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INCREASING ACCESS TO FAMILY PLANNING AMONG THE POOR IN PERU:

BUILDING ON AND STRENGTHENING FINANCING MECHANISMS FOR THE POOR

APRIL 2008
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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

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Abbreviations

AIDS	acquired immune deficiency syndrome
CCT	conditional cash transfer
DHS	Demographic and Health Survey
DIRESA	Regional Directorate of Health
ENDES	Demographic and Health Survey
FP	family planning
FONASA	National Health Fund, Chile
HIV	human immunodeficiency virus
HPI	USAID | Health Policy Initiative, Task Order 1
IEC	information, education, and communication
INEI	National Institute of Statistics and Information
MEF	Ministry of Economy and Finance
MINSA	Ministry of Health
NGO	nongovernmental organization
OPI	Office of Planning and Investment
PRODES	Pro-Decentralization Program
RH	reproductive health
SIS	Integral Health Insurance
SNIP	National System of Public Investment
TOT	training-of-trainers
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

I. Introduction

Peru is a heterogeneous country, both geographically and culturally. It has three distinct geographical regions (coast, mountains, and jungle). The population of 27.6 million is unevenly distributed, with 73 percent residing in urban areas, primarily in the coastal region. Significant disparities in standard of living, income, and access to services are apparent. Although the GDP per capita in 2006 was the highest in the last decade at 7.7 and the primary school completion rate in 2005 was 100 percent, current data show that 53 percent of the population lives in poverty (World Bank, 2008). The proportion of people living in poverty is higher in rural areas, although, in absolute numbers, more poor people live in urban areas. Large-scale inequalities also exist between indigenous and non-indigenous populations.

The government is committed and motivated to addressing poverty and inequality, viewing it as critical to the country's development. Across multiple ministries and other public agencies, the government continues to fine tune its strategies to better reach the poor with a broad range of health and social services. Additionally, Peru continues to undergo health sector reform, presenting many opportunities to ensure more efficient and effective health service delivery, particularly in rural and remote areas where the majority of the poor reside.

To address low levels of family planning (FP) use and to respond to the FP/reproductive health (RH) needs of poor women in the region of Junin, we devised a two-step process. First, we identified the barriers that affect poor women's access to and use of FP services. Second, we designed interventions to address barriers related to existing financing mechanisms to ensure a sustainable and replicable response.

This report includes the background and rationale for the interventions, a review of existing literature on reaching the poor through targeted policies and programs, and a diagnosis of the Junin region that reveals barriers to access and use of FP services and financing mechanisms. The report also details how we selected the barriers to address and the process of implementing the selected strategies. The conclusion presents lessons learned and requirements for scaling up the strategies.

II. Background and Rationale for Intervention

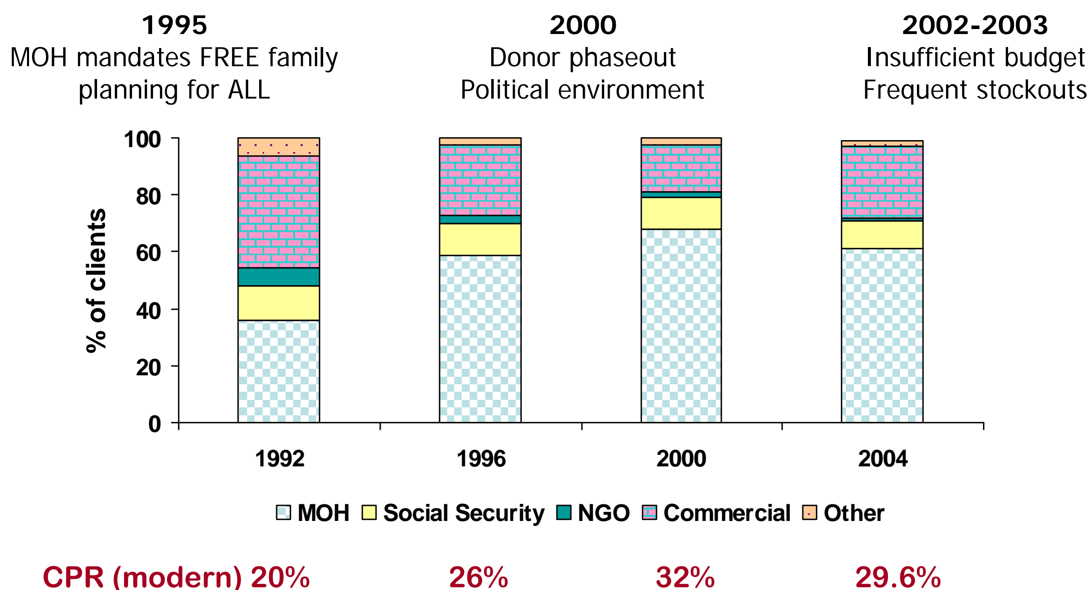
In 1995, the Peru Ministry of Health (MINSA) instituted and widely publicized a policy that mandated the provision of free contraceptive services and methods in government facilities for all Peruvians. The policy came at a time of public sector investment that resulted in a 50 percent increase in the number of health facilities—of which 20 percent were located in the poorest areas—during the period 1992–1996 (Valdivia, 2002). This increased investment meant an 82 percent increase in health facilities in the poorest areas, while just a 20 percent increase in wealthier areas. As a result of government investment and the FP policy change, FP use increased among all Peruvian women, notably among poor and rural populations.

