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OFFICE OF INSPECTOR GENERAL

AUDIT OF USAID/PARAGUAY'S REPRODUCTIVE HEALTH AND FAMILY PLANNING ACTIVITIES

AUDIT REPORT NO. 1-526-06-003-P
January 13, 2006

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Office of Inspector General

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MEMORANDUM

TO: USAID/Paraguay Director, Wayne Nilsestuen

FROM: RIG/San Salvador, Timothy E. Cox "/s/"

SUBJECT: Report on Audit of USAID/Paraguay's Reproductive Health and Family Planning Activities (Report No. 1-526-06-003-P)

This memorandum transmits our final report on the subject audit. We have considered your comments on the draft report and have included your response in Appendix II of this report. Since we deleted one recommendation and since we changed the order of recommendations between the draft report and this final report, we reordered and renumbered your comments to maintain correlation with the recommendations presented in the final report.

The report contains 11 recommendations intended to improve the implementation of the reproductive health and family planning activities in Paraguay. Based on your comments and documentation provided, management decisions have been reached for all recommendations. Determination of final action will be made by the Audit Performance and Compliance Division (M/CFO/APC).

Again, I want to express my appreciation for the cooperation and courtesy extended to my staff during the audit.

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SUMMARY OF RESULTS

The Regional Inspector General/San Salvador conducted this audit to determine whether USAID/Paraguay reproductive health and family planning activities met planned results and whether the Mission and its partners managed these activities in an efficient manner. (See page 4.)

Under the Mission's Strategic Plan for fiscal years 2001 to 2005, the objectives of the reproductive health activities were to increase the use of voluntary reproductive health services and improve maternal health services through pilot projects. The Paraguayan Center for Population Studies (CEPEP) worked to increase the sustainability of its network of four clinics, affiliated health care providers, and reproductive health promoters by improving management skills and financial systems. The Center for Development Information and Resources (CIRD) worked with local health councils to improve the councils' ability to plan activities, identify community needs, and administer health care financing models. Tesape'a, an activity managed by Deloitte & Touche Tohmatsu Emerging Markets, Ltd. and by IntraHealth International, Inc., worked to improve the quality of reproductive and maternal health through providing technical assistance with Paraguay's National Reproductive Health Plan for 2003 to 2008, training health care workers, and providing community education. (See page 3.)

With respect to our first audit objective, USAID/Paraguay met two of the four primary planned results described in its strategic plan and/or in cooperative agreement and contract documents. The first was related to a ratio of core operating expenses to core revenues at CEPEP. Since 2001, CEPEP has increased its ability to cover core operating expenses with core operating revenues. It has improved from covering 64 percent in 2001 to 87 percent in 2005. The Mission's target for 2005 was 80 percent. (See page 7.) The second was related to the number of communities with local health councils facilitating the delivery of basic health services. The Mission had a target of increasing the institutional capacity of 15 local health councils by 2005. That target was met as the local health councils have completed local health plans, data collection processes (i.e. health census), defined basic community health packages, or developed functioning management information systems. (See page 8.)

The Mission did not meet the third primary planned result related to the number of delivery points offering quality reproductive care. The Mission established a target to provide quality reproductive health care at 25 delivery points by 2005 but achieved a minimum quality score at 14 facilities. The quality score was based on three components: service provider skills and abilities, physical condition of facilities, and the health care recipient's perception of the quality of care received. Moreover, only 5 of those 14 facilities scored over the minimum quality level in the service provider skills and abilities component. This indicated that, even within the 14 facilities that met the overall minimum quality target, improvements were needed. (See page 10.)

For the fourth primary planned result, dealing with contraceptives distributed, we could not determine if the result was achieved because the reported data were not reliable. (See page 13.)

Also related to the first objective, high-level documents like the Mission's strategic plan and Congressional budget justifications included statements that could be misinterpreted as describing a greater impact than was actually intended. Although the documents included qualifications on the intended scope of the reproductive health activities, broad conclusions in those documents could lead readers who are unfamiliar with the scope of the Mission's activities to interpret that the activities would have an area of influence that was greater than intended. Likewise, people unfamiliar with the project's scope could infer from the Mission's couple years of protection (CYP) index results indicator, which was based on national figures, a higher level of achievement resulting from USAID/Paraguay activities than the Mission intended. (See page 16.)

In answering our second audit objective concerning whether the Mission and its partners managed reproductive health and family planning activities in an efficient manner, we noted that USAID/Paraguay and its partners used a number of indicators that reflected whether the activities were meeting planned results, but, except for CEPEP's sustainability indicator, those measures did not demonstrate whether results were being met efficiently. The Mission and its partners decided not to use efficiency measures since the Mission's determination of program success focuses solely on attaining results. (See page 19.)

In performing field work, we noted issues that could be improved in either the management or execution of project activities. First, CYP data was not accumulated at the local level where USAID/Paraguay's projects were operating. (See page 20.) Second, the Ministry of Public Health and Social Welfare (MOH) was unable to ensure a reliable supply of contraceptives in the health facilities we visited because service providers needed additional training, inventory control systems needed strengthening, and distribution mechanisms needed improving. Also, while voluntary sterilization is allowed under Paraguay's national reproductive health strategy, voluntary sterilization services were not always available in MOH facilities. (See page 22.) Finally, the Mission did not incorporate activities into its family planning assistance phase-out plan to monitor critical constraints. (See page 25.)

To address the items noted in the report, we made eleven recommendations related to improving the quality of follow-up on reproductive and maternal health activities, enhancing the quality and usefulness of the strategic objective's indicators, and improving the ability to measure the efficiency of program activities. (See pages 13, 16, 18, 20, 21, and 27.)

USAID/Paraguay concurred with the recommendations included in this report but expressed concern that this report did not sufficiently describe the Mission's "notable successes and the positive results achieved to date." We made our best effort to present a balanced, objective view of the program activities. The Mission also asked us to clarify that correcting deficiencies with the MOH regarding the unreliable supply of contraceptives was not part of the Mission's strategic plan until October 2005. (See page 29.)

BACKGROUND

Paraguay has seen a steady improvement in three key indicators dealing with reproductive health. According to the National Demographic Survey on Sexual and Reproductive Health 2004 (ENDSSR 2004[1]), the total fertility rate (TFR) has decreased from 4.3 children per woman measured during the period from 1995 to 1998 to 2.9 children per woman measured from 2001 to 2004. Also according to ENDSSR, contraceptive prevalence, using modern contraception methods, increased from 47.7 percent of women aged 14 to 44 years in 1998 to 60.5 percent in 2004. The United Nations reported in its Human Development Report for 2001 that the maternal mortality ratio for Paraguay was 190 per 100,000 live births measured over 1980 to 1999. This value compares to the figure reported for 2003 by the Government of Paraguay of 174 per 100,000. (By comparison, in the United States the total fertility rate, as reported by the U.S. Census Bureau in 2002, was 2.1 children per woman for the preceding decade. According to the National Center for Chronic Disease Prevention and Health Promotion, the contraceptive prevalence rate was 84 percent in 2002. According to the Centers for Disease Control and Prevention the maternal mortality rate for 2002 was 9 maternal deaths per 100,000 live births.)

As ENDSSR 2004 data shows in Table 1 below, even though improvements were noted in the indicators at the national level, the TFR figure masks important differences between rural and urban regions and between women with different levels of education. The TFR of urban and rural women measured from 2001 to 2004 was 2.5 and 3.7, respectively, compared to 3.2 and 5.6 from 1995 to 1998. From 2001 to 2004, the TFR for women with less than six years of education was 4.2 children per woman compared to 2.1 for women with 12 or more years of education. From 1995 to 1998 the TFR for the same level of education was 6.0 and 2.3, respectively.

Table 1 – Total fertility rate, measuring the number of children per woman, for Paraguay

Category of Women	**1995 to 1998**	**2001 to 2004**
National rate	4.3	2.9
Women in urban areas	3.2	2.5
Women in rural areas	5.6	3.7
Less than 6 years of education	6.0	4.2
More than 12 years of education	2.3	2.1

Under the Mission's Strategic Plan for fiscal years 2001 to 2005, the objectives of the reproductive health activities were to increase the use of voluntary reproductive health services and improve maternal health services through pilot projects. To meet these objectives, the Mission worked with three implementers to improve decentralized community-based health care, expand access to quality reproductive health services, and improve maternal health services. The implementers were the Paraguayan Center for Population Studies (CEPEP), the Center for Development Information and Resources

[1] ENDSSR is the acronym for the Spanish title of the survey, Encuesta Nacional de Demografía y Salud Sexual y Reproductiva. The survey was completed by the Paraguayan Center for Population Studies in 2005.

(CIRD), and Tesape'a. A brief description of each implementer and their activities follows.

CEPEP worked on decentralization activities and provided reproductive health and family planning services through clinics in four major cities in Paraguay. In addition to gynecology, obstetrics, prenatal counseling, family planning, and PAP smear tests and analyses, the clinics also offered dentistry and pediatric services and operated social pharmacies. The clinics and the social pharmacies were run as businesses, but rather than operating with the philosophy of maximizing profits, their primary financial objective was to cover their costs, and they priced medicines, contraceptives, and services at levels that were affordable to low-income individuals. CEPEP provided supplies through these pharmacies to private health care practitioners who wanted to participate; associated institutions and clinics, like the Red Cross; and community reproductive health and family planning promoters through consignment arrangements.

CIRD focused on improving health decentralization by working with local health councils to improve their effectiveness in working with their community health facilities. CIRD worked to increase local health council institutional capacity by helping health councils establish themselves as legal entities, define their operating by-laws, establish strategies, and prioritize their areas of focus. A significant activity managed by CIRD was establishing decentralized financing sources managed by the local health councils to fund health care services in their communities. CIRD developed three decentralized financing models: a health insurance program, a cost recovery model, and a revolving fund mechanism that could be used by social pharmacies. In addition to its activities with local health councils, CIRD managed a community awareness campaign to increase demand for health services in communities with decentralized programs.

