Paraguay: progress and challenges of family planning as a universal right

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The practice of family planning (FP) in the country dates back several decades. The Ministry of Public Health and Social Welfare (MSPBS) has exercised leadership, initially under the label of Family Protection and as a part of its Maternal and Infant Health Program, though by the end of the 1960s, a private institution entitled the Paraguayan Center for Population Studies (CEPEP), subsequently a member of the International Planned Parenthood Federation (IPPF), was slowly taking off in this area. The Ministry's family planning policy and program, however, was not continuous throughout all these years given that, on the instructions of Stroessner's government, the provision of modern methods was suspended during the period between 1982 and 1987, approximately. In the interim, the Ministry promoted FP using natural means though, little by little, it began again to implement its services using modern contraception methods.

In the middle of the twentieth century, the country's total fertility rate (TFR) was still quite high (6.5 children per woman on average) and the debates of demographic explosion was being held in the world and in the region. In spite of this, the Paraguayan government of the time did not consider that the high fertility rates constituted a problem, since it was assumed that Paraguay was a sparsely populated country (approximately 1.4 million inhabitants). In this context, family planning was justified as a maternal and infant health policy, within the realm of the prevention of risky pregnancies and reduction in maternal mortality and of the product of conception and the birth deliveries. Consequently, when Family Planning activities resumed in 1988, these continued to form part of the National Maternal and Infant Healthcare Program.

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From then until the present day, international agencies such as the UNFPA and the PAHO/WHO have backed the Ministry in its efforts to bolster and implement the program, so much so that two years ago the institution began to absorb in its annual budget the cost of Sexual and Reproductive Health and Family Planning inputs as clear proof of its institutionalization. These advances form part of the recent history of reproductive health in an environment of democratic openness, institutional changes and the strong emergence of civil society organizations, particularly those of women, which have been fighting for the acknowledgment and respect of their rights. In this new framework, family planning gradually came to be an element of the National Program for Sexual and Reproductive Health, as part of the Health Policies of this Ministry and as a result of the Program of Action from the Cairo Conference and the Beijing Platform of Action which are currently in force.

In 1992, the National Constitution included article 61 "Family Planning and Maternal and Infant health", in which it is stated that "The State recognizes the right of individuals to freely and responsibly decide the number and frequency of the births of their children, as well as to receive, in association with the respective agencies, education, scientific instruction and the appropriate services in this regard. Special reproductive health and mother/infant health plans will be established for the poorer segments of the population". In 1993, the MSPBS implemented the project "Support for Reproductive Health and Family Planning" through which it continued the actions it had begun, one of the objectives being the development of the 1st National Plan for Reproductive Health and Family Planning together with the National Council for Reproductive Health and Family Planning, which today is fully in operation[2].

When attempting to carry out a quantitative analysis or account of what has taken place in the area of family planning in the country, we are confronted with the limitation that the sources of information represent, which only relate to the female population of childbearing age (15 to 44 years old), when it is known that, in the exercise of reproductive rights, both men and women are involved. Even so, it is possible to present a description of the main indicators, the result of a review of the National Demographic and Sexual and Reproductive Health Surveys (ENDSSR) available between 1987 and 2008.

Regarding to the prevalence of the use of contraceptive methods, understood to be the percentage of women who are married or in a relationship that at the time of the survey were using some form of contraceptive (modern or traditional, except for medicinal herbs on account of the absence of proven effectiveness), a growth of

[2] Paraguay. MSPBS. 1997. National Reproductive Health Plan, 1997-2001.

2% per year was observed, between 1987 and the most recent data of 2008. During the same period, the TFR has been gradually falling, with a notable drop particularly in the last 10 years. Even though there are various factors influencing this reduction (social, cultural and even economic aspects), in the case of Paraguay, the proximate determinant that has had the major impact in this reduction in fertility has been the significant increase in the use of contraceptives, since the prevalence of use demonstrates an inverse ratio to the total fertility rate.

In fact, in 1987, with an average TFR of 5.4 children per woman, a prevalence of contraceptive use of 37.6% was recorded, whereas almost a decade later, in 1995, the TFR had fallen to an average of 4.3 children per woman and prevalence had risen to 50.7% (5 out of every 10 women), and in 2008 getting to the prevalence of 8 out of every 10 women (79.4%) and an average TFR that has tumbled to 2.5 children per woman. However, the information presented at the national level conceals some differentials, both in terms of contraceptive prevalence and TFR levels, according to some specific women's characteristics, such as, the level of education, the language normally spoken at home, and socio-economic level. In this aspect, the highest fertility levels and, in turn, the lowest levels of contraceptive prevalence are recorded in the most vulnerable groups of women with no education or with only 5 years of completed schooling, speakers of the Guarani language, and those of the lowest socio-economic level.