Although a promising attempt to enhance equity, the policy and public sector investment played key roles in the dramatic changes of the Peruvian FP market[1] structure. For example, between 1992 and 2000, the MINSA market share for family planning increased dramatically from 36 to 68 percent (ENDES, 1992; 1996; 2000). The increase in the MINSA market share drew wealthier users away from the commercial sector and toward the MINSA and decreased the commercial sector market from more than 40 percent to

[1] The FP market is defined as the interaction of contraceptive methods, consumers (women of reproductive age, between 15 and 49 years), and providers. To determine which sources of family planning commodities and services reach a given population segment, the population is divided into quintiles based on a standard of living index (SLI). The national quintile scores are only a ranking of relative wealth—households in higher quintiles are wealthier than households in lower quintiles. The quintiles have no priori relationships to the national or absolute poverty lines. Also, the national wealth quintile scores should not be used to ascertain poverty-related inequities within urban and rural populations (Measure Evaluation, 2008).

less than 20 percent (see Figure 1). This finding affirms international literature showing that if free, high-quality contraceptive methods are available in MINSA facilities, private sector users with the ability to pay are likely to switch to a MINSA facility (Foreit, 2002; Bulatao, 2002; Winfrey et al., 2000).

Figure 1: Intended and Unintended Impacts of Policy Decisions on the Family Planning Market



The successes of Peru's national FP program in meeting users' needs during the 1990s can also be attributed in part to donor support, particularly in supplying MINSA facilities with contraceptive commodity donations. Toward the late 1990s, however, donors began to phase out this part of their assistance. In 1999, for the first time, the MINSA budget included funding for contraceptives, and the National Family Planning Program began purchasing contraceptives as part of the donor phaseout plan and continues to do so annually through the National Treasury budget. In 2002, the government declared contraceptives to be strategic public health commodities,[2] which ensured that contraceptives received special protection and funding in the national budget. Unfortunately, the government's investment in contraceptives was insufficient to meet existing demand and close the gap created by donor phaseout. Delays in initiating the contraceptive procurement process further inhibited contraceptive availability in the country.

As a result of insufficient contraceptives and logistical problems, between 2002 and 2004, contraceptive stockouts had an impact on use of government facilities, particularly in rural areas. From 2000–2004, the MINSA's FP market share declined from 69 to 61 percent given its issues with financial resources and contraceptive availability (ENDES, 2000; ENDES Continua, 2004). Providers resorted to prescribing different contraceptive methods or redirecting clients to commercial pharmacies (POLICY, 2005). The Ombudsman's Office reported consumer complaints in 2002 about restricted access to contraceptive methods and FP services in MINSA facilities, such as a reduction in the availability of surgical contraception, limited access to information about contraceptives, stockouts of contraceptive methods, and informal fees in health centers.

[2] Many of Peru's vertical programs—such as tuberculosis, HIV/AIDS, and sexual and reproductive health—have been converted into "Health Strategies," which the government is responsible for implementing. The MINSA is therefore responsible for having sufficient quantities of the medicines and supplies critical to the success of these strategies, or "strategic commodities," available to the population.

