Contraceptive Security in Peru:
Assessing Strengths and Weaknesses

September 1–12, 2003

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

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Abbreviations

APPRENDE	Peruvian social marketing NGO (emergency contraception)
APROPO	Peruvian social marketing NGO (national condoms, VFT, and IUDs)
CS	Contraceptive security
DFID	Department for International Development (United Kingdom
DGSP	MINSA General Directorate of People's Health
DIGEMID	MINSA Directorate of Medicines, Supplies, and Drugs
DISA	MINSA Regional Health Directorate
ENDES	Peru Demographic and Health Surveys
EPS	Private Health Providers (Entidades Prestadoras de Salud)
ESSALUD	Social Security Institute
FP	Family planning
GDP	Gross domestic product
GTZ	German Technical Cooperation
INPPARES	Peru's International Planned Parenthood Federation affiliate
IUD	Intrauterine device
LAC	Latin America and the Caribbean
MAXSALUD	Peruvian NGO (primary health care clinic and outreach in Chiclayo Department)
MINSA	Ministry of Health
NGO	Nongovernmental organization
OGEI	MINSA General Office for Information and Statistics
PAAG	Program for Administration and Management Contracts
PRISMA	Peruvian NGO
SIS	MINSA Integrated Health Insurance
SISMED	MINSA Integrated Medicines and Supply System
SPARHCS	Strategic Pathways to Reproductive Health Commodity Security
TFR	Total fertility rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Primary information sources for this summary include the in-country contraceptive security assessment, and demographic health surveys or national reproductive health surveys.

Executive Summary

The results of the assessment conducted in Peru in September 2003 demonstrate the complex nature of contraceptive security and the many challenges that the Peruvian government will have to face in order to achieve contraceptive security (CS). They reveal how critical political support is for family planning (FP) programs—and sometimes how quickly this support can change in different political climates. After more than a decade of strong government support for the National Family Planning Program, there were several attempts to alter longstanding policies and laws that guarantee Peruvians the right to freely choose, obtain, and use contraceptive methods. These attempts were disruptive, but not successful. Today, once again, there is political support for evidence-based public health policy, including support for family planning as a key element in the effort to reduce maternal and peri/neonatal mortality.

The segmentation of the Peruvian family planning market has changed dramatically in the last decade. From 1992 to 2000, the public sector's share of the FP market increased from 49 percent to 79 percent. President Fujimori's aggressive strategy to expand the public healthcare infrastructure and the Ministry of Health's (MINSA) policy decision in 1995 to provide all FP services free of charge were the primary factors in this dramatic shift. As the public sector increased the provision of FP services from 1992 to 2000, the commercial sector's participation in provision of FP methods and services declined significantly, from 44 percent to 17 percent. The Peruvian Social Security Institute (ESSALUD) serves 11 percent. This dramatic shift in the overall FP market within the last decade represents a major challenge for Peru's contraceptive security, particularly in light of USAID's planned phaseout of donated contraceptives.

The role of the private sector in developing a sustainable market will also be critical. There is strong potential for expanding private sector involvement in the provision of FP services and methods. Several Peruvian nongovernmental organizations (NGOs) have strong institutional capabilities in both service provision and social marketing. These NGOs provide an important opportunity for identifying and testing new private sector partnerships and pilot initiatives to stimulate the private sector's role. In addition, commercial manufacturers and distributors of contraceptive products in Peru are looking for opportunities to expand their market share, and they are open to investment opportunities and creative partnerships to expand the private market share for contraceptives.

Several critical financing issues must be addressed for Peru to achieve contraceptive security. The Peruvian government has made some important progress, including the fact that MINSA first started purchasing contraceptives in 1999 and has purchased increasing quantities since then. In 2003, MINSA budgeted US$2.8 million for contraceptives, approximately 70 percent of its total annual contraceptive

requirement. Given the country's political transition, its current economic problems, and the anti-family planning sentiment at the highest levels of MINSA from 2000–2003, convincing those inside and outside MINSA to commit funding to contraceptive purchases has not been easy. Despite these gains, cost projections show an increasing gap in government funding after USAID donations end in 2004. MINSA in particular will not be able to meet the needs of its current clientele unless its budget for contraceptives is increased by at least 5 percent per year and it continues to achieve very low contraceptive unit prices. Over the short term, as USAID donations end and Peru's public sector budget crisis intensifies, the country may face serious shortfalls in funding for contraceptives.

