



A Multi-tiered Approach to Meeting Family Planning Needs of the Poor in Peru

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Peru is a geographically and culturally diverse country. The population of 27.6 million is unevenly distributed, with 73 percent residing in urban areas. More than half of the population lives in poverty, with significant disparities evident between urban and rural areas and between indigenous and non-indigenous populations. The government is committed to addressing inequality, and various public agencies are implementing strategies to better reach the poor. Additionally, Peru's health sector reform and decentralization presents opportunities and challenges to ensure more equitable and effective health service delivery, particularly in rural and remote areas where many of the poor reside.

Disparities in access to health services among income groups, regions, and ethnic groups are found in family planning (FP) use as well. To help address this gap, beginning in 2006, the USAID | Health Policy Initiative, Task Order 1, worked with in-country partners to design and test strategies to meet the family planning and reproductive health (FP/RH) needs of poor women in Peru's Junín Region.¹ The project devised a two-step process to (1) identify and understand barriers that affect poor women's access to and use of FP services; and (2) incorporate appropriate interventions into existing programs to ensure a sustainable and replicable response.

Background: Be Mindful of Unintended Consequences

The public sector has a special responsibility to assist the poor in accessing social and health services. However, Peru's case reveals that well-intentioned policies, without proper targeting and monitoring, can have unintended consequences.² In 1995, the Ministry of Health (MOH) instituted a policy mandating free contraceptives for all Peruvians through government facilities. The government also invested in a dramatic

expansion of health facilities, particularly in rural areas. As a result, FP use among all women increased, especially among rural and poor populations.

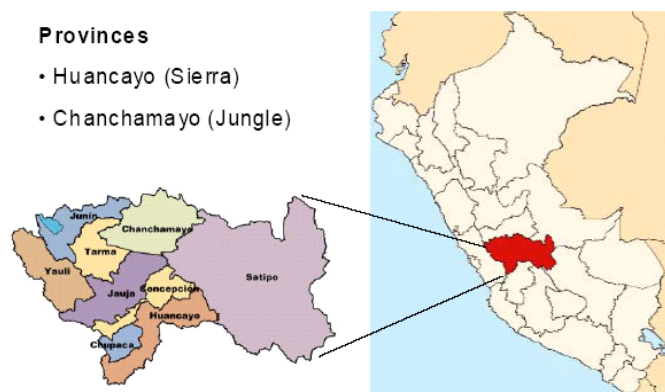
Over time, however, the MOH market share for family planning increased from 36 percent in 1992 to 68 percent in 2000 (ENDES 1992, 2000). The government's increased market share reflected the fact that commercial sector clients began to turn to free government FP services. This shift reinforces findings from several international studies that have found that subsidies, if not properly targeted to the poor, tend to benefit clients who are better off. From 1996–2004, the two poorest quintiles as a proportion of the public sector's clientele declined from 54 to 37 percent. By 2004, the middle, upper, and wealthiest quintiles constituted nearly two-thirds (64%) of public sector clients (ENDES, 1996, 2000, 2004).

Donors also began to phase out support for contraceptives. In 1999, the MOH began to include funding for contraceptives in its budget, yet government investment was not sufficient to satisfy demand. The results were frequent stockouts, limited choice of methods, and, in some cases, charging of informal fees for services. During 2000–2004, modern method use among poor women declined 6 percent, while traditional method use increased 9 percent (ENDES 2000, 2004).

While universal service coverage through the government is conceived as a strategy to help the poor, programs that are not well-targeted may fail to reach the intended beneficiaries. Working toward equity and effectiveness of resource use thus requires a clear understanding of the barriers to access among the poor, a well-defined strategy to remove barriers, and direction of government resources to the poor.

¹ This brief summarizes a detailed report on the Peru activity. See Menotti, E., S. Sharma, and G. Subiria. 2008. *Increasing Access to Family Planning Among the Poor in Peru: Building on and Strengthening Financing Mechanisms for the Poor*. Washington, DC: Constella Futures, Health Policy Initiative, Task Order 1.
² Gribble, J., S. Sharma, and E. Menotti. 2007. "Family Planning Policies and Their Impacts on the Poor: Peru's Experience." *International Family Planning Perspectives* 33(4): 176–181.

Figure 2. Junín Region and District Map



About Junín Region

Junín is a USAID/Peru priority region. The region has two main indigenous groups that reside in the Sierra and Jungle areas (see Figure 2) and are traditionally underserved by social programs. More than 7 in 10 people in Junín live in poverty (53%) or extreme poverty (19%).