The predominant reliance on the MINSA in a time of donor phaseout of contraceptives and insufficient national investment placed a burden on existing public sector health resources, disproportionately affecting access to modern FP methods among the poor. During 2000–2004, modern method use declined by 6 percent among poor women (see Figure 2), while traditional method use increased by 9 percent. The proportion of MINSA clients in the poor and lower middle segments of the population (poorest 40 percent) decreased from 47 to 36 percent, while the proportion of clients from the wealthiest segment increased (see Figure 3). The commercial sector market share shifted back from 17 to 25 percent (mainly pharmacies); women of the two wealthiest quintiles doubled their use of pharmacies between 2000 and 2004. These changes in contraceptive use and source mix *suggest* that between 2000 and 2004, poor women switched to or increased use of traditional methods, while wealthier women continued to access free contraceptives in MINSA facilities or switched to commercial pharmacies and paid for their methods out of pocket (ENDES, 2000; ENDES Continua, 2004).

Figure 2: Use of Family Planning among the Poorest and Wealthiest, 1996-2004

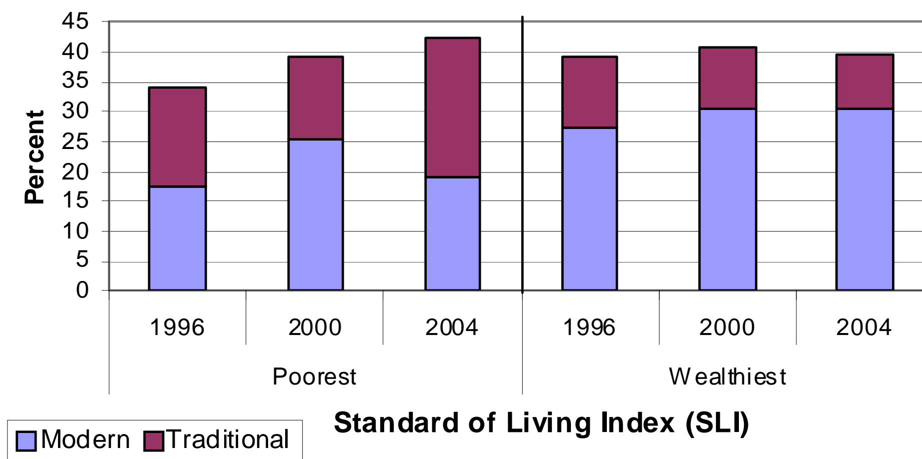
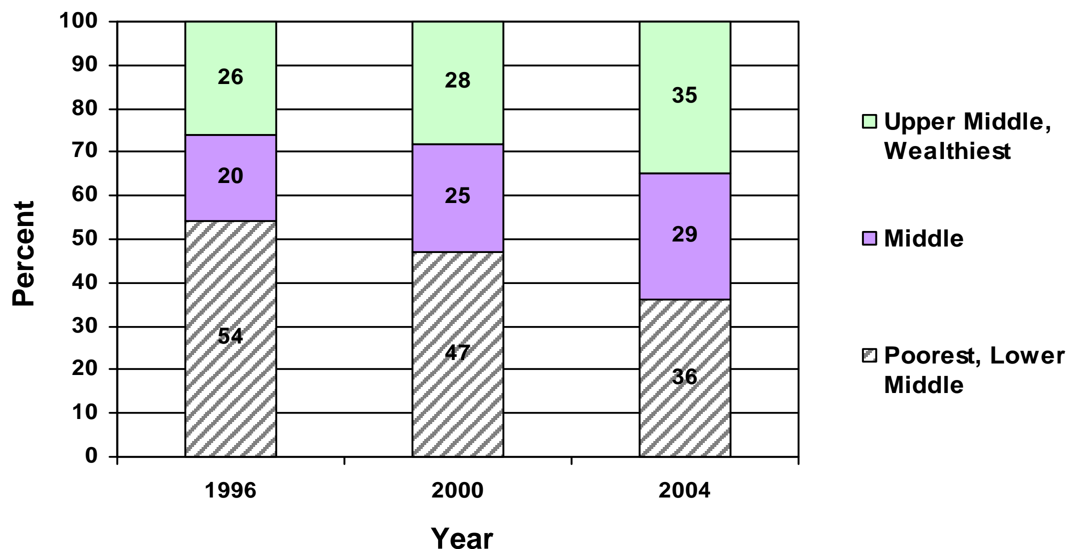