Introduction

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

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

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

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

Background

Peru's population of 28 million is predominantly young and urban. Fifty-three percent of Peruvians are under 25 years of age and 73 percent live in towns and cities. The government's spending on health and family planning increased during the late 1990s and, as a result, health indicators improved markedly. Peru's total fertility rate (TFR) has declined dramatically over the past decade, falling for the country as a whole from 3.5 live births per woman in the early 1990s to 2.9 in 2000. By far, the largest decline has been in rural areas, where the TFR fell from 6.2 in 1991/92 to 4.3 in 2000. The TFR in urban areas also continued to decline during this period, falling from 2.8 to 2.2 by 2000. Trends in knowledge and use of FP methods in Peru are similar to those in other countries in the LAC region where governments and donors have worked together to expand FP programs. Peru's success in rural areas, however, has been more pronounced than in any of the other countries included in the USAID/LAC study. Despite economic growth in the late 1990s, over half of the population is classified as being poor or extremely poor.

Between 1985 and 1990, the administration of President Alan Garcia vowed support to a national FP program, but the country's economic situation and MINSA's limited service delivery capacity affected the success of that effort. With the help of external funding (USAID and UNFPA), FP services improved, and in 1991, the National Family Planning Program was officially launched. During its first five years, the program worked to increase contraceptive prevalence and extend FP service coverage, particularly coverage in previously underserved areas.

Between 1995 and 2000, the Fujimori government increased funding for family planning and, at the same time, embarked upon an ambitious program to expand MINSA's network of health facilities. Although MINSA had been providing FP services since 1983, the number of MINSA health establishments increased by more than 50 percent during this period, and more than 10,000 new health providers were added across the country. As a result, by the late 1990s, the National Family Planning Program was delivering FP services—including counseling and contraceptives—through more than 6,000 service delivery points (4,000 health posts/clinics, 1,500 health centers, and 500 hospitals).

Family Planning Services in Peru

The Peruvian government provides free contraceptives and condoms to the population through MINSA, ESSALUD, and the armed forces and national police. MINSA operates most of the country's primary care facilities and has by far the largest FP clientele. In 2000, MINSA was serving approximately 68 percent of all FP users. ESSALUD's health services cover a quarter of the country's population, but only about 11 percent of contraceptive users. ESSALUD's services are available to employees in the formal sector and their dependents only, and its health establishments are located almost exclusively in cities and towns. Separate data are not available on the contributions of the Peruvian armed forces and national police, as both receive their contraceptives through MINSA.

Peru's NGOs were pioneers in family planning, and several still operate clinics and social marketing programs, but their role in the provision of contraceptives declined in the 1990s as MINSA's role increased. NGO clinics were supplying only about 2 percent of contraceptive users in 2000, and community-based contraceptive distribution programs, once managed by NGOs in many parts of the country, have virtually ceased to exist. Private medical practitioners provide a third of all outpatient services in the country but only 8.6 percent of contraceptives. Pharmacies are an important source of pharmaceuticals for those living in cities and towns who are able and willing to pay for them, but in 2000, pharmacies were selling socially and commercially marketed contraceptives to only about 8 percent of the country's FP users.

International Donors

USAID has been Peru's largest contraceptive donor since 1993, providing support not only to MINSA and a number of NGOs but also contracting an NGO, PRISMA, to assist MINSA in managing the contraceptive supply chain. USAID is in the process of phasing out its contraceptive donations. Although 2003 was the last year in which USAID budgeted for contraceptive donations to MINSA, these donations will continue to arrive in Peru through 2004. USAID contraceptive donations to NGOs will continue, but neither the time frame for these donations nor the annual quantities and values have been defined. UNFPA contraceptive donations ended in 1998, but UNFPA continues to support reproductive health activities and to donate condoms for HIV/AIDS prevention. UNFPA has also been providing reimbursable procurement services to MINSA since 1999. In the past, United Kingdom's Department for International Development (DFID), the German Technical Cooperation (GTZ), and other international agencies also provided assistance to MINSA and select NGOs for family planning, but this assistance has ended.

