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STATE OF THE PRACTICE BRIEF

Meeting the Contraceptive Needs of Families through Strong Central-Level Capacity and Active Public Participation

Creative mechanisms for efficient procurement and distribution are put in place; next steps must be to work on devolving capacity to the local level.

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A client requests products at a pharmacy window

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Contraceptive security has been achieved when individuals have the ability to choose, obtain, and use quality contraceptives whenever they need them.

Peru's population of about 28 million is growing by 1.4 percent annually and is predominantly young and urban: approximately 50 percent of Peruvians are under 25 years of age, and 74 percent live in towns and cities.[1] Peru is classified as a lower-middle-income country,[2] with an estimated gross national income of U.S.$5,395 per capita. After several years of inconsistent economic performance, the Peruvian economy grew by more than 4 percent per year during 2002–2005, with stable exchange and low inflation rates.[3] Despite this economic growth, Peru continues to have disparity in income distribution, with 32 percent of its population living below the international poverty line of U.S.$2 per day[4] and nearly 5 million Peruvians living in extreme poverty.[5]

Government spending on health and family planning (FP) increased during the late 1990s, and as a result, health indicators improved markedly. However, even though the economy has grown in recent years, government health expenditures as a percentage of the gross domestic product have declined, from 2.5 percent in 2000 to 2.1 percent in 2003.[6] FP champions will have to work hard to ensure that these declines in public health expenditures do not negatively affect the provision of primary health care—especially maternal and child health services—in the years to come.

Government and donor investments in FP during the 1990s produced rapid increases in overall contraceptive use and equally rapid reductions in the total fertility rate (TFR). As in many other Latin American countries, the TFR dropped from 3.5 children per woman in 1996 to 2.4 in 2004, while overall contraceptive use almost doubled

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from 47 percent in 1986 to 71 percent in 2004. Modern contraceptive methods account for more than two-thirds (66 percent) and traditional methods less than one-third (31 percent) of all FP methods used. Today, Peru experiences one of the highest overall contraceptive prevalence rates in the region (71 percent). As a result, the median interval between a woman's last two childbirths increased from 37 months in 2000 to 43 months in 2004. Also, in 2004, the method mix among women of reproductive age in union was 16 percent, injectables; 15 percent, voluntary sterilization; 12 percent, condoms; 10 percent, pills; 10 percent, intrauterine devices; 3 percent, other methods; and 31 percent, traditional methods. Between 2000 and 2004, the main shifts in method mix included a reduction of injectables (21 percent to 16 percent) and an increase in traditional methods (25 percent to 31 percent).

Despite gains in the contraceptive prevalence rate, disparities between rural and urban contraceptive use continue to be a challenge in Peru, with significant differences in modern method use between rural (33 percent) and urban (54 percent) populations. Additionally, unmet need is still a cause for concern, with high unmet need among young women (17 percent); women without formal education (16 percent); poor—lowest wealth quintile—women (15 percent); and women residing in rural (12 percent), jungle (11 percent), and highland (10 percent) areas.[7]

Between 1996 and 2000, the Ministry of Health (MOH)—the primary source of contraceptives in Peru—raised its market share from 58 percent to 67 percent while the private-sector's—including nongovernmental organizations (NGOs)—market share decreased from 30 percent to 19 percent.[8] These trends were reversed between 2000 and 2004, when the MOH's market share declined from 67 percent to 60 percent and the private-sector share increased to 26 percent.[9] In spite of the MOH's slight market share decrease, it continued to be the main FP service provider (60 percent) in 2004. Other providers included the Peruvian Social Security Institute (ESSALUD)—which covered about 10 percent of FP users—and NGOs, which covered about 1 percent of users. The two major FP NGOs in Peru are Support to Population Programs (APROPO) and the Peruvian Institute for Responsible Parenthood (INPPARES).[10]

Finally, a comparison of Peruvian MOH clients by wealth quintile between 1996 and 2004 indicates that women with a greater ability to pay have benefited disproportionately from free MOH contraceptives. The proportion of MOH FP clients from the two lowest wealth quintiles declined by 18 percent between 1996 and 2004**,** while women from the upper-middle and wealthiest quintiles—the non-poor—increased by 9 percent.[11] In other words, women with a greater ability to pay have experienced increased access to and use of the MOH's free services while the poorest segments of the population have faced a decline in access to those same services. In addition, ESSALUD, tasked with covering employees' health care needs in the formal sector[12] (estimated at 25 percent of the population), currently serves only 10 percent of FP users. By expanding coverage to member clients, ESSALUD could help alleviate pressure on the MOH to provide services to non-poor clients and free resources to help stop further erosion in access to services among the poor. In addition, NGOs are covering a very small proportion of FP users and could also play an expanded role in serving some of these wealthier clients.