Figure 3: Profiles of Ministry of Health's Clients, by SLI quintiles



In examining the MINSA's FP clientele more closely, it is clear that during 1996–2004, poorer Peruvian women were increasingly less likely to be recipients of government subsidies. Universal coverage through the public sector, while often conceptualized as a strategy to reach the poor, tends to serve those who can most afford care and restricts access among those people who can least afford it; evidence shows that, in many countries, government subsidies benefit wealthier rather than poor population segments (Gwatkin, 2004; Filmer, 2003). Furthermore, research suggests that expansions in health infrastructure can only address certain dimensions of access; it is not enough to improve equity in healthcare use (Valdivia, 2002). Even if fees for services are waived or insurance covers the costs of both medicines and services, often these mechanisms fail to consider the costs of transportation, food, supplies, lost work, or informal/under the table payments that particularly burden those with limited ability to pay (Sharma et al., 2005). Working toward the equity and effectiveness of resource use thus requires a clear understanding of the underlying causes of barriers to access among the poor, a well-defined strategy to remove the barriers, and the direction of public sector resources toward poor, underserved groups.

III. Reaching the Poor Through Targeted Policies and Programs: Global and Latin America Regional Overview

Evidence reveals that low-income groups continue to suffer from poor health status and are not being reached with valuable health interventions. Ensuring that health policies and programs address the needs of the poor and developing and strengthening policies and strategies that actively aim to reach the poor are important in accelerating a country's progress toward poverty reduction. Health policies and strategies designed to reach the poor aim to address poverty in three main ways: improving the health status of the poor so that poverty is not exacerbated; ensuring that high-quality services actually reach poor and vulnerable population segments; and/or protecting the poor from incurring healthcare expenses that can exacerbate poverty (Bennett and Gilson, 2001). Additional dimensions to consider when addressing poverty—not necessarily encompassing health—include implementing economic measures designed to escape poverty; addressing sociocultural and gender factors that could influence participation and access by the poor; strengthening the capacity of the poor as leaders; and involving the poor in the design, implementation, and monitoring of interventions.

Implementing policies and programs to reach the poor entails defining the poor segment of the population so that they will be the program beneficiaries through geographic and/or individual targeting. Involving both national and local government stakeholders can help to identify and reach the poor and reduce barriers to access, as poverty can be concentrated in particular geographic areas or indigenous groups with specific health needs and interests. In addition, involving the poor in the design, implementation, and monitoring and evaluation of these policies and programs can ensure that programs appropriately and adequately address their needs.

Financing is essential to the implementation of health policies and programs, and it is critical to consider financing mechanisms that will increase access to health services or at least not impose additional barriers to access among the poor. Such approaches might include

- Increasing resources for facility-based improvements in quality and type of services offered in areas inhabited by traditionally poor population segments;
- Implementing user fees for the nonpoor and exemptions or waivers for the poor to cross-subsidize services and ensure that the poor do not pay out-of-pocket expenditures;
- Creating social health insurance or community-based insurance schemes for the poor to avoid prohibitive out-of-pocket expenditures; and
- Creating a voucher scheme or another demand-side financing scheme to target public social sector resources toward the poor.

Countries should use multiple financing mechanisms, as one mechanism alone may not appropriately or adequately protect all poor population segments.

Financing interventions to reach the poor can address the supply- or demand-side of services. Demand-side financing puts the purchasing power in the hands of consumers, often the poor, and aims to reduce financial barriers to seeking and receiving social services. Some types of demand-side financing mechanisms include vouchers, conditional cash transfers (CCTs), and in-kind transfers. In contrast, with supply-side financing, the public or donor money goes directly to health facilities/providers and can include social insurance schemes, universal coverage systems in public facilities, and financial investments in facility- or program-based improvements. Supply-based subsidies for social services often fail to benefit the poorest populations, as wealthier populations are often better positioned to receive the services or the barriers to access have not been explicitly addressed. Demand-side financing, on the other hand, may help to target those subsidies so that the poor receive a greater proportion of program benefits and the efficiency of providers and facilities is increased (Ensor, 2004).

