—such as taxes and tariff regulation, pricing of FP services, and health insurance—receive little attention in the DAIA meetings. Also, the decision to procure contraceptives exclusively from UNFPA prevents local and international manufacturers from participating in the public procurement process; therefore they have little interest in participating in the DAIA.

Second, DAIA members are primarily operational and technical staff representing their own organizations. Few of the DAIA members are policy makers or decision makers for their organizations, limiting the DAIA's ability to make policy recommendations and suggest changes for the FP sector as a whole.

The DAIA has programmed for this summer an activity to draft a second Five Year Strategic Plan. This planning exercise presents an ideal opportunity not only to celebrate its achievements, but also to explore strategies to increase representation to include a wider range of private sector groups, and to court policy and decision makers to become DAIA members.

4.3 POLICY ENVIRONMENT SUPPORTING PUBLIC AND PRIVATE SECTOR PROVISION OF FP

The SHOPS team focused primarily on identifying policy constraints to private provision of FP products and services given the DELIVER project's prior assessments (DELIVER, 2004; DELIVER, 2006) of the policy environment that provided a comprehensive review of public sector actions regarding family planning obstacles. In general, Paraguay has a favorable policy environment supporting provision of FP services and products no matter the sector—public, private commercial or NGO. This is due in large part to the successful advocacy role of the DAIA as well as increasing government support of FP. Table 10 summarizes the key findings from the DELIVER report that underscore the conducive policy environment for public provision of FP services and products.

TABLE 10. KEY FINDINGS IN PUBLIC SECTOR FP POLICY

	Policy Highlights
FP Services	• Constitution guarantees individual right to decide number and spacing of children. • National Program for Maternal-Infant Care creates mandate for FP services to be delivered in public sector through MSPBS. • National RH Plan makes FP a priority within MSPBS, and allows public resources to be used to implement FP services; MSPBS uses funds to strengthen institutional capacity and to expand FP services to service delivery points nationally. • Regulatory structure permits licensed obstetricians to provide FP counseling, write prescriptions and perform IUD insertions/removals.
FP Products	• Budget line item created to fund FP commodities. • *Law for Funding RH Program and Provision of Safe Birth Kit* earmarks funds to procure RH commodities including contraceptives. • Public-sector purchases can be exempted from public tender processes for "technical reasons" such as price advantage, opening door for 2006 MSPBS procurement agreement with UNFPA.

Policy Highlights
• FP commodities are part of IPS EDL but are not on MSPBS's EDL. This has not presented a barrier to date. • Increased # of OC cycles and condoms allowed per client visit at public clinics

Despite these policy advances in the public sector FP program, some significant challenges remain:

- Although MSPBS has a budget line item in place, funding has not been to maximum levels. In 2003, only 30% of requested funds were allocated to the contraceptive budget line item. The same thing happened again in 2005. Starting in 2005, the MSPBS planned a gradual increase in the budget request for FP contraceptives, with the eventual goal of having 100% of its needs budgeted and funded by the year 2009.
- Continued problems with UNFPA procurements. Unless the "*ley de excepción*" is adopted by the congress, the strategy to procure from UNFPA will not work as a long-term solution for public sector procurement of FP methods. The "*ley de contrataciones*" forbids public sector procurement of drugs from outside the country, and it does not allow for advance payment, which UNFPA requires. If this exception does not go through before election season begins, the MSPBS may need to go to an alternative strategy that includes local tenders.

Similarly, there are few policy barriers to private provision of FP services and products. As Table 11 highlights, there are minimal barriers to entry for private practices, and a range of private providers can deliver FP and prescribe methods. Moreover, the policies and regulations have helped create a thriving pharmaceutical sector that offers a wide range of FP products at different price points.

TABLE 11. KEY FINDINGS IN PRIVATE SECTOR FP POLICY

	Policy Highlights
FP Services	**Positive** • Limited barriers to private practice • Licensed obstetricians are permitted to prescribe FP methods **Minuses** • NGOs are subject to tax • Private health insurance does not reimburse private providers at market rates, causing many private physicians to opt out of medical insurance and charge fee for services
FP Products	**Positive** • Price controls on all pharmaceutical products keep hormonal products affordable • Drug registration process not cumbersome, taking only about 6 months to complete • Do not require proof of bioequivalence, allowing for many low-cost "*similares*" from South America region to enter into the market **Minuses** • Local manufacturers are allowed to own distribution companies and pharmacy chains, creating vertical monopolies that may crowd out independent pharmacies and limit product choice in the long run • The lack of bioequivalence laws makes it difficult to ensure the quality of locally manufactured products

4.4 CONCLUSION – POLICY ANALYSIS

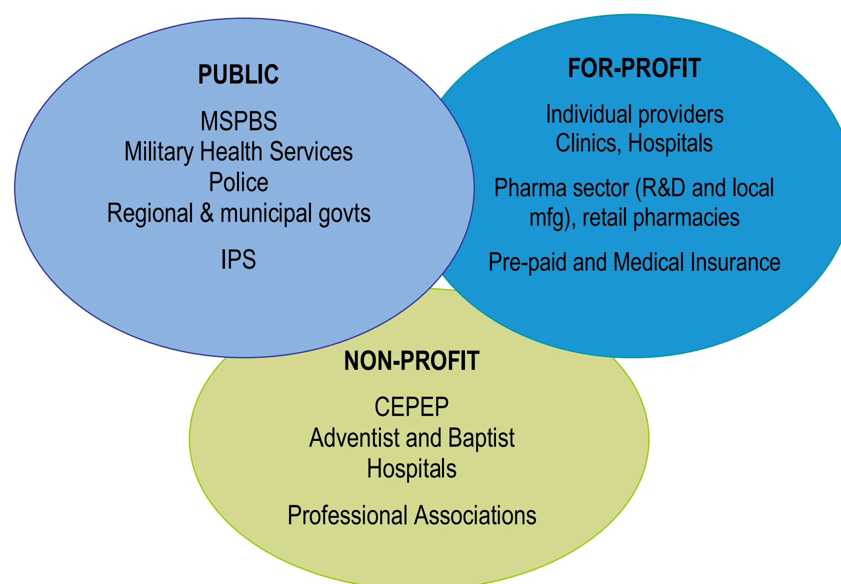
The policy environment in Paraguay is generally supportive of FP, and does not present any particular barrier to a wide range of actors— public, private commercial and NGO alike—playing an active role in delivering FP services and products. What is missing, however, is a vision of how all these groups will work together to continue to deliver FP products and services in a manner that best serves the Paraguayan family. All parties agree that universal access is a desirable goal; what is lacking is a common definition of what universal access means, and more importantly, how to achieve it. The SHOPS team advocates for a whole market approach, which recognizes that consumers have a wide variety of needs and preferences regarding family planning and that providers have a wide variety of resources and comparative advantages. The whole market approach attempts to match providers' comparative advantages with consumer needs so that all needs are met in a manner that is the most efficient at the systemic level. Additionally, it is important that the definition of "universal access" include some element of choice, so that Paraguayans continue to have the array of FP options they currently enjoy, which offers a multiplicity of brands, price points, methods and locations to meet their individual needs. The measure of success will be that universal access increases choice, not sacrifices it.

The policy priority, therefore, in Paraguay is creating a public-private dialogue around inter-sectoral coordination and how to ensure universal access and choice.

5. THE FAMILY PLANNING MARKETPLACE

Both the public and private sectors play active roles in the provision of FP services and products, as illustrated in Figure 4. The public sector is dominated by the Public Health and Social Welfare Ministry (*Ministerio de Salud Pública y Bienestar Social*), followed by the Social Pension Institute (*Instituto de* Previsión Social), and the military and police health services, along with townships and department governments. Section 5.2.1 discusses the dramatic increase in FP coverage during the last 10 years by MSPBS, and the challenges confronting MSPBS in meeting the continued and increasing demand. IPS, on other hand, is positioned to offer FP services to its beneficiaries but faces challenges in re-launching a comprehensive FP program. Section 5.2.2 outlines IPS's challenges and plans to draw its beneficiaries back to IPS for FP services.

FIGURE 4. RANGE OF STAKEHOLDERS IN FAMILY PLANNING



The private sector has a myriad of different actors, including both the not-for-profit and commercial sectors. The principal non-profit actor in the FP marketplace is CEPEP, although it accounts for a small share of the FP market. CEPEP provides services through four directly-owned clinics and a network of affiliated healthcare providers. Some FP services are delivered at religious hospitals, including Adventist, Baptist and Mennonite hospitals. Also included in this group are the different professional associations related to FP that represent health care providers like physicians and pharmacists, health care facilities such as hospitals, and health insurance providers.

The for-profit sector includes a wide range of entities that deliver services, distribute and sell FP products, and finance health services. As in most developing countries, the private sector is composed mostly of individual physicians and other health professionals such as nurses in solo practice. Although most of the these private health care providers serve the top income quintile and accept medical

insurance as a form of payment, increasingly private physicians are opting out of private medical insurance schemes and accepting fee for services (see Section 5.4). Additionally, some private practitioners are serving middle and lower income quintiles, charging lower fees while relying on the increased volume of patients to help recuperate operating costs.

Another important component of the private FP market is the pharmaceutical sector. In Paraguay, the pharmaceutical market is comprised of a mix of multinational Research & Development (R&D) companies and indigenous manufacturing companies. Pharmacies and pharmacy outlets, which are present in all cities, towns and remote rural areas, constitute the primary source for drugs and medicines in Paraguay, including contraceptives. Bayer Schering Pharma is Paraguay's largest supplier of hormonal contraceptives in the pharmacy channel (38.8% of the market in dollar value), followed by local manufacturers that not only produce, but in some cases, also own distribution companies which market their own brands. Section 5.6 describes the pharmaceutical sector as well as the range of FP products available in the private sector. Urban and peri-urban contraceptive users are well served by the pharmaceutical sector, because there is a wide variety of brands available in pharmacies, starting as low as US$1.30 for a cycle of pills and US$1.50 for monthly injectables. IUDs, however, have become scarce in the private market, and the 3-month injectable Depo Provera is only available in the public sector and at CEPEP.