NATIONAL POLICY SETS THE GROUNDWORK FOR INCREASED ACCESS TO REPRODUCTIVE HEALTH SERVICES

The overall policy environment in Peru supports reproductive health and FP. The 1993 Constitution states that the National Population Policy should "promote responsible maternity and paternity" and recognize a person and family's right to be informed and have access to FP methods. Additionally, Peru has ratified various international agreements that emphasize the importance of reproductive health and FP and launched the National Reproductive Health Plan in 2004. This national plan recognizes that more than one-half of births correlate with an unmet need for FP. The plan includes reduction of

maternal and perinatal mortality as one of its general objectives and aims to help families achieve their reproductive goals.

Additionally, strong political support is evidenced by the inclusion of sexual and reproductive health as one of the key national sanitary strategies of the Government of Peru. The National Sexual and Reproductive Sanitary Strategy (NSRSS) was approved in July 2004 through Ministry Resolution No. 771, which guarantees health services (including FP) to all who need them (both men and women) to ensure overall sexual and reproductive health during all stages of life. The MOH has also formed two committees: a technical working group to oversee the implementation of the NSRSS strategy and a consultative committee formed by civil society groups and academic institutions. The MOH has also taken important steps toward integrating maternal and neonatal health goals when planning for FP service provision,[13] as described in its maternal and neonatal intervention plan. This intervention plan includes counseling; information, education, and communication; and provision of FP services.

CIVIL SOCIETY PARTICIPATION HELPS KEEP FP ON THE NATIONAL AGENDA

Civil society advocacy efforts, including participation of women's groups that support improved reproductive and maternal health service provision, have been critical in promoting sexual and reproductive health rights and keeping contraceptive security (CS) on the national agenda in Peru in recent years.

In addition, over the past decade, multisectoral Regional Maternal Health Committees have been formed in several regions of Peru; they are still active and influential. The committees include representatives from local NGOs; colleges and universities (obstetricians, physicians, nurses, and journalists); the regional government; regional health facilities; municipal health commissions; and grassroots organizations. Some of these committees have been integrated into Poverty Alleviation Commissions and are in a good position to influence decisions related to reproductive health and FP. The committees serve to formalize multisectoral participation in planning and oversight of provision of public health care services. Such civil society participation is essential in getting services to vulnerable populations and bridging disparities in health service provision in the future.[14]

PERUVIAN MINISTRY DEVELOPS CREATIVE MECHANISMS FOR FINANCING AND PROCURING CONTRACEPTIVES

In 1999, the Peruvian MOH began to procure contraceptives. Today, Peru is one of the few countries in Latin America to finance 100 percent of MOH contraceptive needs. Procurement is financed by the government and managed through a procurement agreement with the United Nations Population Fund (UNFPA). The agreement between the UNFPA and the MOH was initially signed and approved through a Supreme Resolution in 1999 and renewed with new provisions in 2004. Under the terms of this agreement, the MOH transfers funds to the UNFPA, which then acts as a procurement agent for the government and procures low-priced contraceptives through the international market. In 2004, the MOH also started purchasing oral contraceptives through the local market. By comparing prices over time, the MOH demonstrated its capability to engage in informed buying and thus to obtain the best price on the market, whether local or international. Few countries in the Latin America and Caribbean region have developed the same level of capacity to gather prices, set up multiple mechanisms for procurement, and compare these prices over time to ensure their MOHs are spending funds efficiently. Peru has gone a long way toward building its procurement capacity and developing cost-effective procurement mechanisms.

The government has demonstrated its commitment to CS by prioritizing the allocation of resources to procure 100 percent of contraceptive requirements. The national budget includes a generic budget line item to fund *sanitary strategies*, and the MOH establishes priorities for various programs, including contraceptive procurement. To date, the FP program has received about U.S.$2 million annually for contraceptive purchases. Another positive step

toward achieving CS in Peru is the inclusion of contraceptives on the national essential medicines list.