Social protection mechanisms, such as CCT programs, are increasingly being recognized as effective policy tools to tackle poverty, vulnerability, and social exclusion (Jones et al., 2007). Many Latin American countries—including Brazil, Chile, Honduras, and Mexico—have successfully implemented CCT programs. The programs provide cash to poor families upon fulfilling specific criteria, such as seeking health services and enrolling children in school. The short-term goal is reducing financial barriers to accessing and receiving valuable social services, and the long-term goal is building human capital through health and education so that the poor can escape poverty. CCT programs are some of the first programs to create and implement targeting criteria to ensure that the poor are beneficiaries. In 2006, Brazil's program, Bolsa Familiar, successfully targeted its resources to more than 9 million poor families (81 percent of the intended beneficiaries and approximately 19 percent of the total population) (Mutzig, 2006). In Mexico, the Oportunidades program (formerly PROGRESA), includes a range of conditionalities, such as enrollment and attendance for primary and secondary school students, household attendance at health checkups, and community health education and nutrition sessions. In 2002, the program reached more than 4 million families (20 percent of the population) and achieved health outcomes including declines in maternal and child mortality rates by 11 percent and 2 percent, respectively; a 12 percent increase in the number of prenatal consultations for pregnant women in rural areas; a 35 percent increase in the number of preventive health consultations in rural areas; and a 17 percent increase in contraceptive use among rural women beneficiaries (Rawlings and Rubio, 2003).

State-funded social insurance schemes are also common throughout Latin America and aim to reduce out-of-pocket healthcare expenditures among the poor and to increase access to health services by targeting health resources toward the poor. In Chile, the public insurance system, National Health Fund or *Fondo Nacional de Salud* (FONASA), covers 60 percent of the population, primarily poor, lower-middle, and elderly population segments; while the rest of the population is served by private or other public systems (police, universities). FONASA ensures the financing of public healthcare services, providing the same package of services to beneficiaries regardless of contribution. The fund uses a per-capita system that considers the affiliated population, its socioeconomic characteristics (rural and poverty), and the number of services delivered—effectively redistributing income from wealthier to poorer areas—to determine funding for municipal health facilities (Manuel, 2001). In Colombia, the government initiated a social insurance program to reduce out-of-pocket healthcare spending and financial barriers to access, as findings revealed a large proportion of poor populations' income being used for healthcare (Castano et al., 2002). In Bolivia, Maternal Child Health Insurance provides universal coverage and free services to children and women of reproductive age (15–49 years), focusing on the poor. Peru's Integral Health Insurance (*Seguro Integral de Salud* or SIS) provides free services to poor and indigenous populations, as well as other underserved or priority groups.

A range of initiatives are needed to ensure that the poor have access to healthcare services. No one system or program will ensure access among all poor and vulnerable groups in all geographic areas, and no one approach will be infallible. Leakage of program benefits to nonpoor groups is an ongoing challenge but not necessarily the largest cause for concern. Most important, countries must consider designing and implementing specific strategies to reach the poor, continually monitor and evaluate their impact, and adjust them accordingly to make midstream corrections to better reach the intended beneficiaries.

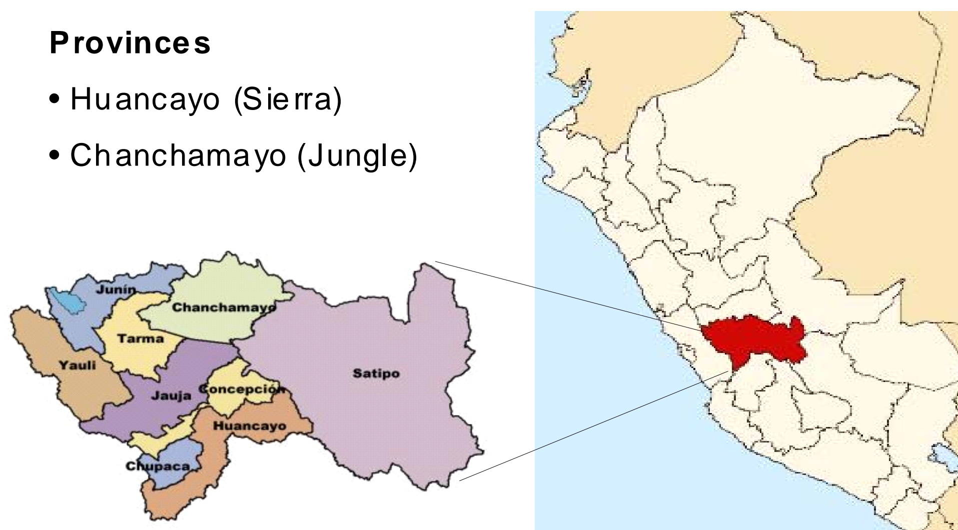
IV. Regional Diagnosis of Junin

Junin, characterized by historically hard-to-reach populations, is one of USAID/Peru's priority regions and thus was selected for implementing this innovative approach to improve access to family planning among the poor. In Junin, 53 percent of the population lives in poverty and 19 percent live in extreme poverty (see Table 1). The region, with geographic and cultural diversity, has two main indigenous groups that reside in the Sierra and Jungle and are traditionally underserved by social programs (see Figure 4). For example, 62 percent of children under 5 years of age whose mother speaks an indigenous language are malnourished—a prevalence double that of the rest of the child population in Junin.