Findings from the Contraceptive Security Assessment

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

Environment

In Peru, there are several critical factors influencing the overall environment for contraceptive security. After more than a decade of strong government support for the National Family Planning Program, there were several attempts between 2000 and 2003 to alter longstanding policies and laws that guarantee Peruvians the right to freely choose, obtain, and use contraceptive methods. These attempts were disruptive, but not successful. Today, once again, there is political support for evidence-based public health policy, including support for family planning as a key element in the effort to reduce maternal and peri/neonatal mortality. Nonetheless, emergency contraception, IUDs, and other modern contraceptive methods are still topics of heated debate in Congress and the press.

In addition, several health sector reforms have weakened management systems for public sector FP services. In 2001, the Minister of Health introduced a new health service model that organized services according to the LifeCycle Approach (i.e., with different packages of care specified for individuals at different stages of life). The LifeCycle Approach was originally developed by the World Bank and the World Health Organization (WHO) and is now a common element of health sector strategies around the world. Normally, it is a robust approach that gives FP information and services priority during adolescence and in the reproductive years. Interestingly, however, Peru's model mentions family planning only briefly. In addition, other government-wide reforms, such as decentralization, planned for 2004 may create new challenges for FP programs as funding and program responsibilities pass from MINSA to 24 newly elected regional governments. All of these factors are beyond the direct control of FP managers, but they must be considered and addressed to achieve contraceptive security.

Another critical factor is that Peru is also in an economic crisis. Government spending on health as a percent of GDP has been on the decline since 2001, and public sector budgets were expected to be significantly lower in 2004 than in 2003. Over the short term, this does not bode well for the government's investment in family planning or its ability to increase MINSA's annual contraceptive budget.

Client Demand and Use

In Peru, government and donor investment in family planning during the 1990s created strong demand and use of contraceptives. Between 1991 and 2000, contraceptive prevalence (all methods, women in union) increased from 59 percent to 69 percent, while total fertility fell from 3.5 to 2.9 births per woman. Use of modern contraceptive methods showed even more dramatic gains, increasing nationally from 41 percent to 61 percent and jumping from 18 percent to 40 percent in rural areas.

Although Peru's upward trend in prevalence is a positive force for reaching contraceptive security, unmet need for family planning continues, and issues with method mix may require future attention. Peru's unmet need for family planning is highest among youth (24%), rural populations (15%), highland residents (13%), and those without formal education (17%), yet fewer organizations are targeting these groups today than in the past.

In addition, the trends in Peru's contraceptive mix do not reflect the increasing maturity of FP users or the expressed desire of many women to avoid future pregnancy. Accusations of coercion, health providers' fear of legal action, and active opposition by religious and political leaders to family planning in recent years seem to have combined to limit the supply of permanent methods. Because of the high demand for injectables and pills, the mix of contraceptive methods provided by MINSA is relatively expensive. IUD use has fallen, with insertion rates reported by MINSA much lower than in the past. IUDs offer many years of protection, and they are both an inexpensive and relatively easy method to provide. The reasons for decline in IUD use are not clear. Population growth will fuel demand for contraceptives into the next decade. Without significant support from international donors for its FP services, maintaining even the current levels of FP coverage will be a challenge for the government of Peru.

Services

While MINSA continues to be the major provider of FP services, there are several key issues that are affecting the accessibility and quality of services. While the physical infrastructure was strengthened significantly during the 1990s, due to turnover among management and clinical personnel, it is not clear how many previously trained workers remain in their posts. The quality of FP care provided in government health establishments became a major concern in the late 1990s when accusations of coercion and poor quality surfaced. Since then, USAID, UNFPA, DFID, and others have supported the government's efforts to improve service quality. Adherence to standards of informed choice is being monitored annually by POLICY, and quality of care is showing measurable improvement. Nonetheless, fear of denunciation persists and a general tightening of restrictions on who is eligible for sterilization is making it more difficult than in the past to obtain permanent contraceptive methods.