Tesape'a is the project name for an activity managed by Deloitte & Touche Tohmatsu Emerging Markets, Ltd. and by IntraHealth International, Inc. The project had two primary tasks: to expand access and improve the quality of reproductive health services among rural and low-income women in four regions and to improve maternal health status in a district of one region. These tasks were pursued by assisting the Ministry of Public Health and Social Welfare (MOH) with the implementation of the National Reproductive Health Plan for 2003 to 2008, implementing a system of health promoters, improving the quality of reproductive and maternal health care through training health care workers, and increasing community knowledge on reproductive and maternal health care topics.

From October 2001 through September 30, 2005, USAID/Paraguay had obligated $6.0 million and expended $4.6 million on the reproductive health and family planning strategic objective.

AUDIT OBJECTIVES

As part of its fiscal year 2005 audit plan, the Regional Inspector General/San Salvador performed this audit to answer the following questions:

- Did USAID/Paraguay's reproductive health and family planning activities achieve planned results described in its strategic plan, in cooperative agreement and contract documents, and its Congressional budget justifications?

- Did USAID/Paraguay and its partners manage reproductive health and family planning activities in an efficient manner?

Appendix I contains a discussion of the audit's scope and methodology.

AUDIT FINDINGS

Did USAID/Paraguay's reproductive health and family planning activities achieve planned results described in its strategic plan, in cooperative agreement and contract documents, and its Congressional budget justifications?

USAID/Paraguay met two of the four primary planned results described in its strategic plan and/or in cooperative agreement and contract documents. The first result met was related to a ratio of core operating expenses to core revenues at the Paraguayan Center for Population Studies. The second result that was met was related to the number of communities with local health councils facilitating the delivery of basic health services. The Mission did not meet its third planned result related to the number of delivery points offering quality reproductive care. We could not determine whether the Mission met the fourth planned result related to the number of couple years of protection[2] (CYP), set as an indicator target in its strategic plan to reflect the overall effectiveness of the program, because the data reported was not supported. USAID/Paraguay's Congressional budget justifications did not include specific planned results; however, they included statements that could be misinterpreted as implying that the Mission's program activities would have a more widespread impact than was actually intended.

The indicators that we considered to be the primary indicators of the program were taken from USAID/Paraguay's strategic plan and from cooperative agreements or contracts with implementers. We selected one indicator for each of the Mission's three implementers plus the indicator chosen by the Mission to reflect overall reproductive health and family planning activity results. The four primary indicators that we evaluated, their targets, and their results are presented in the table below:

Table 2 – Primary indicators by implementer for 2005

Implementer	Planned Result	Source of Target	Target	Actual
Paraguayan Center for Population Studies (CEPEP)	Ratio of core expenses to core revenue	Cooperative Agreement	80 percent	87 percent
Center for Development Information and Resources (CIRD)	Communities with local health councils facilitating the delivery of basic health services	Cooperative Agreement and Strategic Plan	15	15

[2] A common indicator used to measure the impact of reproductive health and family planning activities is couple years of protection (CYP). CYP is calculated as the number of couples protected from pregnancy by family planning services during a one-year period, based on the volume of contraceptives sold or distributed during that period.

Implementer	Planned Result	Source of Target	Target	Actual
Tesape'a	Delivery points providing quality reproductive health care	Contract and Strategic Plan	25	14
Not specifically related to a single implementer, the indicator was designed to reflect overall progress of the strategic objective	Couple years of protection	Strategic Plan	240,000 (2004)	259,901 (2004; this reported value is not reliable)

As shown in Table 2, CEPEP and CIRD met their planned results and Tesape'a did not. We did not conclude on the indicator for couple years of protection because the data supporting the achievement was not reliable. In answering this objective, the following two sub-sections on CEPEP and CIRD briefly outline the evidence supporting our conclusions that they met their intended results. The discussion on Tesape'a begins on page 10. The data quality problems we encountered with the CYP index are outlined beginning on page 13.

Paraguayan Center for Population Studies (CEPEP) – CEPEP had four well-run clinics providing a wide variety of reproductive health services, medicines, and contraceptives. Prices for contraceptives provided through CEPEP's social pharmacies are lower than those from commercial pharmacies. CEPEP has also established three youth centers to address the family planning and reproductive health needs of adolescents. These centers have adopted a new model of youth-friendly service delivery that has been successful in increasing the number of youth consultations from 893 in 2001 to 4,111 in 2004.

In terms of CEPEP's impact in providing reproductive health services through its various distribution outlets, CEPEP reported CYP achievements for the years 2000 – 2004 as follows:

Table 3 – CYP attained by CEPEP (not audited)

Distribution Outlet	2000	2001	2002	2003	2004
Clinics	3,478	2,995	3,453	4,341	6,135
Professional practitioners and associated clinics and institutions	15,477	18,385	18,129	33,623	38,848
Reproductive health services promoters	15,835	14,736	17,097	30,828	15,116
Total	**34,790**	**36,116**	**38,679**	**68,792**	**60,099**

The significant increase between 2002 and 2003 resulted from CEPEP providing contraceptives directly to health professionals and to customers who had typically relied on free contraceptives from the MOH during periods when the MOH was out of stock. The contribution of promoters to the CYP attained by CEPEP fell off again in 2004 when the supply of contraceptives via the MOH was reestablished.

USAID/Paraguay promoted sustainability of CEPEP by financing activities to improve management skills and financial systems. Some of the activities included providing training to management staff and community promoters, developing monitoring statistics, purchasing computer equipment, making improvements to physical facilities, and, until 2003, donating contraceptives. CEPEP measured its sustainability through a ratio that compares core operating costs with revenues from core services. The ratio is measured as a percent. If equal to 100 percent, it would signify that CEPEP had generated revenue from core services at a level equal to the cost to provide those services. USAID/Paraguay's assistance has enabled CEPEP to increase its ratio from covering 64 percent of core expenses with core revenues in 2001 to covering 87 percent in 2005.

Though not measured as part of the results indicator, on our site visits we noted other factors that reflected the successful progress of the Mission's activities with CEPEP. USAID, in its publication *Health and Family Planning Indicators: Measuring Sustainability* (Office of Sustainable Development, Bureau for Africa, July 1999), identified four categories of indicators for measuring the institutional capacity of service providers: planning and management, human resources, information systems, and logistic systems. Within each of these categories, CEPEP demonstrated institutional capacity with a number of practices that resulted in the presence of a strategic plan; a system for preparing annual operational plans; written personnel policies; presence of detailed, accurate, and up-to-date job descriptions; presence of an accounting system that regularly provides income and expense data; and presence of a system for tracking commodities.

Center for Development Information and Resources (CIRD) – One of the results contributing to increased access to reproductive health was an activity to develop the capacity of local health councils to plan activities, identify community needs, and administer different types of decentralized health financing models. The Mission's planned result of having 15 communities with local health councils facilitating the delivery of basic health services was met for 2005. The result was judged to be complete when the local health council in the community completed at least one of the following: a local health plan, a data collection process (i.e. a health census), a definition of a basic health package for the community, or a functioning management information system (either manual or automated). The number of health councils meeting each of the four criteria is presented below:

Table 4 – Number of local health councils completing outputs

Item	**Number of Councils Meeting Criteria**
Local health plan	14
Data collection process	13
Basic health package defined	9
Management information system	12

Of the 15 communities counted as meeting the planned result, local health councils in two had met only a single criterion. Eleven met at least three of the criteria. USAID/Paraguay's partner reported that in addition to the 15 communities being directly assisted, an additional 17 communities had signed decentralization agreements with the MOH and had requested assistance from CIRD to improve the capacity of their local health councils.

The difficulty of securing assured sources of funding is a common obstacle to achieving sustainability in development projects. In pursuit of sustainability, USAID/Paraguay designed its program to incorporate business-based mechanisms to generate revenues. Thirteen of the communities had implemented at least one of the following decentralized financing models: a health insurance program (2 communities), a cost recovery model (9 communities); or a revolving fund at the social pharmacy (13 communities).

- Insurance - The health insurance program operates by collecting a monthly premium from insured customers or by collecting a fee from uninsured customers for basic services. Services are provided by social pharmacies, local MOH health centers, and by other private parties. Revenues received from both sources are managed by the local health council who administers payments to the service providers. The success of the program hinges on the insured customers receiving care that is commensurate with the premiums they are paying under the program. The insurance program was operating in one community and another had been started in a second community. As of the time of the audit, the insurance program in the longest running community had 513 subscriber families out of 1,745 families living in the area.

- Cost recovery - The cost recovery model connects local operations of the MOH at the health care facility with community needs by allowing local health councils to administer funds generated by the local health center. Local health centers are able to do more than strategize and create plans. Through their decentralization agreements with the MOH, they can retain revenues generated through services and use the money to autonomously replace supplies needed for programs that are a priority with their communities rather than wait for the supplies to be restocked from the MOH centrally.

- Revolving funds - Revolving funds have been created in 219 social pharmacies in 61 municipalities. The social pharmacies are located in rural and urban areas and, once again, are administrated by local health councils. Customers, after receiving health care services, can obtain medicines at lower prices from these pharmacies than can be obtained from commercial pharmacies. Money from the pharmacies is channeled through a revolving loan fund managed by local health councils in each community in coordination with the municipal and departmental governments. The managers of the funds are responsible for the procurement and distribution of supplies, medicines, and contraceptives. The prices of medicines are kept low because the revolving loan fund allows local governments to buy medicine in bulk from suppliers. In order to target the program to those most in need, only low income families have access to social pharmacies.

Along with successes in the Mission's reproductive health program with CEPEP and CIRD, we noted that Tesape'a did not meet its planned result for improving quality in 25 facilities providing reproductive health care.