Table 1: Health and Population Indicators

Indicators	Junin	Peru
Population (2003)	1.2 million	27 million
Infant Mortality Rate (per 1,000 live births)	43	45 (rural)
Maternal Mortality Ratio (per 100,000 live births)	144.5	185
Total Fertility Rate	3	2.5
▪ Satipo	5	
▪ Jauja and Chanchmayo	4	
Percent of Population in Poverty	52.6	48
Percent of Population in Extreme Poverty	18.6	24

Figure 4: Junin Region and District Map



To understand how to improve access to family planning among the poor in Peru, we reviewed available data and information and collected new information to serve as a foundation for the design of a cohesive strategy. Specifically, in Junin, we analyzed market segments for family planning, diagnosed the health system, and conducted key stakeholder interviews and focus group discussions with local residents to fully understand the barriers facing poor women in Junin in accessing FP methods and services.

Data Analysis

Secondary analysis of Demographic and Health Survey (DHS) 2004/2005 data, including FP market segmentation, unmet need analysis, and trend analysis reveals a profile of poor women and their behaviors regarding use of family planning. We analyzed key demographic indicators disaggregated by the Sierra and Jungle to understand the regional issues and challenges (see Table 2). The Coast region includes Lima and other urban areas and serves as a comparison group.

Table 2: Family Planning Use, Source Mix, and Unmet Need by Natural and Urban/Rural Regions in Peru (2004 and 2005)

	Coast	Sierra	Jungle	Urban	Rural
Current Use of Family Planning					
Not using	55.7	56.3	48.9	55.3	54.7
Traditional	11.4	19.5	16.6	12.5	19.6
Modern	32.9	24.2	34.5	32.3	25.7
TOTAL	100.0	100.0	100.0	100.0	100.0
Family Planning Source Mix					
MINSA	53.3	70.6	71.8	51.5	85.7
EsSALUD	10.1	10.1	11.1	12.3	4.2
Other government	1.2	1.8	0.9	1.3	1.2
Nongovernmental organization	2.1	0.6	0.2	1.9	0.2
Private provider	6.9	1.9	2.6	5.8	2.8
Pharmacy	24.8	13.7	12.6	25.5	5.4
TOTAL	100.0	100.0	100.0	100.0	100.0
Status of Last Pregnancy					
Wanted then	50.2	35.6	42.6	48.9	36.0
Wanted later	49.8	64.4	57.4	51.1	64.4
TOTAL	100.0	100.0	100.0	100.0	100.0

Source: DHS, 2004 and 2005. The current DHS is a continuous round, and data collection is ongoing; sample sizes were not large enough for the region of Junin (N=461), so proxies were used.

Women of reproductive age residing in the Sierra (20 percent) and Jungle (17 percent) are more likely to use traditional methods than their coastal counterparts (11 percent). Those in the Sierra are the least likely to use modern methods. Regarding sources for FP methods, the MINSA plays an important role in the FP market, serving 71 and 72 percent of FP users in the Sierra and Jungle, respectively, and 86 percent of FP users in rural areas. The private sector has a much smaller role in FP provision due to a lack of providers or private sector outlets and limited ability to pay for FP methods among Sierra and Jungle residents. Given the limited government resources available and a small private sector, the reliance on the MINSA for family planning is a concern.

Regarding birth planning, 64 percent and 57 percent of women residing in the Sierra and Jungle, respectively, wanted their most recent pregnancy later. These data suggest that women are interested in spacing and limiting births but are not using effective methods, not using methods correctly and consistently, or not accessing FP services at all.

We also conducted political mapping and systems analysis of Junin, which included mapping regional stakeholders, identifying other social programs and efforts to reach the poor, and documenting planning and resource allocation processes at the decentralized level. Regional stakeholder mapping helped to identify organizations and individuals to involve in designing the strategy. Ongoing or new social programs for the poor include the SIS, which aims to reach the poor with a range of preventive and curative health services; and JUNTOS, a CCT program being launched in selected districts of Junin.