Contraceptive availability at service delivery points is another important aspect of access and quality. Between 1997 and 2000, PRISMA was instrumental in helping to eliminate contraceptive stockouts and wastage in MINSA health establishments, but over the past two years, stockouts have again become a frequent occurrence. A recent study of 67 health establishments in Lima, Callao, and Ica found that 53.7 percent of those establishments had experienced one or more stockouts during the preceding 12 months. Depo-Provera and pills were the methods more frequently out of stock, but condoms and IUDs were also affected. Stockouts appear to have been caused by a combination of factors, including the worldwide shortage of Depo-Provera in 2002 and 2003, delays in contraceptive procurement through UNFPA in 2002 and 2003, and problems, since MINSA's reorganization, with the consumption and inventory data upon which procurement and contraceptive distribution plans are based.

ESSALUD's FP service delivery capacity also appears to be weakened. ESSALUD's FP consultations have declined in recent years, and ESSALUD is considering limiting its nurse midwives to FP counseling only, a step that would further weaken its service delivery capacity and its beneficiaries' easy access to care.

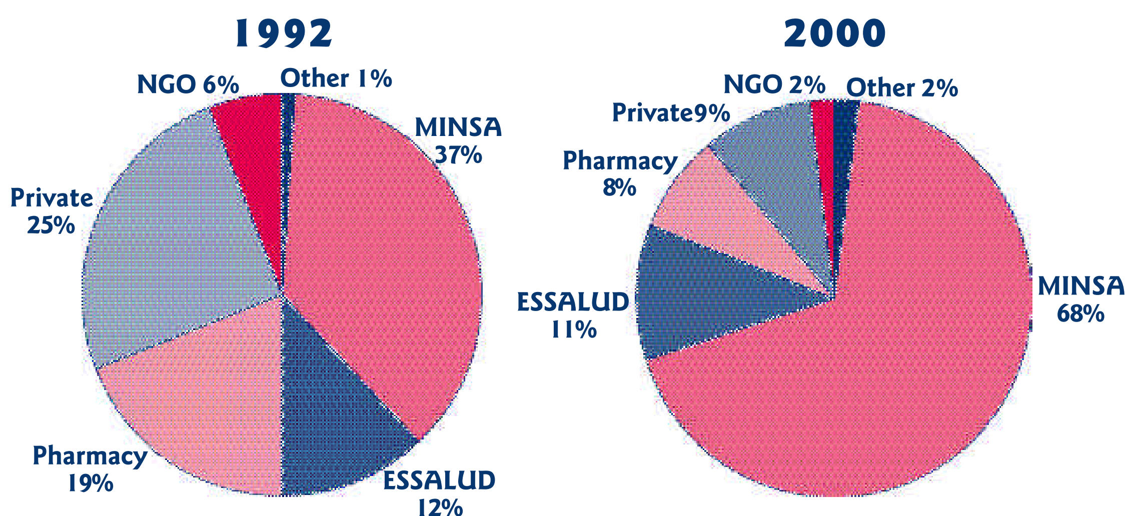
NGOs are currently in a "survival" mode in Peru, trying to adapt to a difficult period of donor phaseout. The NGOs that have survived without USAID support have the infrastructure to be able to mobilize the private sector for provision of FP services and contraceptives, but they lack the financial resources for major expansion of their work. From 1990 to 1999, a major part of the activities of INPPARES, Peru's International Planned Parenthood Federation affiliate, was focused on family planning. Following phaseout of USAID support, the FP services provided by the organization have decreased significantly. INPPARES anticipates that its FP services will decrease as a proportion of its total services in the future as it focuses its efforts on groups with special needs and special issues, including youth, adolescents, HIV/AIDS prevention, and gender. Among others, the NGO APROPO has worked in the technical areas of social responsibility, communication, and social marketing–all designed to increase the breadth and depth of choices available to Peruvian men and women.

Market Segmentation

The segmentation of the Peruvian FP market has changed dramatically in the last decade. From 1992 to 2000, the public sector's total share of the FP market increased from 49 percent to 79 percent, including both MINSA (68%) and ESSALUD (11%), as seen in Figure 1. The commercial sector's share decreased from 44 percent to 17 percent. This dramatic shift in the overall FP market within the last decade represents a major challenge for Peru, particularly in light of USAID's planned phaseout of contraceptive donations to both MINSA and remaining NGO recipients.