In this regard, it should be emphasized that the knowledge of modern contraceptive methods is practically universal today. The three main methods such as the male condom, the pill and the contraceptive injection, are known by more than 95% of women living in Paraguay, in both urban and rural areas. Even so, it is interesting to note that two principal causes that lead women between 15 and 44 years of age to use contraceptive methods are, on the one hand, the decision to space out the births (52% of women, ENDSSR 2008) and, on the other hand, the desire not to have children (a cause cited by 29.9% of women, ENDSSR 2008). Amongst other reasons, the rest of the women mention protection and postponing birth.

Throughout the years of family planning practices in the country, qualitative changes have taken place, which are varied in nature, such as women taking the decision to use contraception and their choice of modern methods. Whilst two decades ago, 6 out of every 10 women did not use any method (62.4% of women in a relationship), at the present time (2008), this number has fallen to just 2 out of every 10 women (20.6% of women in a relationship). Another change of note has been the source used for obtaining modern contraceptive methods. Historically, the drugstores were the main source of supply, but in 2008, thanks to the support

and cooperation of international entities as well as domestic initiatives, the public sector has succeeded in establishing itself as the main provider of modern methods for women aged 15 and 44 years in union. Presently, this sector is responsible for providing contraceptives to 42.3% of those women.

Despite everything said so far, and the attempt by both the government and non-governmental entities to universalize the right to family planning, there is still an unsatisfied demand in the country. The vulnerable group of women who are non-users, at risk of an unwanted pregnancy and needing modern methods, is shaped by those women who are sexually active who are neither pregnant nor presently amenorrheic and who do not wish to have any more children, but who are not using any contraceptive method, as well as those who are using a traditional method (Billings, rhythm, withdrawal). A total of 12.1% of all women are part of the abovementioned group, a figure which rises to 12.9% for women who are married or in a relationship (ENDSSR 2008).

An important indicator for properly evaluating the dissemination, knowledge and family planning services is the use of methods in the first sexual encounter. In this country, sexual relations most often take place prior to marriage or consensual union, therefore there is a tendency for women between 15 and 24 years old to use contraceptive methods at the time of the first premarital sexual encounter, with the obvious exception of those women whose first experience was rape. The first time that information on this indicator was collected was in 1987, when it was revealed that 12.2% of adolescent and young adult females had used some method for their first sexual experience. The next measurement recorded in 1995 and showed an increase of 11% (23.5%) compared to 1987. A similar increase was found in a much shorter period of time, between 1995 and 1998, when the proportion of women that had used some form of contraception at the time of their first premarital sexual experience was 33.2%. Between 1998 and 2004, the proportion rose to 57.6% and has risen by a further 20% by 2008, reaching a figure of 71.3% of adolescent or young women using some form of contraception.

In brief, the advancement of family planning in Paraguay has been developed and supported in an institutional context comprising various actions which have been creating and playing important roles in the promotion of sexual and reproductive health, with special emphasis on family planning. The following merit particular mention:

- The National Reproductive Health Council (CNSR), created in April 1994 by Decree 3197, composed of representatives from government, non-government and external agencies with the aim of coordinating work lines, form action plans and decide on reproductive health policies as well as unify

the various initiatives, resources and benefits, in order to be able to prioritize the welfare of women, teens of both sexes and their families. The CNSR boasts a technical team, a Steering Group, made up of technical professionals who, in 1999, formed the National Committee for Family Planning and Assured Availability of Contraceptive Inputs (PF-DAIA), whose aim was to propose and develop strategies favoring access to services and supplies with the appropriate quality and continuity.

- From 1997 to the present day, National Sexual and Reproductive Health programs are prepared every four years, under the direction of the MSPBS. One of the action lines of these plans is family planning. Moreover, the national plans have their counterparts in departmental plans in each of the departments which divide the country politically.
- Approved in 2005, the Population Policy incorporates family planning in the Family axis strategy making explicit mention of the promotion of information and communication programs and the axis strategies of Human and Social Capital requiring that the Labor Code and Childhood and Adolescence Code be reviewed and updated in terms of access to health and basic family planning services.

In conclusion, over the last decade, it has been possible to confirm a significant increase in the prevalence of contraceptive methods, which shows that counseling and training has grown, both in terms of services and educational institutions. This comes as a consequence of the advances in the institutionalization of the Family Planning Program as an element of Reproductive Health. Greater participation and protagonism has been displayed by the State, which is reflected in both the creation of executive actions of family planning axes and the greater and more efficient supply and uptake in the demand for modern methods. Significant advances have been seen in the execution of the universal right to family planning, though there is still work to do to eliminate inequalities, particularly those affecting women and couples of lower socio-economic levels, with a lower level of education and high levels of parity. Moreover, the continuous provision of modern family planning methods still needs to be assured, both in the public and private sectors, and in social security services, so as to guarantee the principal of voluntary choice given the supply. The challenge for the country is to achieve better awareness and the universal practice of the right to family planning and reproductive health, since accomplishing this the benefits would be twofold: On one side, the full exercise of sacred human rights would be guaranteed and on the other, avoidable deaths through the unsafe practice of abortion on account of unwanted pregnancies would be reduced.

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