Key Informant Interviews and Focus Group Discussions

Regional health authorities interviewed at the Regional Directorate of Health included the director; officers for Strategic Planning, Regional Office of Medicines, Supplies and Pharmaceuticals; and the coordinator of the Health Network. The questions focused on existing FP/RH policies and programs and implementation challenges, perceptions of barriers faced by the poor in accessing FP services, and the feasibility of strategies for reducing financial barriers to family planning. HPI staff interviewed local governmental authorities in both Huancayo and Chanchamayo—including representatives of the social development, commerce, and municipal management areas—to determine existing social responsibility initiatives and local development programs and policies. One health authority revealed that family planning is less of a priority in the region: "In recent years, family planning has become less of a priority; maternal mortality, rather, has become of greater importance." This loss of priority status has likely been accompanied by decreased financial resources for family planning, as another health authority explained: "We've seen a strong decline in the areas of follow up and counseling. [Financial] resources directed toward family planning are now scarce." Healthcare administrators in hospitals and the assistant dean of the Huancayo Midwives College discussed perceptions of the barriers faced by the poor in accessing FP services and considered the feasibility of possible strategies for reducing financial barriers to family planning.

HPI conducted focus group discussions with healthcare providers in two health facility locations, Chilca, Huancayo (Sierra); and Pichanaki, Chanchamayo (Jungle). The discussions helped to identify service-level barriers that providers encounter that potentially complicate the delivery of FP products and services for those who want them. Focus group facilitators asked providers about the availability of FP/RH informational/educational materials and contraceptive products in their facilities, opportunities for training and the presence of technical materials, and experiences with their clientele's health-seeking behavior. One provider revealed a lack of culturally appropriate FP/RH informational materials: "We haven't had FP/RH information, education, and communication materials [in the health center] since last year, and they came with Sierra characteristics, and you can see that here we are Jungle."

Focus groups with poor women using and not using family planning and poor men helped to identify barriers to using contraceptives; explore strategies for reducing financial barriers to family planning (e.g., vouchers, transportation reimbursement, waiver of registration card fee); and determine knowledge and use of existing state-funded social programs targeting the poor. HPI conducted these focus groups with 46 poor women from Chilca, Huancayo (Sierra) and Pichanaki, Chanchamayo (Jungle); and with 15 poor men in Pucará, Huancayo and Pichinaki, Chanchamayo (see Figure 4). These locations were chosen to ensure appropriate representation of the local population.

Findings of the focus groups with poor women did not reveal differences between the Jungle and Sierra areas/ethnic groups regarding FP experiences and expectations of alternative strategies. Women tended to

have limited knowledge about local social programs but were aware that FP methods were free in MINSA facilities, with the exception of the required registration fee. Differences did exist, however, between the groups regarding experiences in the health facilities, such as schedules of operation and quality of care.

One woman FP user commented on the lack of information provided in the health center on family planning and the lack of time during a health center visit to ask questions: “There isn’t any additional information; when you register as a family planning client they give you information, but nothing more after that.” Another FP user implied that more complete information could be provided and in a more client-centered manner: “When I don’t menstruate, [health personnel] tell me it is normal, but I know it is not normal.” Nonusers revealed concerns about side effects: “There are rumors that injectables or pills shock your system, that mothers can turn more nervous, you have pain, lots of head problems…we’re afraid of that.” One woman revealed cultural beliefs about blood flow and its effect on the body: “[FP methods] do harm, you can form a cyst because when there is no menstruation, the blood accumulates and brings illness.”

Focus groups with men revealed their interest in greater and improved communication about modern methods. One man commented that his wife “would change to a more effective FP method that was not harmful to her, but only if and when there is enough information.” Discussions with men also suggested that gender dynamics within these populations, in general, appear to facilitate FP use rather than impede its use, thereby ruling out the question of whether husband opposition is a barrier. One man said, with agreement from the others, “It’s very important to have conversations and dialogue with your partner to discuss how to ‘plan’ [your family] for the future.”

To determine why nonpoor women seek free FP services from MINSA, HPI conducted exit interviews with 90 nonpoor women (generally middle economic status) using the ministry’s FP services. Of these women, 51 percent would consider paying for their FP products if this meant a decrease in waiting time and improved information provision about family planning. Furthermore, they stated that they could only pay the lowest prices available (2 soles for 3 condoms, 8 soles for an oral contraceptive cycle, 50 soles for an intrauterine device, and 120 soles for voluntary female sterilization). When the MINSA faced contraceptive stockouts, the majority of women interviewed said that they changed their method to one that was in stock rather than buying their current method (Subiria, 2006).