Certainly, one issue that affects market segmentation is the absence of existing mechanisms for targeting free FP services in the public sector. All users that seek MINSA FP services are provided free services, regardless of their socioeconomic status. In addition to the "free-for-all" policy within MINSA, there is also evidence that clients who have healthcare coverage through the social security system also seek services through MINSA. Moreover, there is no mechanism for MINSA to seek reimbursement for the

Figure 1. Changes in Sources of Contraceptives and Condoms



Source: ENDES 1992 and 2000

services it provides ESSALUD beneficiaries. Although it does not currently offer family planning to its beneficiaries, the new national health insurance for women, children, and vulnerable groups (SIS) is based on the premise of targeting the lower socioeconomic groups for maternity care and infant and child health services. But even this program lacks eligibility criteria based on income or ability to pay. As a result, SIS enrollment is universal, that is, it is open to all families with pregnant women and children under 18 who choose to enroll, regardless of income or need.

The role of the private sector in developing a sustainable market is also critical. There is strong potential for expanding private sector involvement in the provision of FP services and methods. Several Peruvian NGOs have strong institutional capabilities in both service provision and social marketing. These NGOs provide an important opportunity for identifying and testing new private sector partnerships and pilot initiatives to stimulate the private sector's role. In addition, commercial manufacturers and distributors of contraceptive products in Peru are looking for opportunities to expand their market share, and they are open to investment opportunities and creative partnerships to expand the private market share for contraceptives.

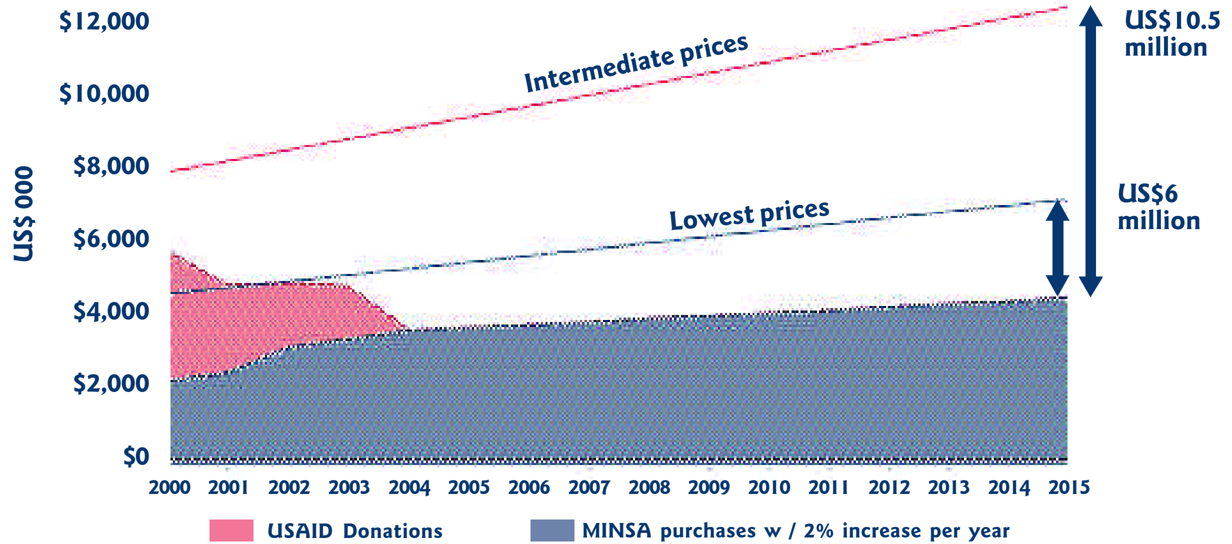
Financing

The Peruvian government has made important progress on the financing of contraceptives and condoms, but it remains vulnerable in this regard. MINSA first purchased contraceptives in 1999, and has successfully increased its annual contraceptive budgets since that time. In 2003, MINSA invested US$2.8 million in contraceptive and condoms, or approximately 70 percent of its total annual requirement. Given the country's political transition, its current economic problems, and the anti-family planning sentiment that existed from 2000–2003 at the highest levels of MINSA, convincing those inside and outside MINSA to commit this funding to contraceptive purchases has not been easy. Important factors contributing to MINSA's success have included the existence of an earmark for family planning in the national budget, support from the Ministry of Finance for family planning, and pressure from civil society and a public that is convinced of its right to obtain family planning methods in all government health facilities.