To understand how to improve FP access among the poor in Junín, the Health Policy Initiative reviewed available data and information and collected new information to serve as a foundation for the design of a cohesive strategy. Specifically, the project analyzed market segments for family planning, diagnosed the health system, and conducted key stakeholder interviews and focus group discussions with poor women and men to fully understand the barriers facing the poor in accessing FP methods and services. This research identified several barriers to access (see Box 1).

Identifying Appropriate Policies and Strategies

To select appropriate policy and finance strategies to help ensure FP access among the poor, indigenous populations in Junín, the project considered

- Relevant issues at the local, regional, and national levels;
- Involvement of regional authorities and the local community;
- Local capacity of organizations and individuals;
- Existing mechanisms and current work being done to reach the poor; and
- Financial sustainability and replicability of strategies.

The project worked with in-country counterparts to raise awareness of the needs of the poor and weigh existing opportunities, challenges, and requirements for the implementation of appropriate responses. This process resulted in a package of strategies:

1. Strengthen the FP/RH educational component of the conditional cash transfer program for poor families and draft culturally appropriate FP counseling guidelines and training (local).
2. Mobilize regional resources for information, education, and communication (IEC) and quality improvement strategies for FP/RH through public investment funding (regional).
3. Include FP in the package of services offered to poor women through social insurance (national).

The strategies aimed to increase the resources directed to family planning for the poor and build on existing financing mechanisms that provide health services to the poor by incorporating FP/RH. The strategies addressed different levels (national, regional, and local) in recognition of Peru’s decentralized government and mobilized various types of financing to create a system that reaches the poor via multiple approaches.

Box 1: Selected Barriers to the Provision of and Access to Family Planning in Junín

- Lack of accurate, culturally appropriate information about modern FP methods
- Limited financing for FP-related training, supervision, monitoring, and information dissemination
- Operational barriers and resource restriction resulting from the integrated health model and its effects on FP product and service provision

Strategy #1: Strengthen FP/RH Component of JUNTOS

In 2005, Peru launched a conditional cash transfer program called JUNTOS (“Together”). The program provides a monthly cash transfer of 100 *soles* (US\$31) to poor households with pregnant women and/or children under age 14 on the condition that recipients meet certain requirements—such as enrolling children in school and obtaining prenatal care. The program targets support specifically to the poorest households and gives funds directly to female household members, enabling women to have some control over resources.

One component of JUNTOS is participation in FP/RH *charlas* (“community chats”), but it had yet to be fully implemented. Strengthening the *charlas* program required the consideration of demand- and supply-side issues: On the demand side, addressing the lack of culturally appropriate and adequate FP/RH information for poor, indigenous women would likely increase the demand for FP services. On the supply side, healthcare providers must be able to provide high-quality, culturally appropriate counseling.

Through policy dialogue and advocacy, the Health Policy Initiative secured commitment from national and regional authorities to strengthen the FP/RH-related components of JUNTOS. The project integrated cultural beliefs of indigenous populations into existing MOH FP/RH counseling guidelines and designed guides and a training-of-trainers (TOT) program for healthcare providers. The project trained 19 healthcare personnel as trainers who, in turn, trained 83 medical doctors, nurses, midwives, and paramedical personnel in the Sierra and Jungle. The TOT and the three-day training program included sessions on skills building and culturally appropriate counseling, as well as field visits to rural health facilities for practical skills development. Having a cadre of experienced and well-trained healthcare personnel in poor districts will help to build sustainability. As part of the training, health personnel also prepared action plans and monitoring indicators for their facilities.



As part of the effort to create a welcoming environment and provide culturally appropriate counseling, health facility counseling rooms have been re-designed to resemble the homes of indigenous populations. Photo by Suneeta Sharma, 2007.

Outcomes: From Nov./Dec. 2006 to Aug./Sept. 2007, the average number of weekly FP/RH information sessions held each month tripled (from 1 to 3), and the

weekly attendance at sessions nearly doubled (from 568 to 1,000 women). The strategy also resulted in improved quality of culturally appropriate counseling. In addition, through JUNTOS, the MOH allocated 82,500 *soles* (US\$27,000) to produce culturally appropriate FP/RH informational materials. Moreover, in April 2008, the MOH approved the guidelines on culturally appropriate counseling (*Documento Técnico de Adecuación Cultural de la Consejería en SR*) for use in health facilities in all areas with substantial indigenous populations.