Reproductive Health Services Activities Were Not as Successful as Expected

Summary: The Mission assessed the quality of reproductive health services using a measurement methodology that assigned points based on provider skills, the physical condition of service facilities, and client perceptions of the quality of services provided. The Mission's target was to have 25 facilities (of 790 total MOH facilities) that scored at least 80 points, a level which corresponds to the World Health Organization baseline for minimum quality. Tesape'a did not meet this intermediate result target, achieving a score of 80 or higher in only 14 facilities. An additional limitation was noted in that the scores in those 14 facilities masked low provider skills scores with only 5 of the 14 facilities scoring over 80 for the provider skills component. Inconsistent progress in strengthening provider skills resulted from limitations in training delivery, inadequate follow-up on training activities, and a lack of integration between family planning and other health services. As a result, overall quality is not improving as expected.

Tesape'a Did Not Meet the Overall Planned result for Improving Reproductive Health Quality – The Mission used an indicator of reproductive health care quality that included three components: skills and ability of service provider personnel, physical condition of the health facility where service is provided, and the health care recipient's perception of the quality of care received. Staff from Tesape'a measured the results for the indicator based on their observations of service delivery, observations on the physical facilities, and interviews with patients. Scores were compiled for the three components and averaged for an overall score for each health facility. Under the indicator's development methodology, a score of 80 has been set by the World Health Organization as the score that represents a minimum requirement for acceptable quality. For 2005, the Mission established a target of 80 points or more in 25 of the 790 total MOH facilities but attained that score in 14 facilities.

Score for Overall Quality Masked Low Quality in Service Provider Skills – Reviewing the scores from the three components that combine to make the overall score, one notes that the overall score for the 14 facilities scoring at least 80 was attained largely on the strength of the result of the recipients' perceived quality of service component. The implication is that provider skills and abilities need improvement even though people receiving care think they are receiving quality care. The table below shows the average scores in the three components for the 14 facilities that achieved an average score of 80 or higher. It also details the number of facilities that measured more than 80 in the component areas.

Table 5 – Results measured by Tesape'a of quality in reproductive health facilities

Indicator Component Area	Average Score of 14 Facilities Whose Overall Average Score Was 80 or Higher	Number of Facilities Scoring Over 80 in the Indicator Component Area
Skills and ability of service provider personnel	73.7	5 of 14
Physical condition of health facility	86.5	13 of 14
Health care recipient's perceived quality of care received	94.5	14 of 14
Overall Average	**84.9**	

Although the indicator noted above only measures quality in the centers where USAID/Paraguay was supporting activities designed to improve reproductive health services, Tesape'a was also implementing activities related to maternal health at 11 other health facilities. Because, the same conditions that limited improvement to the reproductive health score were also noted in the facilities where the implementer was assisting with maternal health activities, we will discuss limitations in the execution of both the reproductive health activities and maternal health activities in the following sections. Though activities for both programs focused on improving performance, limitations in training delivery, inadequate post-training follow-up, and a lack of integration between family planning and other health services hampered improvements to the service providers' skills.

Issues with Training Delivery – We visited four hospitals and six health facilities assisted under the reproductive and maternal health programs assisted by Tesape'a. Staff at 8 out of 10 health facilities visited reported that the training would have been more useful if it had been conducted in their respective health facilities, took into account resources available to them, was shorter, and addressed some services delivery issues such as implementing a referral system, modifying working hours, and working to schedule staff to ensure a continuous provision of services. Even though the health staff has indicated that they prefer training that is conducted on site and which is more closely linked to their actual jobs, the implementer continued to provide long, off-site training courses. Medical staff in two out of three maternal health facilities reported not being able to attend the entire training course. Medical staff had other obligations and could not be away from their working locations for a 5- or 6-day training course. Each site faced different challenges in increasing access to its services and providing quality services. Launching activities in a hospital setting is more complex and challenging than a health center or health post. Yet, the implementer did not develop training that took into account these different contexts. These problems were also raised by a joint USAID and USAID-recipient mid-term evaluation of the reproductive health project that was conducted in 2003.

Issues with Follow-Up – A lack of on the job training and follow-up visits compromised the quality of reproductive and maternal health services. As a result, most of the techniques learned could not be implemented due to a lack of resources within the health facility. The medical staff interviewed complained of inconsistent follow-up on how to implement what was learned in the training course. This lack of follow-up was also raised by the evaluation mentioned in the above paragraph. For example, several

health centers visited had not received a follow-up visit from the implementer for several months and did not know when the next visit would occur. In one hospital, even though USAID/Paraguay's partner had conducted training on the implementation of the computerized information system to track sterilizations and provided a computer for this purpose, the tracking form was not utilized by the medical staff. The computer needed for this purpose could not be used efficiently since it was locked in the hospital director's office. In another health facility assisted, the computer system could not generate accurate counts of family planning supplies distributed, and an electronic report did not reconcile with a paper-based inventory tracking report.

We found that there was insufficient post-training follow-up with trainees where skills and approaches were reinforced. Only 3 out of the 10 health facilities visited had received regular follow-up visits by Tesape'a staff. Mission personnel working on these activities also expressed frustration at the lack of follow-up visits by Tesape'a to maximize the learning opportunity and ensure implementation of the new approach.

Insufficient follow-up visits contributed to the following issues. At one hospital where the implementer was working on improving reproductive health, there was a sign on the door of the gynecology consulting room placing invalid prerequisites on conducting a PAP smear test[3], which made it more difficult for women to have a test done. Additionally, only one health facility had the capacity to process PAP smear test samples. All other facilities had to send the test away for analysis and wait about one month for the result. This was a major problem mentioned in all sites visited. In another maternal health facility, the family planning officer in charge of conducting PAP smear tests, believed that a PAP smear test should not be conducted on pregnant women as it might affect the baby. However, according to the National Cancer Institute, pregnancy does not preclude a woman from having a PAP smear. Follow-up visits to the site should have noted the unnecessary restrictions on tests and made efforts to correct them. Likewise, follow-up visits should have noted that delays of up to a month were common between when PAP tests were conducted and when results were provided to patients. Solutions could have been pursued with the concerned medical staff as a quality-of-service issue. These conditions impact the quality of care and maternal mortality as cervical cancer is a significant cause of death in Paraguay. Finally, among seven MOH sites we visited that conducted female sterilizations, only two sites had on hand the consent form that, as per government policy, patients must sign before the procedure can be conducted. At the other five sites, medical staff had never seen the consent form and was unaware that a consent form must be completed and signed.

According to USAID/Paraguay, Tesape'a has not developed a specific step-by-step approach on improving services through techniques learned during training and strengthening the link between communities and health facilities. Tesape'a did not have an implementation plan for each technical intervention to ensure a consistent approach in implementing the interventions and to facilitate replication of a model. This problem was also reported in the 2003 USAID evaluation and USAID/Paraguay had requested Tesape'a to supply this implementation plan.

Issues with Integration of Services – In all three maternal health program sites visited (two hospitals and one health post), there was little emphasis on family planning

[3] The PAP smear test (also known as the PAP test) is used to screen women for cancer of the cervix.

services and there was little integration between the maternal health and family planning services. According to the World Health Organization, family planning services are an essential component of any maternal health program since contraception reduces health risks arising from factors such as an inadequate recovery period for mothers between pregnancies. In the two hospitals we visited where the maternal health project was implemented, there was little coordination among the various health services to ensure that pregnant woman will be referred to other health services (gynecology, obstetric, or pre-natal family planning) when attending their prenatal visit. The maternal health programs concentrated on pregnant women; however, it should have included a component to ensure that these women would receive counseling on various health related subjects, continue their participation in the program after giving birth, and conduct outreach to future mothers so that they will receive information and access to family planning services.

With regard to the reproductive health program, Tesape'a did not monitor the CYP indicator in its targeted areas to measure access to family planning services. Tesape'a also did not ensure that family planning users that had been referred by a promoter were being recorded so that the success of their social mobilization program, in terms of referring clients, might be measured. In four health facilities where we reviewed their user tracking system by method and by month, there was no tracking of the number of dropouts.

Given the level of performance that Tesape'a has achieved, and given that little time remains to correct the deficiencies since its activities are scheduled to end in September 2006, in our opinion the Mission will be better served by concluding these activities when currently obligated funds are expended and reallocating unobligated funds to other projects.

> *Recommendation No. 1: We recommend that USAID/Paraguay obtain a plan from its implementer to use currently obligated funds to reinforce training topics and integrate maternal and reproductive health and family planning services.*
>
> *Recommendation No. 2: We recommend that USAID/Paraguay reprogram the $311,237 that has not been obligated under the reproductive and maternal health quality improvement agreement to activities with greater potential.*

Mission Did Not Follow ADS Guidance to Ensure that Reported CYP Data was Reliable

Summary: According to ADS 203.3.5 guidance, performance data should be precise and reliable and missions should take steps to ensure that submitted data is adequately supported and documented. However, USAID/Paraguay did not ensure that the 2004 CYP data was reliable and accurate, and the data was not adequately supported. The unreliable data was not detected because the Mission official in charge of collecting the data did not verify that the data was of reasonable quality, review data collection processes, or obtain supporting documentation. As a result, the impact of the program could not be properly assessed.

ADS 203.3.5 requires performance data to be precise and reliable and that missions perform effective data quality assessments and take steps to ensure that submitted data are of reasonable quality, adequately supported, and documented. Although a data quality assessment was done in 2005, it did not identify problems associated with the 2004 CYP performance data.

In order to validate the accuracy and reliability of the 2004 CYP results, as reported by USAID/Paraguay, we tested the 2004 CYP-related data produced by MOH, PROMESA,[4] CEPEP, and USAID itself. The following table summarizes the results of our testing and identifies problems concerning the reliability and accuracy of the data for all four sources.