The Peruvian government may face serious shortfalls in funding for contraceptives in the future. Projections show an increasing gap in government funding for contraceptives and condoms after 2004, when USAID's contraceptive donations to MINSA end. Given expected population growth and current method and source mixes, by 2015, MINSA will need approximately $6 million per year at the lowest unit prices currently available to meet the contraceptive needs of its clientele. At intermediate prices, or those more in line with local/national purchase of contraceptives, this amount could increase to as much as $10.5 million per year (see Figure 2).

To avoid future contraceptive shortfalls, MINSA must fight to increase its contraceptive budget by at least 5 percent every year from now through 2015. It must also continue to pay the lowest possible prices for the contraceptives it purchases. MINSA currently procures contraceptives through UNFPA, which offers prices for its contraceptive commodities that are among the lowest available. If MINSA's contraceptive budget is not increased sufficiently, or the unit prices of contraceptives and condoms increase, MINSA will have to shift at least some of its current financial burden to others and begin targeting its limited financial resources (i.e., free contraceptives) to those who need them most.

Figure 2: Peru MINSA Contraceptive Funding Gap, 2000-2015



In addition to MINSA, other future sources of financing for contraceptives include SIS, ESSALUD, the Peruvian armed forces, the national police, EPS, private insurance companies, large employers, and individuals and households. Household financing could be increased in various ways, including cost recovery in government health facilities, but it is dependent on the ability and willingness of individuals to pay for contraceptives. Because the public has grown to expect free contraceptives, both cost recovery and targeting of free contraceptives would require the support of civil society.

Procurement

Both public and private sector institutions in Peru have experience in contraceptive procurement, yet there are still many challenges that these organizations are facing. MINSA, ESSALUD, and the four NGOs contacted during this assessment–APROPO, INPPARES, MAXSALUD, and APPRENDE–currently purchase contraceptives with their own funding.

Since 1999, MINSA has achieved excellent value for its money by using UNFPA's reimbursable procurement mechanism. However, the process has been fraught with complications inside MINSA and plagued by delays that have been an important cause of contraceptive stockouts over the past two years. Therefore, while continuing to work through UNFPA on the 2003 procurement, MINSA is considering other options.

Over the short term, UNFPA offers the best value for limited MINSA resources, therefore steps should be taken to streamline the UNFPA procurement process. In the future, however, national procurement may become a viable option. National procurement regulations and practices favor national suppliers and ESSALUD recently purchased oral contraceptives from an international laboratory at prices that

were higher than UNFPA's, but still very favorable. Although contraceptives procured nationally would be more costly than those purchased through UNFPA, laboratories appear motivated to negotiate their prices. They may also be willing to offer add-ons, such as transport to service delivery or distribution points, which could make them an attractive alternative to procurement through UNFPA.

NGO social marketing programs have forged partnerships with international producers, but they complain of constant changes in the worldwide pharmaceutical market, leading to unreliable supply and inconsistent pricing.

Procurement planning is an important step in budgeting for future contraceptive needs. Procurement plans should be based on up-to-date consumption and inventory data, as well as projections of future needs. Peru has an excellent logistics information system that was, prior to integration of the National Family Planning Program in 2002, providing reliable consumption and inventory data on which forecasts were based. Data flow issues have made this system less effective than it might have been since 2002, because reliable consumption and inventory data have not been available to those doing the forecasting for the government and USAID (PRISMA and Program for Administration and Management Contracts–PAAG).

Logistics Management

Peru has had one of the most effective contraceptive logistics systems in Latin America. From 1997 to 2001, PRISMA and the National Family Planning Program established a functioning logistics information system, prepared and disseminated reference materials, trained MINSA and ESSALUD staff, instituted maximum and minimum stock levels, improved warehousing, created a functioning distribution system, performed annual contraceptive inventories, and provided on-the-job training and supervision of logistics functions in the regions. As a result, MINSA was able, for the first time, to base its contraceptive forecasts, annual procurement plans, and distribution lists on reliable consumption and inventory data, thereby virtually eliminating stockouts and product wastage.