OVERVIEW OF FAMILY PLANNING SERVICE PROVIDERS

5.1 *MINISTERIO DE SALUD PÚBLICA Y BIENESTAR SOCIAL*

Overview: The family planning program at the *Ministerio de Salud Pública y Bienestar Social* is one of its strongest programs, despite a "rocky" start. With donor investment, beginning with USAID focus in the mid-90s and UNFPA donation of commodities, the MSPBS has been able to extend FP services across its service delivery points. The MSPBS FP program also received targeted technical assistance from several USAID-supported projects. Key among them is the DELIVER project, which has helped the MSPBS address many implementation challenges while scaling up its FP services. DELIVER's key intervention focused on: redesigning the MSPBS logistics systems; building FP counseling and clinical skills, and logistics management capacity, among MSPBS staff; improving the logistic and warehouse infrastructure; and removing access barriers to FP (e.g. user fees, hours, etc.—see DELIVER, 2008). In addition, MSPBS also invested heavily in scaling up the FP program, and established core staff at the central level (a five-person team) and regional level (approximately 18 staff) dedicated to managing and overseeing MSPBS's FP program.

The results have been impressive:

- **100 % extension to all service delivery points.** A recent report (DELIVER, 2008) stated that in 2005, 80% of the MSPBS providers cited some form of barrier to their provision of appropriate contraception. By 2008, only 21% said there was a barrier. MSPBS addressed many of the barriers, for example, by increasing hours, removing user fees and generating demand among rural population groups through IEC. MSPBS will continue to "push out" family planning under its new initiative called "*Unidad de Atencion Primaria*"**.** MSPBS launched this strategy last year to extend service coverage to remote populations by opening remote service centers for communities as small as 3,500 people. FP is an integral part of the services delivered through this extension program. MSPBS had opened 179 such sites by January 2010, with plans for an additional 150 this calendar year.

- **MSPBS is fulfilling its mandate to serve the poor.** The text box illustrates the "typical" MSPBS FP client in 2008. It demonstrates that the vast majority (70%) of public sector users come from the bottom two wealth quintiles.

- **Dramatic reduction in stock-outs and leakages of FP products.** Under MSPBS leadership, systems were put into place and staff were trained to ensure an adequate supply of contraceptives in all SDPs (DELIVER, 2008):
    - Eighty-seven percent of all SDPs and 50% of the regions received their supplies in less than one week, while the other 50% received them in less than two weeks.
    - Only 15% of SDPs experienced stock-outs of OCs during the last six months of 2008, compared to almost 30% in 2005.
    - Only 24% of SDPs experienced stock-outs of injectables in 2008, compared to 70% in 2005.

The MOH User in 2008

- Median age: 30
- Parity: 2-3 children (43%)
- Education: less than 2 years (60%)
- Wealth quintile: poorest/poor (70%)
- Residence: rural (60%)
- Region: north/south Central (60%)
- Working: no (65%)
- Most used method: pill & IUD

The advances made in the MSPBS family planning program still face certain challenges, including:

- **Uncertainty over regional staff's continued role in FP**. MSPBS has invested in training and building the regional staff's capacity to supervise FP services and logistics. These staff members have played a critical role in improvements seen throughout the FP program. Although FP has been a primary focus of their job, they do not have a title or job description that officially recognizes their FP responsibilities.

- **Added strain on FP services as a result of MSPBS's new policy** (see below). Since the government of Paraguay declared that all medical services are free, the MSPBS FP program has experienced a dramatic increase in demand, resulting in increased waiting time and internal reshuffling of FP products to meet demand.

- **The MSPBS faces difficulties in procuring contraceptives through UNFPA.** Although UNFPA offers the lowest available prices for FP commodities, the MSPBS continues to experience difficulties in procuring through this mechanism. UNFPA requires the MSPBS pay "up front" for its purchase of a year's supply, which often does not coincide with the government's annual budgeting cycle. To deal with these budgetary constraints, the MSPBS has to request an "exception" to the budgetary process on a yearly basis to secure adequate funds to pay UNFPA. Moreover, there have been problems associated with delays in shipments, incomplete orders and defective products. (Last year IPS received a shipment in which 4,000 IUDs out of 5,000 were defective.) The DAIA, with assistance from DELIVER, has designed a new law to help address the issues around advance payment and procurement from international organizations. DELIVER staff is confident they have sufficient support in congress for this law to pass, but others, both inside and outside of the Ministry, do not share the same level of optimism.

The IPS user in 2008

- Median age: 36
- Parity: 2-3 children (64%)
- Eduaction: 3-5 years (35%)
- Wealth quintile: rich/richest (62%)
- Residence: urban (77%)
- Region: Gran Asuncion/South Central (59%)
- Working: yes (70%)
- Most used method: Female Sterilization

- **Public sector willingness to work with private health sector:** MSPBS leadership states that the Law 1032 passed in 2006 created a *national* health system based on the principles of equity, quality, efficiency and social participation. However, different leaders of MSPBS interpret the law in different ways. There is some variation in the definition of what universal access means and what success in achieving this goal will look like. Some believe the MSPBS has already been quite successful, particularly in reaching the 50% of the Paraguayan population living below the poverty line. Some are concerned that universal health care provision through MSPBS is unrealistic, because many will prefer to seek care with their private and/or NGO health care providers and the Ministry may not have sufficient resources and manpower to deliver on the promise. Furthermore, the private sector also offers a much wider array of product choice, and is likely to keep introducing new methods and brands that will continue to attract a large proportion of users willing and able to pay out of pocket for their methods.

5.2 *INSTITUTO DE PREVISIÓN SOCIAL*

The *Instituto de Previsión Social* (IPS) was created in February, 1943 to offer pensions and health care to Paraguayan workers. IPS is considered to be parastatal and is financed by taxes levied on both employees and employers. IPS health services are available to employees working in the formal sector and their dependents. Currently, IPS has approximately 1.2 million beneficiaries, representing approximately 18% of Paraguay's total population. IPS health facilities are located primarily in cities and towns. In fact, 70 to 80 percent of all of IPS beneficiaries are served in 20 facilities located in Gran Asunción[4]. As Table 12 demonstrates, IPS does not have a comparable infrastructure (size and number) and geographic reach to that of MSPBS.

TABLE 12. COMPARISON OF MSP&BS AND IPS INFRASTRUCTURE

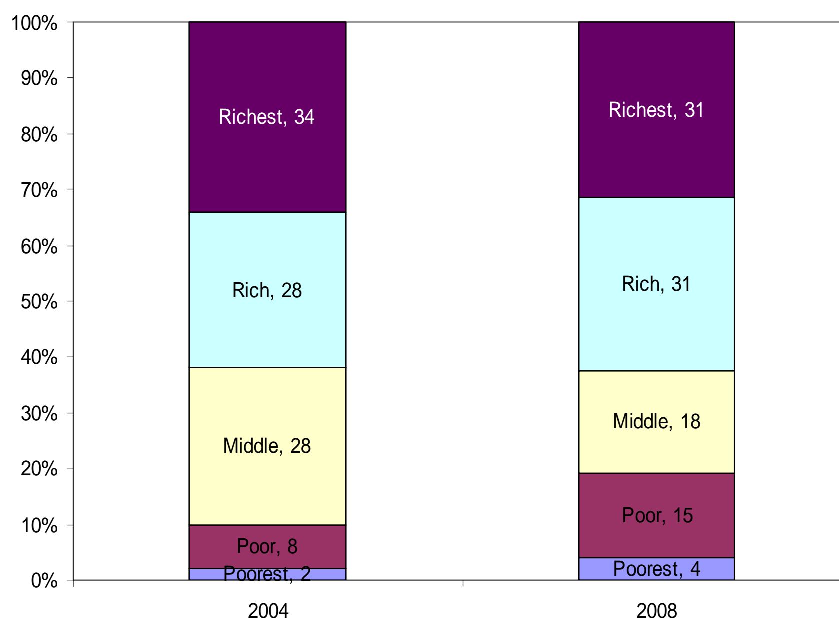
FACILITY TYPE	MOH *	IPS**
Regional Hospitals	17	10
District Hospitals	33	
Specialty Hospitals	10	
Maternal Hospitals	7	
Health Centers	113	30
Health Posts	641	50
Family Health Units	228	
Pharmacies, dispensaries	30	0
Total	1079	90

MOH—Numbers updated January 2010: MOH Health Centers include "Centros de salud" and "Centro especializado," and Family Health Units are Atencion Primaria de Salud (APS).
IPS—Numbers updated February, 2010 on IPS website: Regional Hospitals include hospitals contracted by IPS.

IPS recognizes its responsibility to deliver FP services to its beneficiaries, as stated in the Constitution. In fact, IPS already delivers a modest level of FP services to its beneficiaries. IPS' market share within the FP market has been growing over the past 10 years. In 2008, around 3% of all FP users sought FP services at IPS compared to only 1% in 1998. Additionally, IPS has invested in establishing a full-time position within the institutional structure dedicated to managing the FP program within IPS.

[4] This statistic is for all health services, not just family planning and reproductive health.

GRAPH 15. DISTRIBUTION BY WEALTH QUINTILE OF IPS USER, 2004 AND 2008



The "average" IPS FP user is wealthy, highly educated, and resides in Gran Asunción. The IPS user differs from the typical MSPBS user in age, education, worker status, location and socio-economic status. Graph 15 describes the socio-economic profile of the IPS user population. As can be expected, the majority (almost 2/3) are in the top two income groups. The proportion of IPS user population that comes from the upper wealth quintiles did not change in the last 10 years. However, during this same time period, a larger portion came from the two lower wealth quintiles, as more poor women went to IPS in 2008 than in 2004. The relative proportion of middle income women obtaining their method from IPS declined from 28% to 18%. This may be as a result of the influx of new users from the two lower wealth quintiles into the overall user population and also a large push in Paraguay to get domestic workers and other informal sector workers into the IPS system.

Despite IPS' intention to deliver on the government's promise of universal access to FP, IPS faces many challenges to launching an organization-wide FP strategy.

- The primary obstacle is the **lack of full political commitment** among IPS' top leadership. The IPS FP team states that the new IPS Executive Director supports FP; however there still exists some opposition to FP in high levels of IPS. In addition, there has been a significant turnover in IPS mid-management: the majority is new Directors, who have limited information on the proposal to establish FP in all the IPS facilities.

- IPS also faces **procurement barriers**. IPS no longer receives its FP commodities from MSPBS. According to Paraguayan law, IPS has to procure medical drugs and supplies in the local market. IPS has the authority and capacity to issue public tenders, and has done so in the past for FP products. In 2008 IPS purchased 10,000 injectables that lasted 8 months. In 2009, they issued a tender for IUDs and did not receive a satisfactory response: i) they received only two bids, ii) the proposals did not comply with the tender's specifications, and iii) the price ($4 to $5) was too high. The last tender is symptomatic of the challenges IPS will encounter in the local market. The dollar amount

of the tenders is too small to attract many bidders, and the quantity requested is too small for competitive pricing.