Table 6 – Data quality problems with USAID/Paraguay reported 2004 CYP Data

Source	USAID CYP Reported	Problem			
		Mathematical Inaccuracy	Incorrect Conversion Factor	No Supporting Documentation	Double Counting
1. MOH	76,572	X			X
2. PROMESA	92,877	X	X	X	
3. CEPEP	60,837	X	X	X	X
4.USAID/Paraguay estimate of MOH sterilizations	29,615	X		X	X
Total	**259,901**				

Based on our analysis, CYP reported for 2004 was based on unreliable and inaccurate data. More specifically:

1. MOH regional figures did not sum to the national figure presented. The tables provided by the MOH showed regional data totaling 76,572 CYP while the data actually summed to 103,226. Additionally, the data accumulated at the national level did not agree with support documents at the regional level. We selected six CYP result figures from the MOH summary sheet of the distribution of contraceptives, by region, and traced them back to the regional quarterly reports. Three out of six figures taken from the summary sheet that were tested did not reconcile with the results reported in the regional quarterly reports and represented a difference of 18 percent in terms of contraceptives distributed. Further, there was some double counting in the data submitted by the MOH and CEPEP. From March to August 12, 2004, the national warehouse of the MOH had no contraceptive pill supplies. However, the MOH reported that 61,371 pills (which represent a CYP of 4,091) were distributed regionally during the second quarter of 2004. The pills reported by the MOH were provided by CEPEP and were reported by them as well. Also, both the MOH and CEPEP reported 3,190

[4] Population Services International/PROMESA (Promoción y Mejoramiento de la Salud) is a social marketing program that promotes the sale of modern contraceptive supplies.

CYP from sterilizations conducted at the National Hospital. Because the Mission did not review this data, there was a double-counting problem in the data submitted by MOH and CEPEP.

2. PROMESA reported CYP was not properly computed, and we could not reconcile the figures of USAID and PROMESA. USAID reported 92,877 CYP while PROMESA reported 93,621 CYP. PROMESA used a different conversion factor than USAID for both injectable and oral contraceptives resulting in an underestimate of 1,769 CYP. Also, a lack of supporting documentation precluded USAID/Paraguay from validating the computation of CYP by PROMESA.

3. CEPEP detailed data summed to 60,099 CYP while USAID reported 60,837 CYP by CEPEP. We also verified CEPEP conversion factors by method and found that the conversion factor for 1-month injectable contraceptives (13) was not consistent with the factor of 12 that is recommended by USAID. However, this error did not significantly affect the reported CYP because 1-month injectable contraceptives comprised only 0.3 percent of the total CYP.

4. USAID estimated 2,785 sterilizations for 2004, but used a different value of 3,415 sterilizations in the CYP computation. Also, the CYP calculation was supposed to be made by multiplying the number of sterilizations by 10 (i.e. either 2,785 or 3,415 sterilizations times 10 couple years of protection per sterilization), resulting in a CYP estimate of either 27,850 or 34,150. However, the reported result of 29,615 does not correspond to either of these calculations. Finally, USAID/Paraguay did not gather and maintain sufficient documentation to support the estimated CYP from sterilizations.

During the 2005 data quality assessment, USAID/Paraguay staff identified potential errors affecting MOH CYP data; however, they did not report any weaknesses with data collected by CEPEP or PROMESA or limitation with the sterilization estimate. Also, the Mission did not document its efforts to mitigate identified weaknesses. The Mission did not verify the accuracy of the CYP data received by the concerned program partners, ensure that USAID conversion factors had been used, evaluate the data collection process, or obtain documentation supporting the reported results. Data problems were not identified when data was collected in 2004 or during the 2005 data quality assessment because Mission personnel did not perform detailed verification procedures such as tracing numbers from summary schedules back to original supporting documentation, verifying the mathematical accuracy of totals presented on detailed schedules, or assessing whether supporting documents contained enough evidence to supporting the reported results. The Mission explained that 2004 CYP data was not verified because there was insufficient time between when the data was received and when the annual report had to be submitted to Washington. Also, the person responsible for collecting the information was on maternity leave.

Without accurate data, the impact of the program, in terms of CYP achieved, could not be properly assessed. As a result, USAID/Paraguay was without a valuable management tool to guide its program and to determine if the program was progressing towards targets. To ensure that Mission managers have accurate and reliable data for reporting health results to USAID/Washington, the Congress and the public, we are making the following recommendation:

Recommendation No. 3: We recommend that USAID/Paraguay implement a system to verify the accuracy and reliability of each component of couple years of protection indicator data and review the supporting documentation.

Impact of Program Activities Based on Descriptions Included in Congressional Budget Justifications and the Mission's Strategic Plan Could Be Misinterpreted to Be Farther Reaching than Intended

Summary: High-level documents like the Mission's strategic plan and Congressional budget justification included statements that could be misinterpreted to reflect a greater impact than was actually intended. Since such documents are intended for readers who do not likely have a detailed understanding of the program, the information presented should allow them to obtain a realistic understanding of the intended results. The broad reaching statements were included in the documents because the Mission authors did not realize that some of their statements implied a more significant impact than intended. Misinterpretations of the Mission's planned impact could lead high-level managers within USAID or other interested readers of USAID documents to develop unreasonable expectations related to program results. For example, the Congress could conclude that greater impact can be attained than is actually possible with the level of resources appropriated and base future funding decisions on that understanding. The use of a CYP indicator based on national results could increase the possibility for misunderstanding.

USAID/Paraguay probably over-described the intended reach of its activities in its strategy which states that the strategic objective "will enable Paraguay to approach the goal of 'every child a wanted and healthy child, and every mother a survivor.'" Not all statements in the strategic plan imply such a broad reach. A more realistic description of its intended results was presented when the Mission described its focus "on geographical areas identified by a criteria mix of population density, poverty levels, and political representation. The Mission will concentrate on limited, demonstration projects that larger donors or the GOP [Government of Paraguay] itself can replicate." An even clearer, more detailed picture on the intended reach of activities emerges in strategic plan sections where intermediate results are presented along with illustrative approaches. This section continues in terms of "demonstration models" and "pilot projects" that will be available for replication.

Overly broad statements of impact were included in Congressional budget justifications, especially at the beginning of the program. In the 2003 budget justification, the overall goal of the reproductive health program was explained as "to reduce Paraguay's high fertility and maternal mortality rates. The objective is to reach more people with reproductive health services in order to improve maternal and infant health, while at the same time expanding the provision of family planning services to marginalized populations in need of these services." Some context was provided in that the justification stated that "activities will be conducted in a total of 12 sites in four departments to develop demonstration projects of decentralized health care that can be replicated."

Since the 2003 budget justification, the Mission has described in increasingly clearer context the program activities. The 2004 and 2005 justifications describe its decentralization and maternal health activities as technical assistance and describe a plan for working in demonstration models and provide some context that the Mission is working in model projects with a small number of communities. In the 2006 justification (which we reviewed since it had been published before the beginning of fieldwork), activities were more clearly defined than was the case in the previous four justifications and include descriptions of the number of communities, pharmacies, and health care promoters involved in implementation. Nevertheless, the Congressional budget justifications from 2004 to 2006 conclude with overly broad statements that continued progress will result in a reduction in Paraguay's high fertility and maternal and infant mortality rates and that family planning services will have been expanded to marginalized populations. While these statements are true within the scope of project activities, they imply farther reaching impacts than actually expected. The conclusions would be more appropriate if they were qualified to include only impacts in the communities where USAID had a direct, measurable influence.

The possibility of misunderstanding increased with the Mission using an indicator for its 2001 to 2005 strategy that was based on national data even though program activities were designed to have community-level impact. The results indicator included in the strategic plan and reported in the Mission's annual report to reflect the overall progress of the strategic objective was the country-wide CYP index for Paraguay. The CYP performance indicator included data from the MOH, CEPEP, and PROMESA, and an estimate of the number of sterilizations performed. Because the audit was conducted before the end of the year, the 2005 CYP figure was not available. Instead, we evaluated the 2004 result against the target included in the Mission's strategic plan.

For calendar year 2004, USAID/Paraguay reported 259,901 CYP versus a target of 240,000. The result was comprised of the following:

Table 7 – CYP reported for 2004 by USAID/Paraguay by component

Source	**Contribution to CYP**
MOH	76,572
PROMESA	92,877
CEPEP	60,837
PROMESA USAID/Paraguay Estimate of MOH Sterilizations	29,615
Total	**259,901**

Each source of CYP data represents the total achieved on a national level. Because assistance provided by USAID/Paraguay to CEPEP was designed to increase the organization's ability to survive as a self-sustaining organization and because increasing CEPEP's institutional capacity allowed the organization to support all its activities, using the national result of 60,837 generated by the infrastructure being supported was appropriate. However, USAID/Paraguay in reporting national results for the MOH does not reflect that USAID did not provide assistance to the MOH related to sterilizations, provided approximately 85 percent of the donated contraceptive during the year, and worked in reproductive health in a limited number of MOH facilities. Likewise, the result

from PROMESA reflects CYP from a source that was 40 percent attributable to USAID assistance.

Since high-level documents such as strategic plans and Congressional budget justifications are intended for readers who do not likely have a detailed understanding of the program, the information presented should allow them to obtain a realistic understanding of the intended results. The broad reaching statements were included in the documents because the Mission authors, being extremely familiar with the program, did not realize that some of their statements implied a more significant impact than intended. USAID/Paraguay developed and used the indicator in good faith believing that it was the best option to show whether access to reproductive health services was increasing. Mission officials said that using the CYP index was recommended by USAID headquarters after thorough consideration of other indicators. Mission officials said that they had no intention of creating unrealistic expectations.

Misinterpretations of the Mission's planned impact could lead high-level managers within USAID or other interested readers of USAID documents to develop unreasonable expectations related to program results. For example, the Congress could conclude that greater impact can be attained than is possible with the level of resources appropriated and base future funding decisions on that understanding.