The elements of the vertical contraceptive logistics system are still in place, and PRISMA continues to manage it, but the system is no longer performing as effectively as it did prior to MINSA's reorganization. This is primarily because consumption and inventory data received from Regional Health Directorates (DISA) are no longer complete. Information flow within MINSA also appears to have been a problem.

PRISMA has begun to transfer the contraceptive logistics system to MINSA while simultaneously working with the MINSA National Directorate of Medicines, Supplies, and Drugs (DIGEMID), the PAAG, the MINSA General Office for Information and Statistics (OGEI), and others to design a new integrated pharmaceutical management system. PRISMA's current functions and USAID's financial responsibility will be transferred to MINSA under this new system, but the exact plan for this transition is not clear. The challenge of integrating and decentralizing MINSA's logistics management systems is formidable. PRISMA's experience and the opportunity to adapt its well-established system for use under MINSA's Integrated Medicines and Supply System (SISMED) should speed the design of the new system. Nonetheless, the challenges involved in putting together such an integrated and decentralized logistics system should not be underestimated.

Policy

Peru has had a well-established reproductive health policy framework that supports the rights of its citizens to plan their families since the early 1990s. Operational policies in support of FP services are in place, and contraceptives are included on the National Essential Drug List. Under the transition government and the first two years of the Toledo government, many of these established policies were challenged and, at times, ignored, but attempts to weaken the reproductive health rights guaranteed by Peru's Constitution and its General Health Law failed.

Although Peru's reproductive health policies are generally considered to be strong in the context of contraceptive security, certain restrictions exist and should be addressed in the future. For example, the General Health Law and MINSA norms restrict provision of FP services and contraceptives to minors without the written consent of a parent. Peru's pharmaceutical registration process, as dictated by the General Health Law, also contains certain provisions that have delayed the arrival of donated contraceptives in the past, and its restriction on the promotion and advertising of prescription medicines is a serious obstacle to the social marketing of hormonal contraceptives.

Leadership and Commitment

After more than a decade of strong government leadership in family planning, Peruvians experienced an era in which family planning was relegated to the sidelines, public denunciations of those providing FP services were common, and MINSA's FP staff was drastically downsized. Peru's newly appointed Minister of Health and Prime Minister are both supportive of family planning, but their tenure is unsure, and because the Toledo government lacks a firm reproductive health policy, family planning will continue to be vulnerable to changes in MINSA leadership. Public advocacy, continuous monitoring, mobilization of the press, and the active participation of NGOs, reproductive health watchdog groups, health forums, and networks of women's development and social organizations have all played a role in protecting family planning from an increasingly well-organized opposition. As government-wide decentralization moves forward in 2004, another leadership challenge looms—the need to educate and advocate for family planning among the newly formed regional governments. Interestingly, the assessment identified no champions for family planning within the commercial sector in Peru. Even as the private sector's market share has deteriorated in recent years, there has been no visible reaction or lobbying by commercial interests to reverse this trend.

Coordination

There is relatively good external coordination between MINSA and its international partners. Since MINSA's reorganization, however, internal coordination appears to have suffered. The new distribution system, called SISMED, is one effort to improve internal coordination related to supply management. In the future, coordination between MINSA, ESSALUD, and private sector social marketing and commercial representatives will need to be strengthened to improve market segmentation. To lead coordination on contraceptive security, the newly formed, multiagency Contraceptive Security Committee is a positive step toward dialogue and improved coordination between all of the health subsectors.

Recommended Strategies and Next Steps

Strategy 1.

Deliberately segment the contraceptive market by targeting government-subsidized contraceptives to those who need them most and simultaneously providing incentives and encouraging strategic alliances that increase the private sector's role in supplying contraceptives to those who can afford to pay for them.