In addition, Peru's procurement law was recently modified to include new and innovative procurement mechanisms designed to improve efficiency, generate lower prices through competition, and allow public entities to jointly procure commonly used medicines. In the midst of a decentralized health system, the Peruvian government has chosen to promote centralized pooled procurement or price negotiations of medicines to generate cost savings. Centralized negotiation is essential to avoiding higher prices that often occur in a decentralized setting. Peruvian regulations now also allow for decentralized purchasing under emergency circumstances.

EXCEPTIONAL OUTSOURCED LOGISTICS SYSTEM MAKES CONTRACEPTIVES AVAILABLE THROUGHOUT THE ENTIRE MOH SUPPLY CHAIN

Peru has one of the most effective contraceptive logistics systems in Latin America, which is now being adapted for a decentralizing MOH. During the last 10 years, with the U.S. Agency for International Development's (USAID's) technical and financial assistance, the Consortium of NGO Projects on Information, Health, Medicine, and Agriculture (PRISMA) has provided technical support to the MOH in key areas of supply chain management under the MOH National Family Planning Program and the National Directorate of Medicines and Drugs. These organizations have worked to reduce contraceptive stockouts and wastage in MOH health establishments. Numerous interventions have helped to construct this model, including the establishment of a functional logistics information system; design, validation, and dissemination of reference materials; numerous training workshops for MOH and ESSALUD staff; establishment of inventory control systems; annual contraceptive inventories; and design and implementation of a distribution system. PRISMA's work focused on seven priority regions for warehousing enhancement, strengthening of monitoring and supervision capacities through on-the-job training, and supervision at the local level.

The MOH Integrated Essential Medicines System (SISMED) and PRISMA have developed logistics procedure modules for SISMED and have also tested and validated the automated logistics information system—SISMED version 2.0—for adequate logistics decision making and inventory control at all levels of the supply chain. Other efforts to transfer logistics capacities to SISMED include training to improve provider competence for supply chain management, development of training modules and methodological guides, and a proposal to enhance warehousing conditions at the regional level.

Since 1991, PRISMA has also been responsible for customs clearance, central warehousing, inventory control, and distribution of donated contraceptives. On the basis of PRISMA's vast experience in the logistics arena, the MOH has started to outsource services to PRISMA for warehousing and distribution of other health commodities. To date, PRISMA has a state-of-the-art warehouse facility, which is run by a highly motivated staff, and that has been certified by the MOH as having international warehousing standards.

To institutionalize innovative learning methodologies and continue with the dissemination of effective supply chain management practices, PRISMA—with technical assistance from the DELIVER project—is also developing a virtual course on "Essential Medicines Supply Chain Management" in association with a Peruvian school of pharmacy.

CHALLENGES AND NEXT STEPS

Peru's advances in CS serve as a model for other countries in the region. However, a number of major challenges remain before CS will be fully achieved. Peru's future efforts need to focus on improving contraceptive availability for poor and indigenous populations, further reducing supply chain problems and the human resources training deficits associated with them, strengthening procurement capacities in the MOH, securing public funding through a specific budget line item for contraceptives, and exploring market segmentation strategies to increase the private market share. A key effort now underway in Peru links contraceptive supply chain management goals to a larger initiative with the goal of ensuring

high-quality reproductive health service delivery. This effort aims to enforce MOH norms at all facilities as well as clinical practice. In addition, maintaining a vibrant civil society and preserving the ongoing policy dialogue between women's health advocates and the newly elected government will help ensure that reproductive health and FP remain a priority on the new government's political agenda. Finally, as government-wide decentralization moves forward, another major challenge will be to educate and advocate for FP among regional, municipal, and community councils to ensure that, in the future, procurement, logistics, and policy gains of the past are effectively transferred to all levels.

ENDNOTES

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10. See note 7.
11. Sharma S., et al. 2006. *Family Planning Market Segmentation in Peru: 1996-2004.* Draft. Washington, DC: Futures Group/POLICY Project.
12. The formal sector is that area of economic activities that is formally recorded by the state; in other words, it is the area in which the state can intervene either directly or indirectly.
13. The 2004 General Health Directorate presentation on MOH evaluation standards of obstetric and neonatal care in MOH facilities.
14. Policy Project. 2005. *Core Package Final Report: Overcoming Operational Policy Barriers to the Provision of Services Essential to Safe Motherhood in Peru.* Washington, DC: Futures Group/Policy Project, for the U.S. Agency for International Development.

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