- There is some evidence of **provider bias** against FP and certain FP methods. Interviews and site visits revealed that there are still some IPS physicians and managers who do not agree with offering FP services, despite the widespread acceptance of FP among Paraguayans. The most pressing bias, however, is against certain methods. Many IPS physicians stated a preference for OCs. IPS physicians are more similar to private ones, and are likely to be influenced by pharmaceutical companies' detailing of new, innovative products like Yaz and Yasmin. Also, very few IPS physicians recommend IUDs. The IPS physicians who were interviewed stated that there are few IUDs in stock. Moreover, a limited number of IPS physicians are trained to insert IUDs, requiring the majority of IPS beneficiaries interested in IUDs to go to the Central Hospital.
- **Access** is a major barrier as well. IPS FP services, highly concentrated in Gran Asunción, have limited hours and facilities, particularly when compared to the number of service delivery points in the MSPBS. In both the IPS and MSPBS interviews, the key informants stated that many of the FP clients in public facilities were IPS beneficiaries.

5.3 *CENTRO PARAGUAYO DE ESTUDIOS DE POBLACIÓN*

CEPEP, the Paraguayan Center for Population Studies, was founded in 1966 and has been an integral part of family planning in Paraguay since the beginning. CEPEP has made significant contributions to the evolution of the contraceptives market in Paraguay and continues to be a prominent player, although its market share is declining. In contrast to the MSPBS's waxing and waning of family planning support, CEPEP, through its affiliation with IPPF, has been a steadfast and solid driver of family planning in Paraguay throughout the last 44 years. Similar to the commercial sector suppliers, CEPEP has filled the gap in the absence of a strong public sector family planning program, both during the years of no support and the years of poor implementation. During its peak, CEPEP had 18 clinics, a pharmacy with 44 different medical products, a national network of doctors and licensed obstetricians[5] under a program called "*Profesionales Asociados con CEPEP*" (CEPEP-Affiliated Professionals) or PAC, and a community distribution program with 300 volunteer promoters.

USAID provided technical and financial assistance to CEPEP during a 10-year relationship from 1999 through 2009. The support focused on organizational development (self-sufficiency, management systems and organizational structure), clinical service delivery improvement/expansion (pediatrics, minor surgeries, laboratory), diversification of services (research division), and strategic alliances.

As part of an effort to achieve self-sufficiency, CEPEP underwent a massive operational streamlining process. Many clinics and programs were not sustainable. As a result, 14 out of its 18 clinics were closed and the community distribution program was terminated. CEPEP maintains clinics in the following four locations: Asunción (largest city in Paraguay), San Lorenzo (5th largest city), Ciudad del Este (2nd largest) and Encarnación (14th largest, but borders Argentina). Additionally, CEPEP has a sophisticated laboratory service capable of performing various pathological tests including cytology, serology and bacteriology.

In 2001, CEPEP purchased the building that serves as its administrative headquarters in Asunción. In 2004, CEPEP bought both the clinic in Encarnación and the clinic in Asunción (in front of the

[5] In Paraguay obstetricians are licensed practitioners with four years of post-secondary education. In the medical hierarchy they are above nurses (who have two years of post-secondary education). Gynecologists are medical doctors and are the equivalent of what in the US are referred to as OB/GYNs.

administrative headquarters). The purchase of the Asunción site has led to a clinic-level cost-recovery rate of over 100% (see table). However, in Encarnación the cost-recovery rate is still low at 88%, considering that there is no rent payment involved in operating the clinic.

2009 Cost-Recovery Rates, by Revenue Center	
Asunción	102%
San Lorenzo	91%
Ciudad del Este	87%
Encarnación	88%
Lab	67%

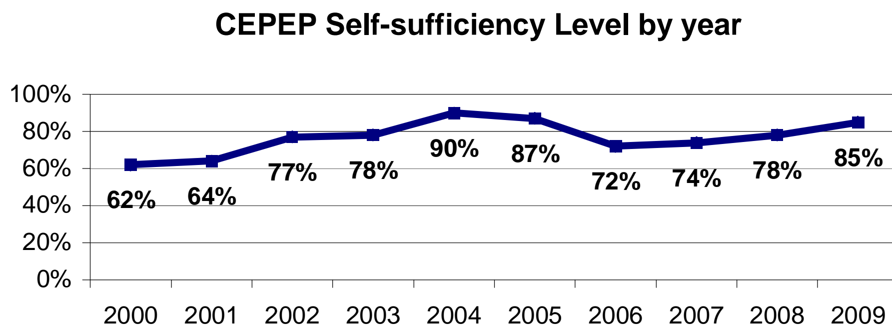
CEPEP is still renting its space in both San Lorenzo and Ciudad del Este. The San Lorenzo facility is by far CEPEP's busiest and largest. This clinic had a cost-recovery rate of 113% prior to the installation of a surgical suite for sterilizations when it experienced a large drop. This is mostly due to the low volume of sterilizations, and an informal referral system from MSPBS that sends interval sterilizations clients to CEPEP, but does not include any reimbursement mechanism for CEPEP to recover its costs. Additionally, space was reallocated for the surgical suite, and doctors' workloads have shifted accordingly. San Lorenzo is the industrial center of Paraguay, and CEPEP's San Lorenzo clinic is the heartbeat of the organization. Transition support and technical assistance to CEPEP need to focus on returning the San Lorenzo clinic back to its prior cost-recovery levels. Ideally, all five revenue centers should be achieving over 100% cost-recovery in order to contribute to the organization's indirect costs (i.e. contribution margin). Any clinic (or lab) under 100% cost-recovery is in fact a cost-center, not a revenue center. There are cases where an organization may elect to maintain a clinic that is under 100% cost-recovery for strategic reasons (e.g. market share, mission purpose, etc.). However, a sustainable organization in a graduation process should have a revenue center average above 100%.

Currently, CEPEP does not have a cost center type accounting system, so it is difficult for the organization to assess the financial sustainability of a horizontal program, such as family planning consultations versus pre-natal care, etc. CEPEP's accounting system can assess the cost recovery of a given clinic (a vertical assessment), but cannot assess the cost-recovery or contribution margin of a particular product or service across its locations. This makes it difficult for the organization to make strategic investment decisions. This barrier is addressed in recommendations below.

At the organizational level, CEPEP peaked in 2004 with an overall self-sufficiency rate of 90%.[6] In this year, the family planning program had its highest volume at 11,902 family planning consultations. This was mostly due to a large stock-out issue in the public sector. It was also the third strongest year for CEPEP's pre-natal program, with 15,999 pre-natal check-ups performed. This led to CEPEP's strongest financial year of the last 10 years (Figure 5 below). By 2009 CEPEP had achieved an overall level of 85% self-sufficiency, 5 percentage points above the goal set out by its agreement with USAID.

[6] Percent of total annual operating costs covered by program income.

FIGURE 5. PROGRESSION OF CEPEP'S SELF-SUFFICIENCY OVER THE LAST 10 YEARS



CEPEP currently does not have a social marketing program, and only sells contraceptives (procured through ICON) through its clients and a very small number of remaining PACs. For the following reasons the SHOPS assessment team does not see a clear opportunity for CEPEP to branch out into social marketing.

1. Strength of both the commercial private products sector and PSI/Paraguay in the marketplace. The current marketplace is vibrant, with 2-3 brands at each price point of low, medium, and high. There is no clear entry point based on price or method diversification, aside from possibly a commercial three-month injectable. CEPEP is the only supplier of DMPA outside of the MSPBS.
2. CEPEP is struggling with procurement and supply issues with its current low, clinic-based volume, due to issues with ICON. A social marketing program would exacerbate these issues.
3. Based on CEPEP's current legal status, CEPEP cannot sell through the pharmacy chain, so it would be extremely difficult to make an SM program viable without changing CEPEP's legal status.
4. CEPEP does not have the available funds to invest in detailing as do the large pharmaceuticals, and so would have difficulty competing with commercial brands.
5. Because CEPEP has not previously distributed its own brands of contraceptives, it would have to spend considerable marketing efforts to position itself in the mind of the consumer relative to well-established existing brands.

The CEPEP user in 2008

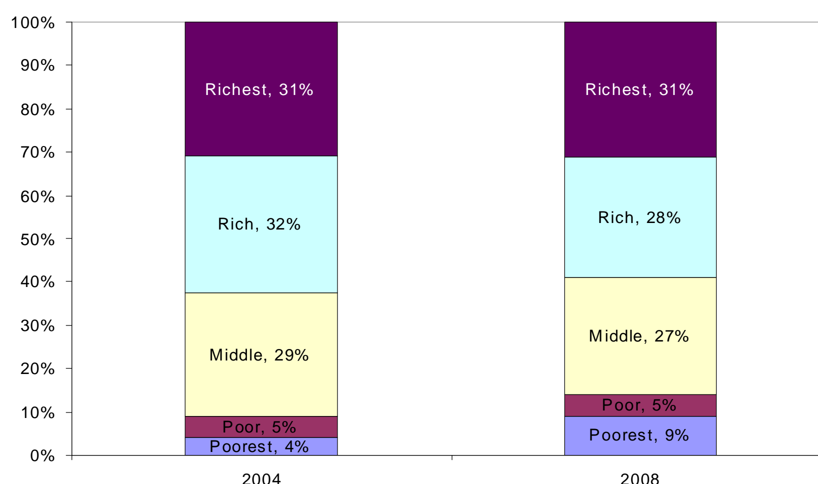
- Median age: 31
- Parity: 2-3 children (69%)
- Eduaction: 3-5 years (59%)
- Wealth quintile: rich/richest (59%)
- Residence: urban (76%)
- Region: Gran Asuncion (48%)
- Working: yes (49%)
- Most used method: IUD

The SHOPS assessment team discussed this reasoning with CEPEP's senior management team, which agreed that social marketing is not a priority investment area for the organization. However, CEPEP does still face a supply issue as ICON ceases operations. CEPEP's market niche seems to be that it is the only player on the market that offers all contraceptive services and products. Its ability to provide the "one-stop shop" offering to the market (products, clinical services and information) is key to its market positioning. This strategy needs to be validated/refined during a market study.

Who is the CEPEP client?

Although CEPEP aims to serve lower-income populations, CEPEP's clientele is predominantly from the three higher wealth quintiles (Graph 16). In fact, in 2008, 86% of CEPEP users came from the three highest wealth quintiles. This is fairly consistent with the 2004 numbers, where 92% of CEPEP users came from the top three quintiles. There is a slight increase in users from the poorest quintile, from 4% in 2004 to 9% in 2009. However, in both years the vast majority of CEPEP users came from the highest three quintiles. Interestingly, most of the uptake in the public sector from 2004 to 2008 has been from the lower wealth quintiles. This bodes well for CEPEP's prospects to retain its core customer base with appropriate targeting and promotion, as it does not appear that the ministry is attracting the average CEPEP user. However, in general CEPEP has not been growing at the same pace as the overall contraceptive market.