- Complete the market segmentation analysis of 2000 Peru Demographic and Health Surveys (ENDES) data and use its findings with public, commercial, and NGO sectors to define their market niches and more effectively target their services to appropriate segments of the population (POLICY is already engaged in this activity with USAID support).
- Work with MINSA to develop mechanisms for targeting free contraceptive methods to those who need them most and with civil society to convince the public that this change is good for all.
- Broker an agreement between ESSALUD and MINSA to ensure that ESSALUD meets the needs of its beneficiaries for contraceptives and/or that MINSA receives adequate remuneration for serving ESSALUD clients at MINSA facilities.
- Offer ESSALUD technical assistance to expand its FP services and to introduce consumption-based forecasting and logistics management.
- Support the expansion of existing NGO social marketing programs, including those managed by APROPO, INPPARES, and APPRENDE, and make sustainable contraceptive supplies an early outcome.
- Engage contraceptive manufacturers/distributors in strategic alliances with government and NGOs and/or offer non-monetary incentives to those who are willing to expand their distribution and sales in areas that have been served exclusively by MINSA.
- Work with the public sector to ensure a policy and legal environment conducive to private sector involvement.

Strategy 2.

Lobby to maintain and increase government funding for contraceptives and obtain the best value for this funding either through UNFPA procurement or other equally beneficial and reliable mechanisms.

- To avoid future contraceptive shortfalls in government health establishments, encourage MINSA to continue to increase its annual budget for contraceptives.

- Given the clear financial advantages of UNFPA procurement, encourage MINSA to continue using this mechanism. Simplify MINSA's own internal approval processes and work with UNFPA to make its process more transparent and acceptable to the Peruvian government.
- Investigate and test other contraceptive procurement options.
- Analyze and advocate to change government policies and laws that restrict public and private sector procurement options and increase contraceptive prices.
- As funding for contraceptives diversifies (with increased purchasing by ESSALUD and NGOs, and potentially by regional governments), investigate the advantages and disadvantages of including ESSALUD and other government-purchased contraceptives in the annual UNFPA purchase.
- Offer procurement training, reference materials, and technical assistance to those in the public and NGO sectors who are involved in non-UNFPA contraceptive procurement.
- Share Peru's lessons learned with other countries that are interested in increasing their governments' funding and purchase of contraceptives.

Strategy 3.

Disseminate the plan for transferring USAID/PRISMA technical and financial responsibility to MINSA; take steps to solve information and other contraceptive logistics management problems during the transition to SISMED.

- Develop and disseminate a written plan that explains the functions that PRISMA currently performs, defines to whom these functions are to be transferred, and includes a timeline.
- Estimate the future costs of the logistics functions that PRISMA is transferring to MINSA and agree with MINSA on a plan and timeline for absorbing these costs.
- Continue to work with the DISAs to improve the accuracy and timeliness of their contraceptive reports and inventories, and take steps to improve the data flow between the MINSA General Directorate of People's Health (DGSP), MINSA Directorate of Medicines, Supplies, and Drugs (DIGEMID), PAAG, and PRISMA at the central level.

Strategy 4.

Advocate for future health sector and government reforms that preserve past family planning achievements and improve the population's ability to choose, obtain, and use contraceptive methods in the future.

- Analyze all proposed health sector and governmental reforms in the context of the contraceptive security framework and lobby for changes to mitigate possible negative effects.
- Provide technical assistance for policy and systems analysis when significant legal or procedural barriers prevent the adoption of a beneficial reform.

- Ensure that individuals who understand family planning and the contraceptive supply chain are on decentralization planning committees and/or that those making reform decisions are informed about contraceptive security.
- Share successful tools and approaches from other reform settings with Peru's planners and decisionmakers and provide direct technical assistance for their adaptation and testing, if required.

Strategy 5.

Strengthen the CS Committee as a mechanism for interagency dialogue, planning, advocacy, and joint implementation of strategies toward greater contraceptive security.

- Position the CS Committee under an individual or individuals with sufficient authority and credibility to influence MINSA policy and broker necessary public–public and public–private partnerships.
- Define the roles, responsibilities, and structure of the CS Committee.
- Work with the committee to prioritize the many issues identified during this assessment and develop its own action plan.
- To ensure team building and full participation, provide a trained facilitator for the initial meetings of the CS Committee and its planning sessions.

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