> *Recommendation No. 4: We recommend that USAID/Paraguay avoid overly broad conclusions when describing reproductive health activities in the 2007 Congressional Budget Justification that could be misinterpreted by readers who are not familiar with the scope of the program.*
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> *Recommendation No. 5: We recommend that USAID/Paraguay develop indicators for its upcoming family planning and reproductive health strategy that measure results that are reasonably attributable to Mission efforts.*

Did USAID/Paraguay and its partners manage reproductive health and family planning activities in an efficient manner?

The Paraguayan Center for Population Studies (CEPEP) made management decisions based on the impact the decisions would have on its ability to meet its efficiency objective. However, USAID/Paraguay and its other partners, the Center for Development Information and Resources (CIRD) and Tesape'a, did not develop efficiency indicators and therefore did not guide program activities based on efficiency concerns.

Efficiency Indicators Not Established

Summary: USAID/Paraguay and its partners used a number of indicators that reflected whether the activities were meeting its planned results, but, except for CEPEP's sustainability indicator, those measures did not demonstrate whether results were being met efficiently. The Mission and its partners decided not to use efficiency measures since the Mission's determination of program success focused solely on attaining results. Although not required by the Automated Directives System and therefore not included as indicators in performance monitoring plans, USAID recognizes the need for being efficient. The Project Management Institute also identifies monitoring for efficiency

as a best practice. To better manage program activities, the availability of efficiency measures would allow managers to make decisions on how to maximize results given limited resources.

Effectiveness measures outputs or results in total. Typical effectiveness measures, like ones used by USAID/Paraguay, report on the number of local health councils that hold regular meetings, the number of health promoters working in a community, and the number of individuals trained. Efficiency measures typically relate achievements to the resources required to achieve the result. Examples of efficiency measures could include the amount of money spent per local health council or cost per person trained.

USAID/Paraguay's project with CEPEP was designed to improve sustainability which implies a certain level of efficiency. CEPEP's indicator measured the ratio of its costs needed to provide core services with the revenues from those services. Efficiency is measured through this indicator since improvements in the measure can only be obtained through two factors. Core revenues can increase without increasing core costs or core costs can be reduced without lowering core revenues. Either scenario defines improved efficiency.

CIRD and Tesape'a said they made conscious decisions not to develop and analyze indicators that tracked measures like cost per training session or cost per CYP attained. Since they were being measured on effectiveness, they chose not to incur the costs of collecting and analyzing efficiency measures. These implementers' attitudes toward monitoring for efficiency are consistent with USAID's lack of emphasis on monitoring for efficiency. The Automated Directives System (ADS) provides no guidance or requirement related to monitoring for efficiency. Efficiency is not even defined in the ADS glossary, while terms needed to describe effectiveness like "output" and "result" are defined. Nevertheless, USAID acknowledged the need for efficiency when it published the following statement related to efficiency in reproductive health programs in *Health and Family Planning Indicators: Measuring Sustainability* in 1999. "Governments need to overcome inefficiencies and stop spending scarce resources on less effective aspects of family planning and health care. Instead, governments should focus resources on the services that do the most good for the greatest number of people at the lowest cost."

Project management best practices also outline a need for monitoring efficiency. The Project Management Institute in *A Guide to the Project Management Body of Knowledge* (*PMBOK® Guide), 2000 Edition* outlines earned value management as a "method for integrating scope, schedule, and resources, and for measuring project performance. It compares the amount of work that was planned with what was actually earned with what was actually spent to determine if cost and schedule performance are as planned." It is the combination and comparison of these three factors (scope, schedule, and resources) that produces a measure for efficiency.

Even though CIRD and Tesape'a had detailed expense information available through the normal course of business that could have been used in developing and reporting on efficiency measures, their emphasis was on not exceeding budget authorizations and on achieving overall, high-level results.

For example, although it could have been produced and regularly evaluated, the resources spent per local health council assisted were not tracked. The availability of such information would have been useful. The information could have provided insight into obstacles needing to be overcome. It might help explain the slower progress of some local health councils when compared to others or differences in quality between clinics if the level of resources consumed between the two could be related. With efficiency information, partners could more easily target resources to areas showing the most promise or cut back resources to the highest performers in order to focus on others. The approach depends on management's judgment, but the information is necessary to facilitate an informed decision.

We do not want to create the impression that USAID/Paraguay and its partners did not manage or monitor project activities. However, the techniques they used were better suited for managing the effectiveness of projects rather than efficiency. To manage activities, the Mission and its partners developed detailed, defensible budgets; developed annual work plans; developed performance monitoring plans; reported on progress of work plan activities in regular reports; reviewed progress reports; performed mid-term program evaluations; conducted status review meetings; compared actual expenditures to planned budget levels; conducted site visits; and followed procurement practices designed to obtain goods and services at cost-effective prices.

Even though USAID/Paraguay's partners prepared detailed, defensible budgets that represented their planned expenditures to meet their desired results, without efficiency measures incorporated into the design of the project's execution, we must rely on the budget reviews by cognizant technical officers during the approval process for assurance that the planned activities and corresponding budget levels are reasonable to meet the expected results.

> *Recommendation No. 6: We recommend that USAID/Paraguay include indicators in the strategy that is currently under development to measure the efficiency of its reproductive health program.*

Other Matters

During the course of our site visits, other matters came to our attention related to conditions that could be addressed to improve the effectiveness and management of the Mission's reproductive health and family planning activities. Those matters include using CYP data at the facility level to measure effectiveness of the program, improvements that are needed in the Ministry of Public Health and Social Welfare's (MOH's) contraceptive supply chain, and planning to monitor critical constraints related to the Mission's upcoming family planning and reproductive health activities phase-out plan.

CYP Was Not Used to Assess Progress Toward Achieving Results in Targeted Areas

Summary: USAID/Paraguay's implementing partners collected achievement-related data. However, the collected data did not support the calculation of community-specific CYP figures. Accordingly, progress toward achieving results in improving access to family planning services in targeted areas could not be assessed. ADS 203.3.2 states that indicators need to show progress toward meeting results, and ADS 203.3.4.2 states that indicators should measure results that are attributable to program activities.

CYP data at the community level could have been collected and utilized to more clearly show the progress made towards expanding access to family planning services within each partner's area of operation. However, the Mission and its implementers chose to monitor other indicators that they felt better reflected progress towards meeting results.

In gauging the impact of increasing the voluntary use of reproductive health services, the Mission used the national CYP index as a performance indicator but did not have Tesape'a develop CYP data specific to the geographic areas where it provided assistance. Therefore, the Mission could not effectively monitor achievements specifically related to its objective of improving access to family planning services in targeted facilities. In so doing, the Mission could not measure the efficiency and effectiveness of the program and apply those measurements to improving program implementation. There are several advantages of using CYP to measure family planning program output. The data needed to calculate the figure is readily available. The calculation is relatively simple. CYP tends to focus on an output (contraceptives distributed) rather than a process (activities conducted to promote contraceptive use). Finally, the indicator is well known, understood, and widely used.

Tesape'a chose to use other indicators that its management believed would best allow it to monitor progress toward meeting results. Some of the indicators Tesape'a collected measured progress by assessing their referral and counter-referral system, the number of information, education, and communication (IEC) materials distributed, the number of community promoters working, and the number of referrals from promoters.

In its 2nd Quarterly Progress Report ending June 2005, Tesape'a stated that it developed and disseminated posters on family planning and developed IEC materials to be used by promoters. Even though these indicators may be valuable in measuring the quality of the family planning services, CYP, which measures the contraceptive supplies distributed to users of a health facility, would have provided more useful data with which to measure overall progress.

ADS 203.3.2 states that operating units must establish a systematic process for monitoring the results of activities; collecting and analyzing performance information to track progress towards planned results; using performance information to influence program decision making; and communicating results achieved or not attained. Further, ADS 203.3.4.2 says, "Performance indicators selected for inclusion in the PMP should measure changes that are clearly and reasonably attributable, at least in part, to USAID efforts," the Mission's activities with the MOH would have been better conveyed by presenting CYP attributable to the specific MOH facilities receiving assistance.

In addition to providing valuable information related to the indicator of the strategic objective on improving access, the information would have assisted USAID/Paraguay in identifying and addressing logistical and data collection problems. For example, deficiencies with inventory tracking forms (discussed in the next section) would have been detected and more effort could have been placed on improving access to family planning services.

> *Recommendation No. 7: We recommend that USAID/Paraguay instruct its partners to monitor and report on the couple years of protection indicator in their respective project areas so that the Mission can evaluate each partner's progress towards meeting the Mission's strategic objective.*

Unreliable Provision of Modern Methods of Contraceptives Impacted Reproductive Health Program

Summary: The Ministry of Public Health and Social Welfare was unable to ensure a reliable supply of contraceptives in the health facilities we visited. Several factors contributed to the shortage of contraceptives including untrained service providers, weak inventory control systems, and inadequate distribution mechanisms. Also, sterilization was not easily available as a family planning method. Without a reliable supply of modern contraceptives, it will not be possible to achieve the Mission's objective of improving maternal health through increased access to family planning services. Supply problems have resulted from the Government of Paraguay's history of inconsistent political and financial support for family planning programs.

Without a reliable supply of modern contraceptives and improved access to female sterilization, it will not be possible to make progress towards providing family planning services and thereby have a significant impact on maternal mortality and morbidity. Many people in Paraguay are not receiving adequate family planning services due to the lack of a reliable supply of modern contraceptives available through government health facilities. According to the Paraguayan Demographic Health Study, the unmet demand for modern contraceptive methods among all women was 15 percent from 2001-2004. The same survey found that the total demand for modern family planning methods among married women was 79.4 percent while only 60.5 percent of the demand was met. Thus far, the MOH has been unable to ensure that contraceptive supplies are available to the most vulnerable segments of the population. The MOH does not have a well managed, sustainable, and self-reliant procurement operation.