GRAPH 16. DISTRIBUTION BY WEALTH QUINTILE OF CEPEP USER, 2004 AND 2008



Changes in the environment

One characteristic of sustainable organizations is their ability to recognize major changes in their operating environment and their ability to adapt appropriately to these changes. Changes are constant, so organizations that can survive change have a favorable future outlook. CEPEP currently has two enormous changes affecting it: a stronger public sector and the USAID family planning support graduation process. Arguably, the combination of these two hitting at once could be conceived as the biggest challenge for CEPEP in its 44-year history. The public sector family planning program began achieving visible results in 2006 (e.g. reduced stock-outs, government procurement of contraceptives, etc). CEPEP's financial performance took a downturn during the same time from its peak 2004 levels. Additionally, CEPEP has experienced a decline in market share since 1998, when almost 4% of all users sourced from CEPEP, to 2008, when only 1% of all users sourced from CEPEP.

CEPEP's strength is affordable service provision, with the most comprehensive market offering in the private sector (i.e. "one-stop shopping"). Because Paraguay's rapid contraceptive growth has been in the product market, this has driven CEPEP's diminishing market share, relative to product suppliers from both the public sector and the private, commercial sector. Simultaneous to diminishing market share, CEPEP is losing support from USAID. Although CEPEP hasn't received support from USAID for as long as some other family planning associations, USAID has been an important leg to CEPEP's stability in the last 10 years in terms of both technical assistance and financial support.

In addition to these changes, CEPEP is still adjusting to the 2006 Fiscal Reform, which eliminated tax-exempt status for non-profit organizations in Paraguay from both value-added tax and customs duties. This negatively impacted CEPEP's overall cost of goods sold (COGS).

In order to adjust to the drastically different operating reality, CEPEP will need to play to its niche by positioning and targeting its market offering in order to retain enough market share to cover its costs and become self-sufficient. This will be tricky for CEPEP, because the overall trend in Paraguay is towards resupply methods, which is not CEPEP's competitive advantage. However, CEPEP is practically the only provider of family planning consultations in the private sector, and has strong market share in terms of the provision of information.

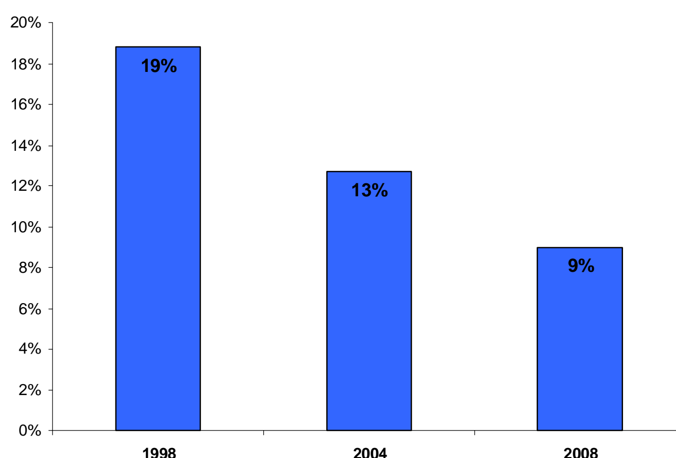
5.4 PRIVATE FOR-PROFIT PROVIDERS (SERVICE AND INSURANCE)

The private commercial providers in Paraguay include OB/GYN medical doctors, licensed obstetricians, maternal-infant nurse technicians and traditional midwives. Only licensed obstetricians and OB/GYN doctors are legally allowed to prescribe hormonal contraceptives. Both are also allowed to insert and remove IUDs. Obviously, only OB/GYN medical doctors can perform sterilizations. Generally, the OB/GYN doctors are male and the licensed obstetrician is female. Industry practice, especially in urban areas, is that the licensed obstetricians and OB/GYNs practice together. When they are practicing together, the licensed obstetrician provides counseling (when it is provided) and assists the doctor with procedures (mostly deliveries), but generally does not write prescriptions or perform IUD insertions/removals on her own, even though she is allowed to legally. In the rural areas, it is more common to see the licensed obstetrician running her own practice. There are approximately 800 -1,000 OB/GYN medical doctors and 2,000-3,000 licensed obstetricians in Paraguay. The association of licensed obstetricians (*Obstetras de Paraguay*) has 800 members. The OB/GYN society (*Sociedad Paraguaya de Ginecología y Obstetricia*) has 450 members.

Licensed obstetricians must re-certify every five years with the MSPBS. However, the process is quite weak and consists only of "re-presenting" their degree title. The OB/GYN society requires a much more rigorous process than MSPBS for its members, requiring each doctor to receive 100 points in continuing education. Those who do not reach 100 points during the five-year period are required to take an exam in order to re-certify. The association of licensed obstetricians could implement a similar program for its membership. During several interviews with licensed obstetricians, there was still a surprising inconsistency in information provided regarding contraceptives (e.g. number of times per year emergency contraception could be used, safety of IUDs, etc). In terms of family planning sourcing, the majority in the for-profit provider category are clinic-based small group practices. Individual providers account for only 2.7% of the contraceptive market in Paraguay. Private hospitals, such as the upscale La Costa Hospital in Asunción, and "*sanatorios*" (clinic-based small group practices) account for 8.1% of the market.

For-profit private providers overall do not have a large share of the family planning market in Paraguay, and increasingly their portion is becoming smaller (Graph 17). In both urban and rural areas there has been a significant decrease over the last 10 years in sourcing from the for-profit private providers. In urban areas sourcing from this group decreased from 19.5% in 1998 to 9.8% in 2008. In rural areas the decrease went from 13.6% in 1998 to 7.9% in 2008.

GRAPH 17: PERCENTAGE OF USER POPULATION THAT SOURCES FROM FOR-PROFIT PRIVATE PROVIDERS



This trend may be a result of a strengthened program in the public sector, which has improved supply in public clinics and decreased the leakage that may have been a supply vein for private providers previously. An additional factor, based on interviews with consumers and private providers, is that many women do not seek a family planning consultation in and of itself. It appears most women sourcing from the commercial sector go directly to the pharmacy. Private providers consistently said that the vast majority of contraceptors in their client population were first their client during pregnancy, and that family planning counseling was performed as part of the pre-natal visit regimen and then the client began using a contraceptive after delivering with the provider. The other initial point of contact with private providers was as a result of improper self-management of contraceptive use, which had led to amenorrhea or irregular bleeding. Private providers indicated that they have seen an increase in these cases, especially related to the use of emergency contraception. The assessment team heard many accounts from pharmacies, private providers and CEPEP of increased use and possible overuse of the emergency contraceptive pill in Paraguay. Several pharmacists said they have seen the same person purchase the emergency pill five or six times in one year.

The Private Sector user in 2008

- Median age: 33
- Parity: 2-3 children (54%)
- Education: 3-5 years (28%)
- Wealth quintile: rich/richest (52%)
- Residence: urban (63%)
- Region: Gran Asuncion (29%)
- Working: yes (49%)
- Most used method: Female Sterilization & IUD

An additional explanation for the decrease in sourcing from commercial providers is that the majority of private "pre-paid" health insurance plans do not cover contraceptives. According to the Paraguayan OB/GYN Society approximately 40% of Paraguayans have some type of private health insurance. In fact, there were many accounts of IPS beneficiaries who purchase private, pre-paid health insurance on top of their IPS coverage because they are dissatisfied with IPS services[7]. Many plans cover "prescription medicine" up to a certain maximum, although it is unclear whether hormonal contraceptives would

[7] This is in reference to all IPS services, not necessarily family planning or reproductive health.

count under this benefit. Additionally, almost all of the plans cover gynecological visits, including one pap smear per year. These visits could potentially include a family planning consultation, but as mentioned above, that is not a common practice.

At the same time, private OB/GYNs have been significantly under reimbursed by the health insurance plans—so much so that the OB/GYN Society, leveraging its membership, forced a hard negotiation with insurance carriers to accept across-the-board rate increases. Eighty-two percent of the carriers accepted; the providers walked away from the insurance carriers that did not.

Interestingly, the oral contraceptive is the one exception to the trend of movement away from commercial providers. In 2004, only 2% of pill users sourced from for-profit private providers, whereas this percentage increased to 6% in 2008. This could be a result of detailing efforts by pharmaceutical companies and sample stocks.

5.5 CONCLUSION—SERVICES

The service providers have not benefited from the rapid growth of the Paraguayan contraceptive market to the same extent that providers of resupply methods have. Both CEPEP and commercial providers have experienced decreases in their market share. In 1998, the NGO and commercial providers accounted for 20% of the sourcing of all users; this had decreased to only 11% by 2008. Additionally, the tendency towards short-term methods is seen in the 2008 method mix, where 61% of users were using a short-term, resupply method.

Both IPS and CEPEP were fairly insignificant in the marketplace in 2008, and could benefit from repositioning strategies in order to gain or regain their market share. Additionally, commercial providers generally are not seen as a source for family planning unless connected to a pregnancy event and/or a medical issue related to self-management of contraception. This leaves some opportunity to reposition the commercial private provider as well, by improving counseling and taking advantage of points of interface with the consumer.

Overview of the pharmaceutical sector

The pharmaceutical market in Paraguay is composed of a mix of multinational Research & Development (R&D) companies and domestic manufacturing companies. Paraguay's thriving local pharmaceutical industry is increasingly supplanting foreign suppliers in meeting the country's drug needs. Locally owned companies now meet 70% of domestic consumption, and have begun to export their products to other countries in the region.

Paraguay's pharmaceutical industry resembles those of other South American markets (Brazil, Argentina, and Chile). Local manufacturers produce few original drug formulations, and typically market copies of formulations developed by R&D companies. It is important to note that South American manufacturers usually do not produce generic products (which require stringent bioequivalence studies) but *similares*, or products that merely contain the same active ingredients and are administered according to the same indication as originator products. Thus it is possible for Paraguayan and other companies in the region (Chile, Argentina) to manufacture copies of existing products without investing in costly bioequivalence studies. *Similares* are not authorized in the US or other highly regulated markets such as Western Europe and Japan. As a result, these products typically cannot be exported outside the region.

Another common occurrence in the South American region is the tolerance of patent infringement practices. Local manufacturers copy not only off-patent products but also formulations owned by (R&D) companies that are still under patent protection. As a result, knockoffs of high-margin patented products are sometimes introduced prior to the registration of the originator brand. A 1998 Memorandum of

Understanding and Enforcement Action Plan with the US that called for intellectual property rights protection and measures against counterfeiting has not been fully enforced, and piracy levels in Paraguay remain high.