Strategy #2: Resources for IEC and Quality Improvement

The National System of Public Investment (SNIP), created in 2000, is designed to (1) allocate resources to public investment activities that will have an impact on the population’s well-being; (2) make efficient use of scarce public sector resources; and (3) ensure that public investment projects are of high quality. Although this funding is available for local government and civil society to finance public investment activities, applying for and accessing funds can be a difficult process. Thus, the Junín Regional Directorate for Health requested assistance in preparing technically strong proposals for needed activities that are aligned with regional health priorities, including FP/RH needs, IEC, and quality improvement.

In response, the Health Policy Initiative gathered information on barriers to accessing funds for health programs; gained governmental interest in accessing public investment funds; and fostered collaboration with nongovernmental actors, including academic institutions. The project also worked with PRODES—a USAID-funded project that supports decentralization in Peru—to adapt its proposal writing course to include a focus on health issues.

Outcomes: The National Central University provided credit and diplomas to participants (in conjunction with the Regional Directorate for Health) and waived the 10 percent fee usually charged for an external course credit. A total of 29 participants completed the course and prepared six funding proposals, which are under review. In addition, the university now offers the proposal writing course for policymakers and implementers from different regions. With increased capacity, regional authorities will be better able to access SNIP and other funding mechanisms to support FP/RH IEC and quality improvement.

Strategy #3: Integrated Health Insurance

Peru's principal government mechanism to extend health services to poor and vulnerable populations is Integrated Health Insurance (*Seguro Integral de Salud* or SIS), a social insurance program. SIS, created in 2002 as a decentralized public entity of the MOH, effectively targets government healthcare resources to the most vulnerable populations, including children, adolescents, pregnant women, and, since 2006, men and women in poverty and extreme poverty who are not covered by any other social security or insurance schemes. Prior to 2007, the SIS service package included FP *counseling* when it was a part of prenatal and postpartum care but did not cover other FP counseling or FP services or methods.

To promote inclusion of FP in the social insurance scheme for the poor, the Health Policy Initiative:

- Conducted a feasibility analysis of including family planning in the SIS;
- Carried out evidence-based advocacy and policy dialogue with key government officials, highlighting the cost savings and added value of including FP in the package of services;
- Fostered consensus and mobilized political support;
- Provided technical assistance to the MOH to revise the package of services, including determining and revising itemized costs for FP counseling, methods, and services; and
- Drafted operational guidelines and norms to guide implementation of the proposed policy change.

Outcomes: On March 17, 2007, the President of Peru and Minister of Health published Supreme Decree N°004-2007-SA. The decree lists reproductive health (counseling and family planning as established in MOH norms) as one of eight preventive priorities, with 100 percent coverage. The policy promotes equitable and affordable access to high-quality FP/RH services for the poor by adding FP services and supplies to the list of priority interventions that all facilities receiving SIS funding are required to provide.

Lessons Learned

- **Understand the dynamic policy environment.** Peru's experience demonstrates that well-intentioned policies can have adverse outcomes. Thus, policymakers and planners must think through both the short- and long-term consequences of alternative policies prior to implementation.
- **Support an evidence-based, country driven process.** Planning is an iterative process of assessing a situation; setting short-, medium-, and long-term goals; identifying priorities; understanding the feasibility of options; and knowing the resource requirements. National and regional stakeholders should evaluate strategies for feasibility, challenges, opportunities, and key steps in the implementation process, as well as consider the country context and specific needs and issues.
- **Use a comprehensive approach involving multiple stakeholders.** No single strategy or organization can adequately meet the needs of the poor. Use of multiple strategies and financing interventions helps to reach different segments of the poor population and ensure sustainability in the long run.
- **Involve the poor in identifying problems and designing solutions.** Policies should be designed not only *for* the poor, but *with* the poor to ensure that programs properly address their needs.
- **Build on existing mechanisms.** Integrating FP/RH components into existing financing and social assistance mechanisms for the poor sets the stage for potential scale up and fosters sustainability.
- **Conduct equity-based monitoring and evaluation.** Too often, governments are not held accountable for meeting equity-related objectives. Regular monitoring is needed to ensure that programs are on track and are reaching intended beneficiaries. Development of FP/RH indicators by wealth quintiles and rural/urban differences can measure progress and help identify needed course corrections to reduce inequalities in use of FP services by the poor.