There are several factors contributing to the inability of the MOH to ensure a reliable supply of modern contraceptives. Even though the government has been receiving free contraceptives from USAID and other donors, it has not been able to ensure a continuous supply and develop a delivery system that avoids shortages of contraceptive supplies. For example, the MOH had no supply of oral contraceptives from April to August 2004 and had only a limited supply of other contraceptives during all of 2004. USAID has provided assistance to the MOH to strengthen logistics in the past, but lasting results have not been achieved. As far back as 1996, an assessment done at the end of a related project concluded that regional demand forecasts were not prepared, an inventory control system was not functioning, storage facilities were inadequate, staff had not been trained on how to complete the forms used to collect and report essential logistical data, and consumption reports/data were not properly prepared or used. The problems identified in 1996 continue to persist.

During our visits to 15 MOH health facilities, we found that all of the problems previously reported continued to affect the reliability of contraceptive supplies. Clinics had not been able to supply all users with needed contraceptives, staff had not been trained on data collection, and most health facilities did not have an accurate ending inventory or were not generating accurate contraceptive consumption data including the number of contraceptive users. We also found that regional storage facilities were inadequate, that supplies were not properly stored, and that the distribution system for contraceptives could not be relied upon for timely delivery. These problems are described in detail in the following sections. However, it should be noted that correcting these supply deficiencies was not part of the Mission's strategic plan until October 2005.

Training on Data Collection Needed – Fourteen out of 15 family planning personnel that were interviewed had not been trained on how to complete the inventory tracking forms entitled *Informe de Movimiento de Insumos* (IMI). The IMI forms are used to collect essential logistical and usage data. Each MOH facility is required to complete a monthly IMI report. We reviewed IMI reports completed by 12 facilities.[5] The IMI itself needs improvement since it does not have categories for collecting data on female sterilization, Postinor (emergency contraception pill), or separate categories to distinguish between three-months versus one-month injectable contraception. Four out of 12 facilities had not properly carried over the August ending balance to the September beginning balance. As a result, the IMI contraceptive consumption form could not have been used to generate accurate supplies counts or accurate calculations of the number of contraceptive supplies needed, by method. We reviewed completed IMI forms (August and September 2005) prepared by 12 visited health facilities. None of the facilities had properly assessed the average quantity of supplies needed or the number of contraceptive users. Consequently, the facilities had not ordered the contraceptive supplies that would meet the needs of family planning users. At one facility, no one wanted to be responsible for completing the IMI report.

An analysis of all IMI reports show discrepancies between the number of users that could have benefited by a method and the actual amount of contraceptives distributed. For example, one health facility reported having distributed 41 cycles of pills but having provided family planning services to 60 new users in oral contraceptives. Another health facility reported having delivered 22, one-month injectable contraceptives but claimed to cover 111 users. On a positive note, the reports are timely: three MOH regional offices had received the IMI reports from all the facilities visited for the month of September by the time of our visit in mid-October. At the national level, the IMI data for the first two quarters had been compiled and the CYP had been calculated by region. The data for the third quarter was being inputted during our visit. The person responsible for inputting the data had not been trained and did not know the purpose of the data. With the right training and some follow-up, the quality of data collected in the IMI report could be improved significantly.

Inventory Control Systems Need Improvement – The inventory control systems in 12 of 15 visited health facilities were not producing accurate results. Consequently, the facilities did not have an accurate ending inventory and the stock on hand could not be reconciled with the stock received and distributed. The lack of an accurate inventory makes it difficult to determine the amount of contraceptives to be ordered and supplied.

None of the visited facilities had, as per government norms, a two-month reserve of supplies. Users of oral contraceptives in 10 out of 15 health facilities could only obtain one cycle of contraceptive pills because the clinic was afraid of running out of supplies; this has a particularly adverse impact on women who live far away from the facility. Most clinics had very little stock left at the end of each month. The MOH regional health centers reported having a lack of stock at the end of each quarter.

Only 3 out of 15 visited health facilities had been able to supply all family planning users with needed contraceptives during the period of August and September 2005. Family planning officers reported having difficulty obtaining supplies from their regional health

[5] We did not obtain the IMI reports at two facilities and one IMI report was incomplete.

office at the end of each quarter. During our visits, 12 facilities had a shortage of at least one modern contraceptive method. A total of seven health facilities and two regional warehouses did not have Depo Provera (a three-month injectable contraceptive) during our visit. However, the national warehouse in Asuncion had a sufficient supply and could not explain the shortages at the regional level.

Out of 12 health facilities for which we were able to compare the stocks ordered by the clinic to the stocks delivered by the regional offices, the data reconciled in only two health facilities. In 10 out of 12 health facilities visited, there were discrepancies between the quantity of supplies received as reported by the local and regional facilities. For example, one health post reported receiving 20 cycles of oral contraceptives in both August and September 2005, while, according to the regional facility, 80 and 40 cycles of pills were delivered, respectively. In another facility there was a difference of 132 condoms between what the health facility reported as received and what was reported as delivered by the regional office. There was also evidence that the report of one regional office was altered to cause the data to reconcile. We reviewed two copies of the same IMI report in one health facility and found that the original IMI report from the health facility differed from the copy of the IMI report on file at the regional office, which had been altered to show a balance of condoms of 538 rather than the actual figure of 646. We also noted that there was no mechanism in place to report discrepancies between the supplies received and ordered. There should be a system in place for the health center to validate the quantity of contraceptives received and to report any errors to the regional office.

The storage facilities at four regional warehouses and the national warehouse were inadequate. Boxes were stacked in unsecured hallways and rooms. The facilities did not have air conditioners to maintain recommended storage temperatures, and some boxes were stacked upside down which could lead to reduced effectiveness of the contraceptive Depo-Provera. The risk of loss was high and may have explained why the inventory did not reconcile with the stock received and distributed between regional warehouses and health facilities.

We found highly motivated and dedicated MOH staff that were keen to provide assistance to improve access to family planning supplies. In two regional centers, the staff worked overtime to provide us with the information and to complete their quarterly logistical reports on time. In one regional center, the staff had requested training several times on stock management, but the central level had not approved their request. The staff at the regional offices was aware of the mistakes in the IMI reports and the impact of the mistakes on the family planning program. However, a lack of training, inadequate storage facilities, an improper logistical system, and an inadequate communication system hampered the efforts of the staff.

Distribution System Needs Improvement – The distribution system is inadequately staffed and inefficient. Each clinic has to send someone to the regional center to collect supplies. The center is only open until 1:00 p.m. from Monday to Friday which makes it difficult to complete the task in one day. At the national center and in two regional offices, only one person is responsible for delivering supplies. Consequently, if that person is absent for any reason, the health facilities cannot pick up supplies. Most of the health facilities do not have their own vehicles for distribution and depend on the public transportation system to get their supplies. Also, some health facilities can only go once a month to the regional center due to a lack of funds or because they are in remote

areas. In addition to scheduling and staffing problems, there was inadequate logistical support. For example, one MOH regional office had not been able to obtain from the national warehouse the 14,400 condoms ordered, because there was not sufficient space in the vehicle to carry all the supplies.

Availability of Female Sterilizations Should Be Improved – The Paraguayan Demographic Health Study from 2004 identified a significant unmet demand for female sterilizations. The study noted that, although 34 percent of married women wanted to be sterilized, only 11.5 percent had been sterilized. The study also noted that 10 percent of fertile women who did not want to have more children had been refused voluntary sterilization services. We visited seven MOH facilities that conducted female sterilizations. Consistent with the survey's report, we noted that doctors were willing to perform sterilization operations independent of a Cesarean section operation in only three of those seven facilities.

The problems related to the unreliable provision of modern methods of contraception discussed above have resulted from the Government of Paraguay's history of inconsistent political and financial support for family planning programs. In 1979, the government suspended its activities to supply contraceptives. Nine years later, services were reestablished. However, with a change in government in 1998, services were again suspended for seven months.

We are not making recommendations on these matters because the factors that need to be improved have been incorporated into USAID/Paraguay's current reproductive health and family planning strategy. The Mission's strategy includes strengthening procurement and logistics within the MOH, strengthening the health care decentralization process, increasing access to female sterilization and supporting community mobilization.

Constraints Should Be Monitored During Phase-Out of Family Planning Assistance in Paraguay

Summary: Noting improvements in Paraguay's total fertility rate over the past decade, and facing decreases in family planning budgets, USAID/Paraguay and USAID/Washington have established a plan to phase out family planning assistance to Paraguay. The phase-out plan speaks of Paraguay graduating from USAID assistance and of leaving the country with the tools it needs to manage its own family planning program into the future. The plan details several critical constraints that could impact the success of the phase-out plan, but the plan did not include provisions to monitor that the constraints are not impeding the plan's implementation. Common project management principles require a detailed work plan to include constraints and planned responses and contingencies. If constraints were not monitored and responded to during implementation, the phase-out plan may not meet its goals.

On the strength of promising data from Paraguay's 2004 Demographic Health Survey, namely a total fertility rate of 2.9 children per woman and a modern contraceptive prevalence rate of 60.5 percent, USAID has identified Paraguay as a candidate for "imminent graduation" from receiving family planning assistance. While noting improvements in total fertility and contraceptive prevalence rates generally, the phase-out plan appropriately mentions the differences in rates when comparing rural and urban populations and women with different levels of education.

Certainly, a significant level of effort will be needed to realize USAID's graduation vision "to leave Paraguay with the capability to provide quality family planning contraceptives and services in all districts" and to meet its objective "to ensure that mechanisms are in place, post-graduation, for an institutionalized national program with national and community level advocacy and participation, strengthened procurement and logistics, and greater access to a broad mix of contraceptive methods, including permanent ones."