The pharmacy sector in Paraguay is becoming increasingly concentrated and competitive. Manufacturers are allowed to own distribution companies and retail pharmacies, leading to vertically owned pharmaceutical supply chains. According to CAFAPAR, Paraguay's pharmacists association, the percentage of independent pharmacies has been steadily decreasing. In 2009, pharmacy chains accounted for 23% of overall pharmaceutical product sales, and independent pharmacies accounted for 53% of the market[8]. Urban consumers increasingly purchase medicines from manufacturer-owned pharmacy chains that offer discounts but may not carry brands made by a competing manufacturer.

5.6 THE CONTRACEPTIVE MARKET

Nearly half of all contraceptive products used in Paraguay are sold through commercial pharmacies. In 2008, pharmacies served 45% of all WRA, including 49% of pill users, 70.6% of condom users, and 67.8% of injectables users. Pharmacies attract over 50% of users from middle and upper income quintiles, and this percentage has increased substantially in 2008 from 2004 levels. In contrast, users from the two poorest quintiles are now less likely to obtain their contraceptives from pharmacies than they were in 2004. The cause for this slippage is most likely the improved availability of contraceptives in the public sector.

In some areas of Paraguay a social pharmacy program (*Farmacias Sociales*) provides basic drugs and medicine at prices lower than those offered by commercial pharmacies. The program is implemented by local governments with support from USAID/Paraguay and technical assistance from CIRD, a local NGO. Social pharmacies are financed through rotating funds initiated with seed capital from the regional governments, and are sometimes housed within public sector facilities. PSI/Paraguay reports limited sales of oral contraceptives to social pharmacies in the department of Itapúa. However, the ENSMI does not distinguish between these and commercial pharmacies and it was not possible to determine the proportion of users obtaining their contraceptives from this source.

The contraceptive market includes hormonal contraceptives, condoms, and IUDs. These three markets involve different actors and respond to different influencing factors. The hormonal contraceptive market, which includes oral contraceptives (OCs), injectable contraceptives (ICs) and emergency contraception (EC), was valued at US$ 5.7 million in 2010. It is the third largest segment of the pharmaceutical market, representing 3.27% of overall industry sales revenue in 2009.[9] The largest supplier is Bayer Schering Pharma, with controls 39% of the market (in dollar terms). Gynopharm, a subsidiary of the Chilean company Recalcine, which mostly produces copies of Bayer Schering brands, represents 19% of the market. Population Services International (PSI), a social marketing organization registered as a commercial entity in Paraguay, is third, with 11%.

The hormonal market, which includes oral, emergency and injectable contraceptives, has grown substantially since 2004. The most significant spike in sales occurred in 2008 where the market increased by 61% in value (and 37% in volume). In 2009, sales flattened and registered a 1% decrease from 2008 in terms of value, but a 10% increase in volume.

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[8] Source: IMS Paraguay. December2009.
[9] Source: IMS Paraguay, December 2009.

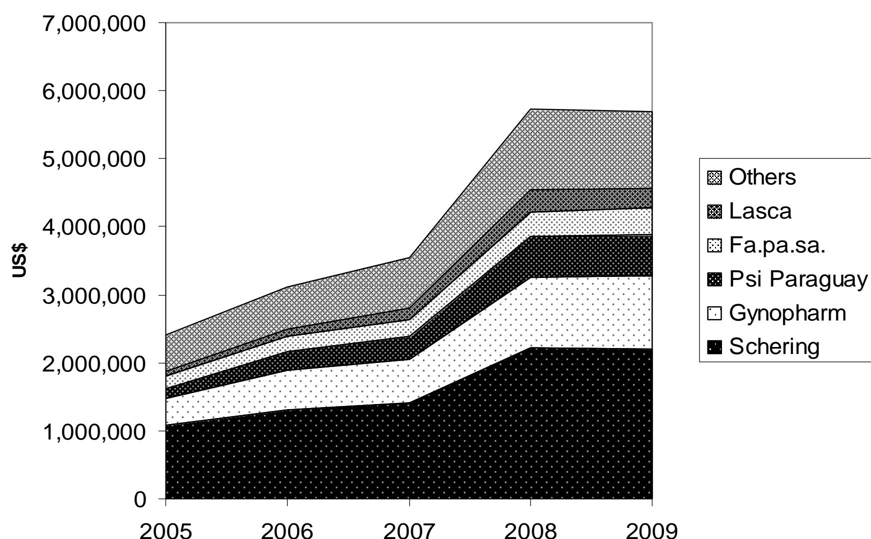
TABLE 13. SALES IN DOLLARS OF HORMONAL CONTRACEPTIVES, 2005 - 2009

	2005	2006	% growth	2007	% growth	2008	% growth	2009	% growth
Schering	1,078,447	1,312,248	**22%**	1,415,988	**8%**	2,226,696	**57%**	2,211,979	**-1%**
Gynopharm	398,510	583,500	**46%**	634,965	**9%**	1,031,583	**62%**	1,072,138	**4%**
PSI/Paraguay	145,757	255,034	**75%**	346,292	**36%**	615,212	**78%**	604,706	**-2%**
Fa.pa.sa.	176,688	229,310	**30%**	239,833	**5%**	350,768	**46%**	393,560	**12%**
Lasca	80,232	120,384	**50%**	167,588	**39%**	328,370	**96%**	296,394	**-10%**
Others	519,825	610,396	**17%**	751,951	**23%**	1,179,537	**57%**	1,122,191	**-5%**
Total Selected	**2,399,459**	**3,110,872**	**30%**	**3,556,617**	**14%**	**5,732,166**	**61%**	**5,700,968**	**-1%**

There was, however, no significant change between 2005 and 2008 in the respective market shares of the different companies marketing hormonal contraceptives. All suppliers appear to have benefitted almost equally from the remarkable growth of the market during that period.

The dominance of the pharmaceutical market by local and regional manufacturers, together with Paraguay's high contraceptive prevalence (79.4%), has led to the proliferation of hormonal contraceptive products in Paraguay. Twenty-two different companies are involved in the manufacturing and marketing of contraceptives in the country, though most make only one product (typically an IC or EC product). No less than 28 brands of OCs, 16 brands of ICs, and 8 brands of EC pills are currently sold in Paraguayan pharmacies, mostly over the counter.

FIGURE 6. MARKET SHARE IN PHARMACY CHANNEL OF TOP BRANDS-HORMONAL CONTRACEPTIVES



Pharmaceutical companies typically promote their products through detailing, a form of medical marketing conducted by company representatives who visit doctors and hospitals on a regular basis. Detailing helps doctors understand drug indications and manage patients and is instrumental in building trust in a company's products. In Paraguay, Bayer Schering and Gynopharm are the two contraceptive manufacturers that invest most heavily in detailing. Bayer Schering brands are reputed to have the highest loyalty among health providers (particularly gynecologists).

PSI/Paraguay, which received funding from USAID to socially market condoms in Paraguay between 1997 and 2003, is now registered as a for-profit entity. Its contraceptive brands are some of the least expensive on the Paraguayan market. PSI/Paraguay is self-sufficient but has a small product portfolio. However, two of their four products are the market leaders in terms of unit sales; *Segura* in the OC category and *Pronta* in the emergency contraceptives category.

The Dutch contraceptive manufacturer Organon marketed several contraceptive products in Paraguay, until it was acquired by Schering-Plough in 2007, which then merged with Merck in 2009. The Merck representative for Paraguay, who is based in Buenos Aires, is considering re-entering the Paraguayan market with new products.

TABLE 14. AVERAGE UNIT PRICES FOR HORMONAL CONTRACEPTIVE

	Average Price in US$
Schering - (8)	6.0
Gynopharm - (12)	5.2
PSI/Paraguay - (2)	1.9
Fa.pa.sa. - (2)	3.8
Lasca - (1)	1.7
Galeno - (1)	2.1
Medical Farmac - (1)	1.5
Boehringer Ing - (1)	2.5
Silesia - (3)	4.1
Parafarma - (1)	1.6
Others (10)	3.8

Contraceptive prices are not particularly high in Paraguay. Although the price of oral contraceptives can reach $US 13.00 for a cycle of pills, the average price of a hormonal product is closer to US$3.50. Table 14 provides average prices of products made in and outside Paraguay. Local manufacturers (Lasca, Galeno, Fa-pa-sa) and PSI/Paraguay offer the most affordable products on the market.

5.7 ORAL CONTRACEPTIVES

The OC market is described by manufacturers as "polarized," with a high proportion of both low-cost oral contraceptive brands and high-priced new formulations (Table 15). The main difference between these two categories is their composition: recent formulations tend to be lower-dosed, and contain newer generations of progestins (drospirenone, gestodene). Pharmaceutical companies invest more in new brands because they carry a higher margin and need to recoup R&D costs. Many doctors are partial to these brands, which can be better tolerated by patients, but they are sensitive to the fact that not all users can afford them. In contrast, PSI and other local suppliers depend almost exclusively on over-the-counter sales rather than doctors' prescriptions.

The lowest-price OC brand on the market is PSI's *Segura* (US$ 1.30). *Segura* is similar to Bayer Schering's *Microgynon*, and is the market leader in volume (25% of all OCs sold). The uncontested market leader in value sales (US$) is *Yasmin*, which retails for $12.3 and represents 44% of yearly OC

sales (in dollar terms). The most expensive brands are *Yaz*, a newly introduced Bayer Schering product, and its local copy *Femelle 20,* retailing for $12.90 and $13.00 respectively. These brands are the fastest-growing on the market in volume.

One brand of high-dose oral contraceptives (with 50mcg estrogen) is still in use in Paraguay, despite the fact that low-dose contraceptives (with 30mcg estrogen or less) are now considered safer for most women. One explanation could be price: high-dose products, where they are still marketed by companies, are typically sold at a lower price because they are older-generation products.

TABLE 15. ORAL CONTRACEPTIVE BRANDS SOLD IN PARAGUAY

Category/brand ($ sales ranking)	Formulation	Laboratory	Price US$)	Market share (volume)	Units sold 09	% chg 09/08
Low-dose monophasic						
Yasmin[*]	Drospirenone 3 mg + EE[10] 30 mcg	Schering	$12.3	11.53	89,593	7.90%
*Yaz**	Drospirenone 3 mg + EE 20 mcg	Schering	$12.9	3.73	28,953	91.97%
Norvetal	Levonorgestrel 0.15 mg + EE 30 mcg	Gynopharm	$3.7	13.55	105,239	13.58%
Segura	Norgestrel 0.3 mg + EE 30 mcg	PSI/Paraguay	$1.3	25.64	199,138	20.97%
*Microgynon**	Levonorgestrel 0.15 mg + EE 30 mcg	Schering	$2.6	9.51	73,877	-3.27%
Femelle	Drospirenone 3 mg + EE 30 mcg	Gynopharm	$11.0	1.58	12,238	14.59%
Dal	Desogestrel 0.15 mg + EE 20 mcg	Gynopharm	$9.1	1.17	9,079	20.41%
Femelle 20	Drospirenone 3 mg + EE 20 mcg	Gynopharm	$13.0	0.75	5,792	64.97%
*Femiane**	Gestodene 0.075 mg + EE 20 mcg	Schering	$8.4	1.04	8,061	2.49%
Lerogin 20	Gestodene 0.075 mg + EE 20 mcg	Gynopharm	$6.0	1.10	8,525	9.03%
Norvetal-20	Levonorgestrel 100 mcg + EE 20 mcg	Gynopharm	$4.3	0.98	7,633	5.47%
Gineva Md	Gestodene 0.075 mg + EE 20 mcg	Eticos Int'l.	$4.6	0.82	6,371	17.39%
Ciclidon 20	Desogestrel 0.15 mg + EE 20 mcg	Gynopharm	$6.6	0.39	3,033	-4.26%
Anulit	Levonorgestrel 0.15 mg + EE 30 mcg	Silesia	$3.6	0.70	5,453	3.49%
Lerogin	Gestodene 0.075 mg + EE 30 mcg	Gynopharm	$5.3	0.46	3,582	4.86%
*Gynovin**	Gestodene 0.075 mg + EE 30 mcg	Schering	$9.6	1.20	1,554	-20.75%
Ciclidon	Desogestrel 0.15 mg + EE 30 mcg	Gynopharm	$5.0	0.28	2,201	0.46%
Femitine	Levonorgestrel 0.15 mg EE 30 mcg	Catedral	$2.3	0.33	2,535	-3.58%
*Cilest**	Norgestimate 0.25 mg + EE 35 mcg	Janssen Cilag	$9.9	0.05	389	-31.27%
*Nordette**	Levonorgestrel 0.15 mg + EE 30 mcg	Wyeth	$6.6	0.01	107	-46.77%
High-dose monophasic						
*Neogynon**	Levonorgestrel 0.25 mg + EE 50 mcg	Schering	$2.2	11.93	92,671	-55.00%
Triphasic						
Triciclomex	Gestodene 0.05/0.07/0.1 + EE 30/40/30	Gynopharm	$5.7	4.43	34,411	11.21
*Triquilar**	Lev. 0.05/0.075/0.125 + EE 30/40/30	Schering	$3.4	2.80	21,739	-4.8
Trifas	Lev. 0.05/0.075/0.125 mg + EE 30/40/30	Silesia	$4.3	0.79	6,171	35.21

* Originator brand
10 Ethinyl Estradiol (estrogen).

Category/brand ($ sales ranking)	Formulation	Laboratory	Price US$)	Market share (volume)	Units sold 09	% chg 09/08
Tridette	Norgestimate 0.18/0.215/0.25 + EE 35	Gador	$6.3	0.09	730	-30.87
			Progestin-only			
Linosun	Lynestrenol 0.5 mg	Silesia	$4.2	3.61	28,042	10.36
Normalac	Lynestrenol 0.5 mg	Gynopharm	$3.3	1.51	11,741	20.31
Arlette 28	Desogestrel 0.075 mg +	Gynopharm	$5.2	0.52	4,008	4.95

5.8 INJECTABLE CONTRACEPTIVES

Only combined monthly ICs are available in Paraguayan pharmacies. This segment generates $US 1.3 million in annual sales, or 23% of the total contraceptive market. Two original formulations are marketed by Bayer Schering (*Mesigyna),* and Boehringher Ingelheim's (*Perlutal)*. All other brands on the market are copies of *Perlutal*. One reason for the popularity of monthly injectables may be their cost: starting at $1.50 for a monthly dose. Another reason might be their favorable side effect profile. Combined ICs are associated with more regular bleeding patterns, lower risk of amenorrhea, and less likelihood of infrequent bleeding than progestin-only ICs[11] (such as *Depo Provera*). Monthly injectables have not been provided by the MSPBS in the past because they were not included in USAID's commodity donation program. As a result, commercial suppliers have been able to occupy a niche where competition from free and subsidized products is not a significant barrier.

[11] Source: Hassan EO and El-Gibaly OM Combination injectable contraceptives for contraception : RHL commentary (last revised: 1 October 2009). The WHO Reproductive Health Library; Geneva: World Health Organization.

TABLE 16. INJECTABLE CONTRACEPTIVE BRANDS SOLD IN PARAGUAY

Brand name	Formulation	Laboratory	Price (US$)	Market share	Units Sold 09	% chg 09/08
Selene	Dihydroxyprogesterone acetophenide 150 mg + Estradiol benzoate 10 mg	Lasca	$1.7	24.80	176,858	2.8
Unigalen	Dihydroxyprogesterone acetophenide 150 mg + Estradiol benzoate 10 mg	Galeno	$2.1	19.21	136,939	27.04
Clinomin	Dihydroxyprogesterone acetophenide 150 mg + Estradiol benzoate 10 mg	Medical Farmac	$1.5	23.34	166,391	6.79
*Perlutal**	Dihydroxyprogesterone acetophenide 150 mg + Estradiol benzoate 10 mg	Boehringer Ingelheim	$2.5	10.56	75,318	57.52
*Mesigyna**	Norethisterone Enanthate 50 mg, Estradiol valerate 5 mg	Schering	$3.6	7.16	51,022	17.29
Cycloven	Dihydroxyprogesterone acetophenide 150 mg + Estradiol benzoate 10 mg	Parafarma	$1.6	8.52	60,731	-20.25
Neolutin-n	Dihydroxyprogesterone acetophenide 150 mg + Estradiol benzoate 10 mg	Fa.pa.sa.	$2.3	4.85	34,558	9.82
Ovoginal	Dihydroxyprogesterone acetophenide 150 mg + Estradiol benzoate 10 mg	Guayaki	$2.0	0.63	4,458	-16.39
Norges	Dihydroxyprogesterone acetophenide 150 mg + Estradiol benzoate 10 mg	Dutriec	$1.9	0.4	2,885	81.9
Neogestar	Dihydroxyprogesterone acetophenide 150 mg + Estradiol benzoate 10 mg	Guayaki	$2.0	0.22	1,575	-15.91
Perlutin	Dihydroxyprogesterone acetophenide 150 mg + Estradiol benzoate 10 mg	Unifarma	$1.7	0.17	1,236	-89.16
Permisil	Dihydroxyprogesterone acetophenide 150 mg + Estradiol benzoate 10 mg	Bional	$1.6	0.10	713	-95.5
Subligin	Dihydroxyprogesterone acetophenide 150 mg + Estradiol benzoate 10 mg	Almos	$2.0	0.05	337	23.9

5.9 EMERGENCY CONTRACEPTION

Approximately 200,000 units of emergency contraceptive products were sold in Paraguay in 2009. All three brands on the market are based on formulations originally developed by HRA Pharma (France). PSI and a local manufacturer market the older formulation, consisting of two .75mg Levonorgestrel tablets. Fa.pa.sa, a Paraguayan manufacturer, is the only company marketing a similar version of HRA Pharma's newer product containing a single 1.5mg Levonorgestrel tablet. Total sales of EC by manufacturers amounted to US$683,000 in 2009, or 12% of the total contraceptive market. Emergency contraception is provided in the public sector, but not in urgent care clinics. However, the convenience and expediency of obtaining this product in pharmacies probably outweighs the cost savings afforded by public sector outlets.

TABLE 17. EMERGENCY CONTRACEPTION BRANDS SOLD IN PARAGUAY

Brand name	Formulation	Laboratory	Price (US$)	Market share	Units sold 09	% chg 09/08
Pronta	Levonorgestrel 0.75 mg x 2	PSI/Paraguay	$2.7	60.40	126,323	7.58
Control Uno	Levonorgestrel 1.50 mg	Fa.pa.sa.	$4.6	32.81	68,623	35.37
Gynosep	Levonorgestrel 0.75 mg x 2	Catedral	$2.1	6.79	14,194	79.69

5.10 INTRA-UTERINE DEVICES

As in many other countries, IUDs are not typically sold through pharmacies because they are used primarily by health providers using various sources of supply. For a long time, private providers in Paraguay used IUDs that were somehow leaked from the public sector. With the strengthening of controls within the MSPBS procurement office, it has become more difficult for providers to find IUDs. A company called "*Casa del Médico*" supplies a variety of devices and equipments to private doctors, and will obtain IUDs from importers on demand. According to a sales representative, *Casa del Médico* considers the market to be almost insignificant, both in volume and dollar value, and merely procures IUDs as a service to its provider clientele. The most widely used IUD in Paraguay is the Copper T IUD, which is typically manufactured in Asia.

The lack of a profitable market for suppliers of IUDs is linked to the low proportion of IUDs inserted by private health providers. Most users obtain this method from the public sector, and those willing to pay the cost of an insertion in the private sector (starting at $40) remain in the minority. The cost of the product itself (about US$3.00) is not likely to be a barrier. Low demand for IUDs in the private sector, compounded with the absence of public sector tenders (with the exception of one very small tender issued by IPS in 2009), has resulted in sporadic availability of this product in Paraguay aside from those provided by UNFPA. One notable exception is *Mirena*, a hormone-releasing IUD marketed by Bayer Schering. This product is indicated for the treatment of menorrhagia (heavy and prolonged menstrual period), but is not routinely prescribed for ordinary contraception in Paraguay, in part because of its high cost.

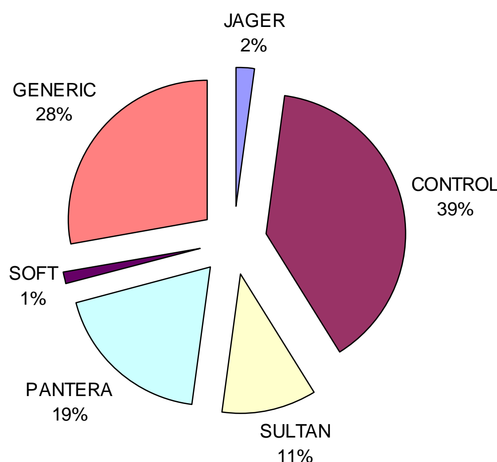
5.11 THE CONDOM MARKET

Condoms are mostly sold through pharmacies in Paraguay. As in other markets, condom brands tend to come and go depending on what distributors choose to import. Five brands of condoms were imported in Paraguay in 2005, each marketed by a different company or local distributor. In 2007, this number increased to eight; it then fell back to five brands in 2009. Condom retail sales were not available for this report. However, importation of condoms through private sector channels in 2008 and 2009 show a decrease from 11 million to 8 million units. In 2008, more than 7 million condoms were donated to Paraguay by UNFPA and USAID. The decrease in commercial sales may have been caused by widespread availability of free condoms through public channels that year, suggesting sensitivity in the private market to changes in the public sector.