To meet its phase-out vision and objective, the Mission has identified three principal work components. Based on the Mission's assessment of priority, the components are strengthening procurement and logistics with the MOH, community mobilization and strengthening the health care decentralization process, and increasing access to female sterilization. Working with the MOH to strengthen procurement and logistics is the obvious first choice for an activity to successfully phase out of family planning assistance. The MOH, by virtue of its size, established organization, national coverage, and responsibility to serve its population, is in the best position to make an impact large enough to enable USAID to successfully phase out its reproductive health and family planning activities. The Government of Paraguay has shown signs of a new commitment to family planning by, for the first time, establishing a line item for the purchase of contraceptives in its annual budget. With USAID/Paraguay's assistance, Paraguay has developed and adopted a reproductive health strategy covering 2003 to 2008. The Mission and USAID/Washington have determined that staff within the MOH has the technical capability to take on Paraguay's procurement and logistical challenges.

Meeting the objective of the phase-out plan will require effort, which the Mission fully recognizes. It has identified four significant factors that could limit the successful implementation of the plan:

- The Mission and USAID's Latin America and the Caribbean (LAC) Region face decreases in funding. U.S. government funding may not be assured over the entire period of the phase-out plan.

- The level of commitment of the government of Paraguay to continue funding family planning and reproductive health could decrease. Indeed, the government has a history of curtailing support for family planning activities. In 1979, the government suspended its activities to supply contraceptives. Nine years later, services were reestablished. However, with a change in government in 1998, services were again suspended for seven months. Even with the favorable current political climate, Paraguay faces economic challenges that will test its ability to provide funding.

- Health districts within the MOH can autonomously decide on the level of support they provide for family planning services.

- The phase-out plan itself is tightly scheduled and modestly funded.

To these factors, we would add one more constraint, corruption. During a visit to the MOH central storage facility for contraceptives, a MOH official commented that petty theft of contraceptives was an issue. During our audit, on a site visit to a MOH clinic, stock counts did not reconcile to documents showing the inflow and outflow of

contraceptives. When asked about the deficiencies, the official said she had consigned contraceptives to a local convenience store for sale. However, an employee at the convenience store said that no contraceptives were being sold at that store. At another location, it appeared that records of amounts of stock received had been altered in attempt to reconcile the quantity available. Also, at the national MOH warehouse, the year end inventory value for 2004 was not carried forward and was not the same number used at the beginning of 2005. The difference was approximately 400,000 condoms. Officials explained that condoms were distributed to the Paraguayan army but that the records were lost. Inadequate recordkeeping noted during site visits and inadequate storage facilities increase the risk that contraceptives could be stolen. It must be noted that according to Transparency International's corruption perception index, Paraguay received a ranking indicating a high level of corruption, the 12th most corrupt out of 155 countries. It would be reasonable to expect that some level of corruption exists within the government entities with which USAID/Paraguay will need to work during the phase-out plan.

The risk of corruption facing program activities and USAID's new anti-corruption strategy should be considered when developing program activities under the phase-out strategy. During 2005, USAID launched an activity to promote anti-corruption components within its regular programs. Per USAID's Anticorruption Strategy, one of the four directions to follow includes deploying resources to strategically fight corruption. "The Agency must deploy its resources strategically and must allocate a greater proportion of available resources to reducing corruption. Missions and bureaus can leverage resources by incorporating anticorruption components into all sectoral programs affected by corruption (including agriculture, education, energy and health, in addition to democracy and governance, and economic growth)."

The Project Management Institute in *A Guide to the Project Management Body of Knowledge (PMBOK® Guide)* 2000 Edition identifies the need for a detailed plan to include constraints and assumptions and planned responses and contingencies to be used to guide both project execution and control. It also identifies the need for resource planning in "determining what physical resources (people, equipment, materials) and what quantities of each should be used and when they would be needed to perform project activities." A detailed work plan is the primary input into resource planning and should be "closely coordinated with cost estimating." If the necessary level of resources is not available for an expectation, the project goal may need to be adjusted, a new set of activities developed, resources identified, and budgeted.

The Mission focused on defining activities in the phase-out plan and did not consider including provisions to monitor critical constraints. However, these constraints should be monitored to reassess the viability of the program at different points during the implementation in order to ensure that activities can be successfully implemented.

> *Recommendation No. 8: We recommend that USAID/Paraguay assess the likelihood that USAID, the government of Paraguay, and other donors will fully fund their resource commitments needed under the Mission's family planning phase-out plan.*

Recommendation No. 9: We recommend that USAID/Paraguay establish milestones that measure USAID's, the government of Paraguay's, and other donors' political, financial, human capital, and other resource commitments to implementing the family planning and reproductive health phase-out plan.

Recommendation No. 10: We recommend that USAID/Paraguay prepare alternative activities that could be quickly implemented if commitment milestones are not met by the parties involved in providing resources to the family planning and reproductive health phase-out plan.

Recommendation No. 11: We recommend that USAID/Paraguay incorporate anti-corruption efforts into its family planning and reproductive health phase-out plan.

EVALUATION OF MANAGEMENT COMMENTS

USAID/Paraguay's comments to the draft report are included in Appendix II.

In its comments to the draft report, the Mission agreed with ten of the recommendations presented but did not agree with two others. After further consideration of one of those recommendations, we decided that the recommendation was not practical and have deleted it from this report. We have also deleted the related section from Appendix II. Mission management likewise did not agree that Recommendation No. 5 could be implemented since the strategy's final reporting period had passed before this audit report was issued. To compensate for this, we modified the recommendation to address the Mission's upcoming strategy period. USAID/Paraguay concurred with the recommendation as modified. Accordingly, management decisions have been reached for all eleven recommendations included in the report. Determination of final action will be made by the Audit Performance and Compliance Division (M/CFO/APC).

In its comments, USAID/Paraguay also expressed concern that this report did not sufficiently describe the Mission's "notable successes and the positive results achieved to date." We made our best effort to present a balanced, objective view of the program activities. The Mission also asked us to clarify that correcting deficiencies with the MOH regarding the unreliable supply of contraceptives was not part of the Mission's strategic plan until October 2005. We have done so in the report section beginning on page 21.

SCOPE AND METHODOLOGY

Scope

The Regional Inspector General/San Salvador conducted this audit in accordance with generally accepted government auditing standards. The purposes of the audit were to determine whether the program achieved the planned results described in USAID/Paraguay's strategic plan, in the Congressional budget justifications, and in the cooperative agreement and contract documents; and whether USAID/Paraguay and its partners managed program activities in an efficient manner.

In planning and performing the audit, we obtained an understanding of and assessed the Mission's controls related to the management of its reproductive health and family planning program. The management controls identified included performance monitoring plans; the Mission's Annual Report; the Mission's annual self-assessment of management controls through its annual Federal Managers Financial Integrity Act; and cognizant technical officers' field visits, reviews of progress reports, and day-to-day interaction with implementers.

We judgmentally selected sites to visit giving preference to communities that had activities falling under more than one strategic objective activity. Notwithstanding, we made our selections to ensure a representative mix of urban and rural facilities. In several communities all three implementers conducted activities. Those communities received preference since it allowed us to minimize travel time between facilities. The number of locations visited and the number receiving assistance through USAID/Paraguay's implementers are detailed in the table below:

Table 8 – Breakdown of sites visited categorized by implementer

Implementer	Type of Facility Visited[6]	Total Receiving Assistance	Number Visited
Paraguayan Center for Population Studies (CEPEP)	Clinics	4	4
Center of Development Information and Resources (CIRD)	Departmental Warehouses	3	1
	Health Councils	15	6
	Social Pharmacies	16	5[7]
Tesape'a	Health Centers	8	4
	Health Posts	17	2
	Hospitals	11	4
No USAID assistance	Health Posts	-	4
	MOH Regional Offices	-	4
	Social Pharmacies	-	2

[6] A health center is typically larger, has more technical staff, and offers more services than a health post.

[7] Includes one health center.

The audit was conducted at the offices of USAID/Paraguay, the offices of the Mission's implementers in Asuncion, as well as 15 MOH facilities (six health posts, five health centers, four hospitals), the national office of the Ministry of Public Health and Social Welfare (MOH), four regional offices of the MOH, and four clinics of the Paraguayan Center for Population Studies from October 12, 2005 through November 3, 2005.

From October 2001 through September 30, 2005, USAID/Paraguay had obligated $6.0 million and expended $4.6 million on the strategic objective.

Methodology

To answer the audit objectives, we visited health care facilities, social pharmacies, and supply warehouses. At those facilities, we interviewed family planning service recipients, service providers, and administrators. We collected and analyzed data on contraceptives provided by the health care facilities and social pharmacies, counted inventory, and reviewed reconciliations. We interviewed Mission Cognizant Technical Officers and other responsible officials and examined documents such as the Mission's Performance Monitoring Plan and Annual Report. We visited with officials from the Mission's implementing partners and examined agreements, work plans, budgets, performance monitoring plans, and progress reports.

We selected indicators to evaluate to answer our first audit objective from the Mission's strategic plan and from the Paraguayan Center for Population Studies' (CEPEP's) cooperative agreement. The strategic plan included four indicators for the reproductive health objective. We evaluated the indicator measuring couple years protection (CYP) since it was the principal indicator for the strategic objective. In order to assess the progress of each of the Mission's three implementers that were conducting activities at the time of the audit, we selected the indicator from the strategic plan that was related to the Center for Development Information and Resources (CIRD). The other two indicators in the strategic plan were both related to activities by Tesape'a. We selected the indicator which we believed reflected the area of the most significant activity. Since the strategic plan did not include an indicator for CEPEP, we chose the indicator we believed was the most significant of the three indicators included in CEPEP's cooperative agreement.

Our audit team included a demographer with experience in implementing family planning and public health activities. To determine the significance of our findings, we judged that the Mission met planned results if all of the conditions stipulated in indicator definitions included in the Mission's strategic plan were completed as described based on our review of supporting documentation and our observations during site visits.