In the private sector, the leading brand is *Control* (54% of private sector imports), marketed by Jose Ruoti, a Paraguayan distributor. The second most imported condom is *Pantera*, marketed by PSI/Paraguay (26%), followed by *Sultan* (16%) and *Jager* (3%), both marketed by local distributors. In Asunción, which accounts for 58% of condoms imported into Paraguay, *Control* enjoys a 67% market

share. *Control* is also the dominant condom brand in most departments, with the exception of Paraguarí, Central, and Cordillera, where *Pantera* is market leader, and Misiones, where *Sultan* has the highest market share (43%).

FIGURE 7. CONSOLIDATED CONDOM IMPORTS, 2008 & 2009[12]



Pantera is the most affordable brand at US$0.85 per pack. Its annual sales in 2009 were 2.1 million, a 3% decrease from 2008. *Pantera* has only one presentation (*hipersensible* or hypersensitive), in contrast with *Control, Sultan* and *Jager* with six to eight different presentations. The condom market appears to be consolidating in favor of higher priced brands. In Asunción, PSI/Paraguay reports increasing difficulties in securing adequate visibility for *Pantera* in pharmacies owned by distributors that market their own condom brands. *Control* is also reportedly the only condom brand available in motels.

5.12 CONCLUSION—PRODUCTS

The contraceptive commodities market overall is very healthy in Paraguay. Pharmaceutical companies have benefitted from a large influx of new users of hormonal contraceptives (pills and injectables) that can be easily obtained from pharmacies. The market is dynamic with a wide variety of brands from both international and local drug companies. There is also decent price variation with two to three brand choices at each price point (low, medium, and high).

Condoms, on the other hand, have shown some sensitivity to growth in the public sector. Donations from international organizations may have caused dips in condom imports in the private sector. Public sector supply levels during this time period would need to be analyzed, in order to assess how one may have influenced the other. In any case, the private sector is still the predominant provider of condoms in Paraguay, with almost 75% of condom users sourcing from the private sector. However, it will be important to keep a close eye on trends in the condom market.

IUD suppliers have almost no presence in Paraguay, and are represented by importers that do not see much potential in this class of product. Thus, although the private product supply has grown substantially

[12] Source: Mercado de Preservativos en Paraguay. IMS Paraguay 2010.

in the past five years, it is resolutely evolving towards a higher reliance on hormonal contraceptives, which is a trend that can be observed in the vast majority of developed countries. For better or for worse, the private contraceptive market in Paraguay now looks a lot like other markets in the Western Hemisphere.

6. ASSESSMENT CONCLUSIONS

The secondary analysis of the ENDSSRs revealed a favorable public/private mix in the provision of FP methods. Far from triggering a shift from commercial to free products and services, among users who are able to pay for them, the ***improvement of public sector FP services may have done precisely what it was intended to do***: increase the CPR among previously underserved population groups. The survey provides evidence that a large proportion of new adopters came from low income quintiles, rural areas, and the North, which were all previously underrepresented in the user population.

Fortunately, improvements in public provision of FP services do not appear to have negatively affected private sector suppliers in the pharmaceutical sector (which supplies hormonal contraceptives). This group of providers underwent impressive growth (+137%) in the period between the two ENDSSR studies, and is now the third largest pharmaceutical category in the country. Clearly, both previous and new adopters continued to use the private sector in growing numbers.

It should be noted, however, that ***not all private sector suppliers enjoyed continuous growth between 2004 and 2008***. Most service providers (CEPEP and private for-profit providers) saw a decrease of their participation in the contraceptive market. This also may reflect the general trend away from long-term methods, particularly female sterilization, towards resupply methods (OC, injectables and condoms). Additionally, there is evidence that the condom market did have some reaction to public sector expansion.

The change in method mix toward resupply methods may bode well for pharmacies, which are still the main supplier of contraceptives in Paraguay. However, it also puts a burden on the MSPBS to ensure sustained access to commodities in public health centers. With the discontinuation of donations from USAID and UNFPA, meeting the needs of a large new constituency and those of the next cohorts will require a long-term financial commitment and a sustainable procurement mechanism.

Private sector service providers (for-profit and non-profit alike) are becoming a smaller piece of the FP puzzle in Paraguay. However, they represent an important missed opportunity because of their interface with both current FP users and non-users. There is an opening for improving FP counseling through these providers and therefore the opportunity to better meet individual needs. This is especially true since there is substantial anecdotal evidence that a large portion of Paraguayans are self-managing their contraceptive use.

Additionally, the private service providers play an important role in maintaining the balance between short-term and long-term methods in Paraguay. Over time, short-term methods are more costly than long-term, therefore it is important for those who have a clear need for limiting (as opposed to spacing) to continue to have options for LAPM methods. ***There is already some evidence that LAPM is becoming more difficult to obtain in Paraguay*** (e.g. MSPBS not offering interval sterilizations and lack of supply of IUDs in private sector).

Ensuring that Paraguayans have a choice about method options and where to obtain appropriate products depends in part on LAPM being made available to all Paraguayans (free and paying). Private providers are an essential piece to this because of the existing human capital, physical infrastructure and interface with clients, whether it is for-profit providers for upper quintiles, non-profit providers for

middle quintiles or non-profit providers being contracted out by the public sector to provide free services to the lower quintiles.

At the policy level there is not any existing barrier to healthy functioning of all three sectors (public, non-profit and commercial). ***The policy factor is currently a neutral element*** in the marketplace; it neither helps nor inhibits the private sector. However, there is opportunity to move the needle on the policy meter from neutral to positive. Through public-private dialogue and a whole market approach, the public and private sectors can work together to meet better Paraguayans' family planning needs in a manner that is efficient, ensures choice and access, and is sustainable. ***A new and expanded DAIA can serve as the platform for achieving increased coordination among the various actors***, which leads to increased efficiency without sacrificing choice. When the public sector views the private sector as a partner, and not as a hazard, universal access to contraceptive security becomes attainable and sustainable.

7. RECOMMENDATIONS TO SUSTAIN AN OPTIMAL MARKET MIX

Based on the SHOPS Project's analysis of the Paraguay FP market place, the project proposes the following recommendations to help maintain the current public-private mix (PPM) as well as ensure a balanced FP method mix. One set of recommendations focuses on working with key FP players—including the private sector—to define the appropriate PPM for Paraguay and assist the DAIA to assume the role of monitoring the PPM. Another set of recommendations centers on strengthening two FP providers—IPS and CEPEP—so they can continue to play an important role in the FP market, particularly in the area of longer-term methods, by delivering affordable or insurance-covered services to a wide range of users.

7.1 THE ROLE OF DAIA TO MONITOR THE PUBLIC-PRIVATE MIX

A common vision of how all the sectors—public, private and NGO—will deliver FP services is missing in Paraguay. Typically a Ministry of Health, with input and collaboration from other actors in the health sector, takes a leadership role in articulating this vision. Given the current political environment in which the GOP is promoting "universal access to health" including FP services, it may be difficult to work with the MSPBS to take on a policy initiative that defines a common vision on how all stakeholders in the health sector can play an active role in delivering FP services.

Instead, the SHOPS Project recommends working with the DAIA to assume a leadership role in monitoring the PPM in FP services and products. The DAIA is well positioned to play this role given its policy achievements and proactive members. To expand the DAIA's focus from contraceptive security and public procurement to a whole market approach, two challenges will need to be addressed: i) the Committee is composed largely of public sector entities and mostly focuses on public sector issues, and ii) few of the DAIA members are policy makers or decision makers for their organizations, limiting the DAIA's ability to make policy recommendations and suggest changes.

Assist DAIA to change its orientation and focus

The SHOPS Project proposes collaborating closely with the DELIVER Project to help change DAIA committee member composition, profile and agenda. Activities include: i) presenting the new focus to current DAIA members for input and discussion on member profile (decision makers complemented by operational staff); ii) meeting with potential new members to solicit their input on, and measure interest in, participating in a different DAIA; and iii) facilitating a meeting with current and new members to reach agreement on the DAIA's new orientation and member profile, and to identify a common agenda that reflects all sectors' interests. The SHOPS Project recommends taking advantage of the DAIA's strategic planning exercise, and can use the planning exercise as a mechanism to discuss the DAIA's purpose, members, and activities.

Help DAIA to become an independent and sustainable policy mechanism

Currently, the DAIA relies on the DELIVER Project to sustain its activities. Based on experiences in Guatemala and Kenya, the SHOPS Project proposes a series of interventions that can help DAIA members assume full responsibility and ownership. The overall objective is to create a level playing field between all sectors delivering FP services, while at the same time putting into place the building blocks for a sustainable policy mechanism.

Potential activities include:

- Conducting a workshop to re-orient the DAIA.
- Secure formal approval of the DAIA "charter."
- Coaching DAIA members in first year.
- Explore mechanisms for financial sustainability.

Assist DAIA to define common vision on appropriate PPM in FP

A proven approach to fostering greater dialogue and confidence in the public sector working with the private sector is to identify a limited number of "low-hanging fruit" opportunities as PPP projects. Building small successes in a short period of time encourages public and private sector members to identify additional projects to work on together. As part of the one day workshop, the DAIA members will identify a couple of PPP opportunities. Activities could include drafting a Public-Private Partnership framework and establishing policy instruments like contracting out and financial mechanisms that encourage greater collaboration between the sectors.

7.2 REPOSITION IPS IN THE MARKET PLACE

The analysis and interviews show that many of the IPS beneficiaries are seeking their FP care at other sources. There are several reasons why IPS does not have a robust FP program despite widespread acceptance of FP among the general population. Factors include: i) lack of political commitment, ii) procurement barriers, iii) limited availability of certain methods, and iv) inconvenient hours and location.

There is a dedicated team of staff spearheading the Sexual/Reproductive Health program at IPS, with one full-time physician and a second part-time consultant. The team designed a comprehensive strategy to "re-launch" FP services in IPS (see Plan de Salud Sexual y Reproductiva, 2009) with the specific objectives of ensuring access for all IPS beneficiaries and dependents to FP services and products. The plan stresses quality FP programs—trained staff, adequate FP commodities, convenient hours and location—to meet the IPS beneficiaries' needs. IPS also plans to deliver SRH services at all levels—hospitals, clinics and health posts.

The SHOPS project recommends supporting IPS' initiative to increase its role in FP service delivery in Paraguay, and assisting the IPS team to implement the proposed SRH strategic plan. Technical assistance should focus on three key areas: i) assist IPS to consolidate political commitment among IPS leadership to re-launch the FP program; ii) assess client needs in the area of FP counseling and services; iii) strengthen IPS institutional capacity to deliver quality FP services and iv) reposition IPS service to attract IPS beneficiaries to source contraceptives from IPS facilities.

IPS has proposed the following short-term activities that will serve two purposes—design a technical assistance program to extend FP services, and foster political commitment for FP services throughout the IPS infrastructure nation-wide. An important prerequisite step will be to conduct assessments of

organizational and institutional needs to launch FP, and analyze FP health-seeking behavior to design an FP program responsive to the IPS client needs. SHOPS will help IPS to carry out the organizational assessment.

Based on findings, assist IPS to consolidate commitment among IPS leadership to re-launch FP program

SHOPS recommends using the data from this report as well as the needs assessment to develop a two-part series of awareness-raising activities to foster support for the FP program.

- *Hold one-on-one meetings with the IPS Executive Director* to present key findings from the SHOPS report and IPS assessment to demonstrate IPS' role and to discuss the proposal to extend FP services in IPS. The objective of the meeting will be to secure commitment to the IPS FP strategy.
- *Hold a half-day workshop for the new Directors and other key stakeholders at IPS* to demonstrate the IPS Director's commitment to, and present, the IPS Strategic Plan to extend FP services. At this meeting, the IPS team will present the plan, discuss respective roles and responsibilities to implement the FP program, and identify resources needed to roll out the SRH program. In preparation for the workshop, the IPS team proposes to assess providers' attitudes and perceptions as well as resource needs (e.g. training, commodities, etc.).

Assess client needs in the area of FP counseling and services

Using available IPS client statistics, in-depth interviews of IPS providers, and a client survey and/or focus group discussions, SHOPS will assess the needs of IPS clients in the area of FP counseling and services. We will also use CPR trends to assess the potential demand for FP products and services and determine any unmet need. The assessment will also assist in estimating the volume and cost of products and services that would be needed to satisfy unmet demand and cover current IPS FP users who are sourcing elsewhere, and facilitate the development of a realistic FP budget.

Strengthen IPS institutional capacity to deliver quality FP services

The key informant interviews revealed reluctance among some IPS physicians to assume yet another task in their already busy workload. Additionally, IPS providers are not always able or willing to provide certain methods such as the IUD. In order to increase physician exposure to the full range of FP methods, SHOPS proposes to address IPS potential provider bias and strengthen providers' ability to meet client needs through workshops on Contraceptive Technology.

Depending on the results of the IPS needs assessment of the IPS training, commodities and equipment needs SHOPS will help design a training and technical assistance program tailored to IPS' needs. The SHOPS Project recommends training IPS providers in clinical skills, including counseling, through Contraceptive Technology Updates (CTUs). Using the same public sector curriculum and training methodology will ensure consistency across institutions. Using the findings from the client needs assessment, SHOPS will work with IPS procurement staff in developing a procurement plan and budget.

Recapture IPS beneficiaries and dependents seeking FP services elsewhere

While IPS is strengthening its institutional capacity to delivery FP services, IPS can also build the foundation to "rebrand and market" IPS FP services to lure clients to IPS. The SHOPS project recommends the following activities:

- *Conduct focus groups of IPS female beneficiaries* —including those who are receiving FP services at other organizations— to better understand their FP needs, where they seek FP services, and potential interest in receiving their FP services at IPS. The findings will help IPS design FP services attractive to the IPS client.
- *Introduce new products*, using findings from the focus group and client needs assessment.
- *Rebrand and market IPS* as a provider of FP with a range of products and services designed to meet the needs of the IPS client population. SHOPS will develop the repositioning strategy in collaboration with IPS and (subject to the availability of resources) develop a communication campaign directed at targeted clients.

7.3 PUT CEPEP ON PATH TOWARDS SUSTAINABILITY

In order to properly position CEPEP in the marketplace we recommend an organizational diagnostic phase that will analyze CEPEP's competitive advantage based on market factors and internal CEPEP asset use. Based on the results of the diagnostic phase, implementation strategies for improving CEPEP's market performance and overall self-sufficiency will be developed and applied. Some general strategies have already become evident based on the assessment findings.

Diagnostic Phase:

- Market Study, which will include a competitor scan, pricing analysis, and customer perceptions of CEPEP.
- Productivity Study to determine current usage patterns of human resources, equipment and physical infrastructure.
- Cost analysis (including transition to a cost-centered accounting system).

Implementation Phase:

- Design re-positioning strategy for CEPEP based on competitive advantage and other diagnostics.
- Provide technical assistance in implementing the re-positioning strategy.

Possible strategies to improve CEPEP's positioning and sustainability:

1. IUDs. Demand for IUDs is still growing; albeit at a slower rate than condoms, pills and injectables. CEPEP has decent market share in IUDs, relative to the other methods, at 5% of the total. IUDs are a good alternative to sterilization if a Paraguayan woman is hesitant to resort to a permanent measure, (with lower overall fertility rates, there may be more hesitation to commit to sterilization). The assessment revealed that sourcing IUDs in the private sector is difficult. This could be a nice niche for CEPEP.
2. Sterilizations. Formalize interval sterilizations referral process with MSPBS so that CEPEP is not subsidizing free sterilizations on behalf of the GOP.
3. Price discrimination. CEPEP is not serving the lower income groups, as some had thought. There is evidence that CEPEP needs to raise all prices. The external evaluation performed by INPPARES (IPPF affiliate from Peru) recommended raising all prices in 2010 using a phased approach over six months in order to minimize negative perceptions. Another strategy for achieving this is price discrimination;

for example, a higher price for guaranteed express service or for extended hours on Sundays. Increased prices for Sundays and holidays were observed in Paraguay in a private commercial provider's office. Additionally, CEPEP could introduce a membership system or customer loyalty program that offers discounts back to offset price increases.

4. Streamlining of laboratory services. The lab services currently have the lowest cost-recovery rates. CEPEP offers over 600 different types of analyses. The organization assumes large costs in purchasing and maintaining all the different reagents necessary for this type of service. CEPEP can narrow down the laboratory services to the most used and most profitable, in order to bring the overall service to a minimum of 100% cost recovery.
5. Client referral discount program. 50% of CEPEP clients in 2009 were referred to CEPEP by another CEPEP client (15,853 out of a total of 30,301 clients). CEPEP can take advantage of this phenomenon by rewarding clients who refer other clients with discounts. This also creates customer loyalty and prevents further market share erosion.
6. Training and technical assistance. Position CEPEP as a family planning/contraceptive technology training institute to be contracted out by various institutions such as: OB/GYN Society, IPS, MSPBS, universities, obstetricians association, and even large companies that are willing to support periodic FP counseling sessions for their employees.

7.4 PRIVATE FOR-PROFIT PROVIDERS

Although this sector will not be a major focus of the SHOPS/Paraguay program, a few activities could prove to be beneficial with these providers.

Improve counseling and quality of private service providers

Working through the two major professional associations of Paraguay, *Obstetras de Paraguay* and the *Sociedad Paraguaya de Ginecología y Obstetricia*, hire CEPEP to provide both counseling techniques and contraceptive technology trainings to respective members. There are many lost opportunities with clients to discuss family planning options. Additionally, there is room for improvement in the accuracy of the information being provided by the licensed obstetricians.

Implement a more rigorous re-certification process with the licensed obstetricians association, modeled after the OB/GYN's program based on continuing medical education (CME) credits point system.

Conduct Price Sensitivity Study of Condom Market

There is some evidence that the commercial condom sector "reacted" to increased supply in the public sector. However, because the sourcing patterns show improved segmentation by wealth quintiles (more poor going to public sector and more rich going to pharmacies), it may be a natural adjustment the market had to make to correct itself from a previous under-supply in the public sector. In order to predict future trends about the sustainability of the ideal PPM in the condom market, further analysis, such as a price sensitivity study, could be beneficial.

7.5 PRIVATE SECTOR SOLUTIONS TO PUBLIC SECTOR PRODUCT SUPPLY CONSTRAINTS – PLAN B

The SHOPS project will collaborate with the DELIVER project to explore alternatives to the procurement of commodities exclusively from UNFPA. The most likely alternative is to align contraceptive procurement with the process used to procure other essential drugs. Both foreign companies with a presence in Paraguay (such as Bayer Schering and Recalcine) and local manufacturers would be eligible to compete on procurement tenders. (Note: the requirement to procure products from local distributors is not a significant barrier: foreign companies with an interest in the tender business can offer very low prices through their local representative in Paraguay. Only companies with no registered products in Paraguay are actually barred from bidding on government tenders). The goal should be to determine how to solicit a high response rate, as well as the best possible prices from local suppliers. SHOPS will work with DELIVER to identify key factors that influence the quality and quantity of responses to government tenders. We will use the findings to make recommendations for a "Plan B," should efforts to secure a legal exception for sustained procurement from UNFPA fail.

Important caveat: Local and international tenders supplied directly by pharmaceutical companies or their local distributors is a more expensive option than procuring contraceptives from UNFPA, because this organization has access to very low prices due to high-volume global purchasing. Thus, the UNFPA option, while not being the only possible procurement channel, is by far the least expensive.

7.6 SHOPS/PARAGUAY PROGRAMMATIC PRIORITIES

The above recommendations will feed discussions with USAID/Paraguay to determine the appropriate interventions for SHOPS/Paraguay. Once intervention strategies are agreed upon, the SHOPS team will submit a corresponding workplan to USAID for approval. The objectives of the SHOPS/Paraguay program will focus on:

- Maintaining a balanced public-private mix
- Strengthening the platform to monitor and oversee PPM-related issues through a new and expanded DAIA
- Strengthening crucial players in the market, such as CEPEP and IPS
- Resolving remaining public sector sustainability issues, coordinating with DELIVER, such as exploring alternative public sector procurement options.

The above four objectives comprise the whole market approach, which is meant to keep a variety of providers active in the market, each servicing their appropriate niche. Sustaining the PPM mix will allow FP programs in Paraguay to be sustainable and efficient, while providing universal access to information and a choice of methods, brands, prices and locations to all Paraguayans.

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ANNEX B: BIBLIOGRAPHY

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