MANAGEMENT COMMENTS

USAID | PARAGUAY
DEL PUEBLO DE LOS ESTADOS UNIDOS DE AMÉRICA

January 3, 2006

MEMORANDUM

TO: RIG/San Salvador, Timothy E. Cox

FROM: USAID/Paraguay Director, Wayne Nilsestuen

SUBJECT: USAID/Paraguay's response to the report on Audit of USAID/Paraguay's Reproductive Health and Family Planning Activities (Report No. 1-526-06-0XX-P)

Under cover of this memorandum we are transmitting our response to the subject draft audit report, as requested in your memo of December 2, 2005. We have responded to each of the 12 recommendations, proposing actions and target dates for completion. We are providing, as requested, a signed and unsigned electronic copy of this memorandum in Microsoft Word.

There are several issues outside the recommendations that we would like to bring to your attention for your consideration. These issues are described at the end of the Mission's responses to the recommendations document attached. The Mission would appreciate if the audit team could consider these issues in finalizing its audit report.

USAID/Paraguay thanks the RIG Audit team for its thorough and thoughtful audit of the Mission's Reproductive Health and Family Planning activities. The audit teams observations and suggestions will assist the Mission in improving current programs, as well as in the design and monitoring of programs under the new Strategic Statement when it is developed.

FAMILY PLANNING AUDIT DRAFT REPORT

USAID/PARAGUAY
RESPONSES TO RECOMENDATIONS

Recommendation No. 1:

We recommend that USAID/Paraguay obtain a plan from its implementer to use currently obligated funds to reinforce training topics and integrate maternal and reproductive health and family planning services.

Audit report discussion, page 12 notes: "... given that little time remains to correct the deficiencies since its activities are scheduled to end in September 2006, in our opinion the Mission will be better served by concluding these activities when currently obligated funds are expended and reallocating unobligated funds to other projects/activities.

Mission comment and plan for corrective actions: USAID/ Paraguay concurs with the recommendation and will work with its contractor to use currently obligated funds in the most judicious way possible considering the limited time remaining in the contract. A new work plan will be developed with the contractor to complete key activities.

Target date for completion: March, 2006

Recommendation No.2:

We recommend that USAID/Paraguay reprogram the $311,237 that has not been obligated under the reproductive and maternal health quality improvement agreement to activities with greater potential.

Mission comment and plan for corrective action: The Mission concurs with the recommendation and will reprogram the $ 311,237 that has not been obligated to activities with greater potential. Regarding this situation, the Mission has been in contact with the RCO concerning the scope and conclusion of Tesape'a activities by September, 2006. The remaining funds will be allocated into key activities designed under the Phase-out plan, including the strengthening of the logistic system and access to voluntary female sterilization activities.

Target date for completion: August, 2006

Recommendation No. 3:

We recommend that, for indicators to be reported in 2005, USAID/Paraguay review the calculation of each component of couple years of protection to ensure that all reported results have supporting information, that data reconciles, and that the calculation is based on proper USAID conversion factors.

Mission comment and plan for corrective action: Although it is beyond the mission's ability to review each and every facility reporting CYP at the operational level in order to assure that each month accurate data is reported, the Mission recognizes the importance of quality data and its supporting documentation. USAID/Paraguay will work

with partners to strengthen the reporting of CYP assuring that the proper conversion factors are utilized.

The Mission concurs with the recommendation and a contractor is now working in logistics improvement (DELIVER). It has been charged with reviewing all calculations and conversion factors and to correct any CYP errors for the Annual Report. The Mission is also developing plans for quality control reviews to be conducted by mission health personnel on field visits. This may include review of randomly select IMI (inventario de movimiento de insumos) reporting forms in order to double check figures. Appropriate partners will be required to include similar reviews in their work plans as part of periodic supervision activities and to assure that MOH personnel's reports and calculations are accurate. CYP conversion factors will be kept updated.

Target date for completion: July, 2006

Recommendation No. 4:

We recommend that USAID/Paraguay avoid overly broad conclusions when describing reproductive health activities in the 2007 Congressional Budget Justification that could be misinterpreted by readers who are not familiar with the scope of the program.

Mission response and plan for corrective action: The Mission concurs with the recommendation and USAID/Paraguay will be more precise in writing the 2007 CBJ to assure that readers unfamiliar with activities will be less likely to misinterpret the scope of the program. The text will include achievements in communities where USAID has had a direct and measurable influence. If future programming includes policy and national systems level improvements they will be described as such, as they will exert influence on a wider scale than specific community/facility/municipality level activities, but in all cases, reporting will follow the guidance in the ADS 203.3.4.2. so that "measurable changes are clearly and reasonably attributable, at least in part, to USAID efforts".

Target date for completion: December, 2005

Recommendation No. 5:

We recommend that USAID/Paraguay clarify the presentation of its couple years of protection figure in its annual report to show the level attained that can be most clearly attributed to its program activities.

Mission response and plan for corrective action: USAID/Paraguay can not concur with this recommendation. While in recent years, somewhat around the 50% of contraceptives have been supplied by the private sector, USAID has provided a large percentage of contraceptives distributed by the public sector during the past 3 years and will continue making donations during the phase-out period. Therefore USAID is primary supplier of public sector contraceptives. Also, the Mission has donated contraceptives to both CEPEP and PROMESA until 2004. Thus, USAID/Paraguay believes it makes a very significant contribution to overall level of available contraceptives and in turn has a major impact on couple years of protection. Accordingly, CYP can be reasonable attributable to program activities.

Recommendation No. 6:

We recommend that USAID/Paraguay include indicators in the strategy that is currently under development to measure the efficiency of its reproductive health program.

Mission response and plan for corrective action: The text on page 26 notes that: "the ADS provides no guidance or requirement related to monitoring for efficiency" and acknowledges as well that USAID has traditionally focused its programs on achieving results. In addition the Mission thanks the auditors (pg 27) for acknowledging that USAID/ Paraguay and its partners managed and monitored project activities, in spite of using techniques that were better suited for managing the effectiveness of projects rather than efficiency.

The Mission concurs with the recommendation. However, according to ADS guidance for developing strategy statements, indicators will not be longer included in the strategy document. The Mission is proposing to include indicators that measure the efficiency of its reproductive health program in the new mechanisms (contracts and/or cooperative agreements) to be developed and negotiated for the implementation of the new strategy. The health team is currently reviewing the recommended PMBOK Guide in order to incorporate best practices in managing projects and programs.

Target date for completion: December, 2006.

Recommendation No. 7:

We recommend that USAID/Paraguay instruct its partners to monitor and report on the couple years of protection indicator in their respective project areas so that the Mission can evaluate each partner's progress towards meeting the Mission's strategic objective

Mission response and plan for corrective action: The Mission concurs with the recommendation and will modify partner's work plans to monitor and report on CYP in their respective project areas.

Target date for completion: July, 2006

Recommendation No. 8:

We recommend that USAID/Paraguay assess the likelihood that USAID, the government of Paraguay, and other donors will fully fund their resource commitments needed under the Mission's family planning phase-out plan.

Mission response and Plan for corrective action: The mission concurs with the recommendation. A committee on contraceptive security (DAIA) involving multiple stakeholders exists and meets regularly to assure that the GOP and other donors fully comply with their resource commitments as needed under the phase-out plan. The committee is working with DELIVER assistance in the elaboration of a Memorandum of Understanding among all stakeholders, in order to officially document commitments and

define responsibilities over the next four years in terms of funding, supplies and technical assistance.

Target date for completion: September, 2006.

Recommendation No. 9:

We recommend that USAID/Paraguay establish milestones that measure USAID's, the government of Paraguay's, and other donors' political, financial, human capital, and other resource commitments to implementing the family planning and reproductive health phase-out plan.

Mission response and plan for corrective action: USAID/ Paraguay concurs with the recommendation and will establish milestones to be reviewed periodically in order to measure progress and monitor resource commitments in the implementation of the FP phase-out plan. This milestone will also be part of the agreement mentioned under recommendation N 8.

Target date for completion: September, 2006

Recommendation No. 10:

We recommend that USAID/Paraguay prepare alternative activities that could be quickly implemented if commitment milestones are not met by the parties involved in providing resources to the family planning and reproductive health phase-out plan.

Mission response and plan for corrective actions: USAID/Paraguay concurs with the recommendation and will work with partners, the DAIA committee, and USAID/W to develop contingency plans to address those issues as effectively and promptly as possible.

Target date for completion: October, 2006

Recommendation No. 11:

We recommend that USAID/Paraguay incorporate anti-corruption efforts into its family planning and reproductive health phase-out plan.

Mission response and plan for corrective action: USAID/Paraguay concurs with the recommendation and has already begun addressing corruption in its activities to improve and "tighten up" the FP logistics system. In addition, the mission's work to implement and strengthen local health councils has involved communities in efforts to decrease corruption by strengthening civil society's over sight of the local health system including funds collected and expended.

Target date for completion: September, 2006

NON RECOMMENDATION ISSUES

1. The report clearly describes the deficiencies and problems identified by the auditors in different projects and activities. However the audit takes scant notice of the many notable successes and the positive results achieved to date in the Reproductive Health Strategic Objective program. For those wishing to gain a balanced perspective of the program or to extract lessons from what worked, the audit offers little insight, despite the many insights that the audit team shared with the Mission while in country. If possible, we urge you to incorporate some of these findings into the report.

2 In the discussion of results found on page 1, it is unclear whether the reference to the "Mission results", refers to the Mission's performance results or the results as specified in cooperative agreements and contracts. Please clarify this discussion.

3) From pages 19 through 21 the report describes the deficiencies of the contraceptive logistics system within the public sector. Although the document presents an accurate description of the situation, the Mission recommends that the audit report clarify that the current strategy did not contemplate making improvements in the contraceptive logistic system. As a part of the Mission's new Family Planning Graduation Strategy, the Mission started a new project in October 2005 with DELIVER to assess the overall public sector family planning system, including contraceptive logistics, with a view to helping the GOP to improve its capacity to forecast, finance and distribute contraceptives to the public.

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