The key informant interviews, focus group discussions, and exit interviews revealed a long list of individual, community, and operational barriers to seeking, receiving, and providing FP methods and services. Box 1 lists some of the main barriers that could be addressed via financing mechanisms, increased resources, and cultural adaptation. Poor women and men reported a lack of accurate, culturally appropriate FP information; and healthcare providers reiterated this point. In addition, providers commented that FP activities—particularly those around staff training; supervision; monitoring; and information, education, and communication (IEC)—are no longer financed adequately, contributing to user complaints about the lack of counseling and information. Local authorities reported that family planning has lost its priority status and faces resource restrictions, in part due to the change to an integrated health model.

Box 1: Select Barriers to the Provision of and Access to Family Planning in Junin

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

V. Selection and Design of Financing Mechanisms to Reach the Poor

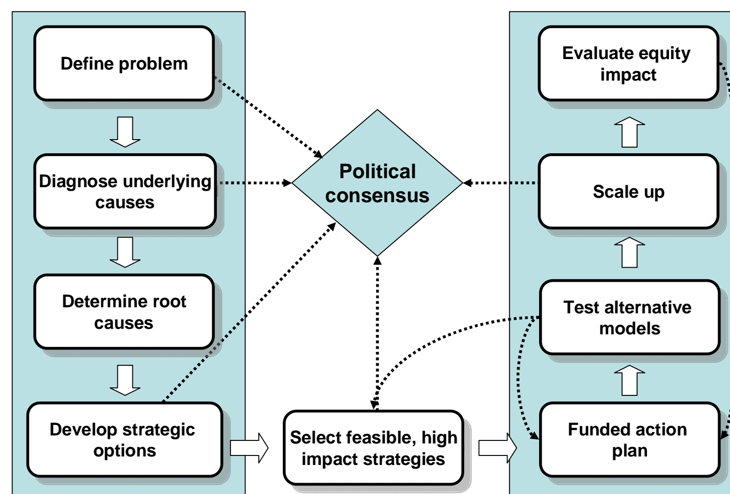
In selecting appropriate policy and finance strategies that would help ensure access to family planning among poor, indigenous populations in Junin, HPI considered the

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

Furthermore, HPI understood that any strategies implemented in Junin would need to be applicable to other regions of Peru and Latin America.

Based on the regional diagnosis and sustainability and replicability concerns, we conducted an analysis, using both primary and secondary data, to identify strategies for implementation (see Figure 5). HPI examined the problems and barriers raised by stakeholders and key informants, listed reasons for these barriers, and discussed possible strategies and how they could effectively address the barriers. To determine which strategies could most effectively address the barriers, we weighed existing opportunities, challenges, and requirements for implementation. This analytical process resulted in a package of feasible strategies that could increase access to family planning among the poor in a sustainable, replicable way (see the matrices in Annex 1).

Figure 5: A Systematic Process of Designing, Implementing and Evaluating Pro-poor Strategies



The selected strategies aim to increase the amount of resources directed to family planning for the poor and to build on existing financing mechanisms to provide health services to the poor by incorporating FP/RH interventions (see Box 2).

Box 2: Strategies to Address Low FP Access Among the Poor in Junin

- Strengthen the FP/RH educational component of the CCT program for poor families and draft culturally appropriate FP counseling guidelines and training (local level)
- Mobilize regional resources for IEC and quality improvement strategies for FP/RH through public investment funding (regional level)
- Include family planning in the package of services offered to poor women through social insurance (national level)

The strategies address different levels of the MINSA—national, regional, and local—in recognition of Peru's decentralized government and mobilize different types of available financing to create a system that reaches the poor via multiple approaches (see Box 3). The strategies also address different types of interventions: strategic, in amending health policies at the national level; tactical, in addressing the administrative components of translating policies into programs at the regional level; and operational, in addressing implementation and service delivery at the local level.

Box 3: Levels and Types of Intervention within the MINSA

National Level: Ministry of Health
Directorate of the People's Health Directorate of Health Promotion
Health Policies→STRATEGIC

Regional Level: Regional Directorates of Health
Health Networks
Units/Strategies (Reproductive Health, Health Promotion)
Administrative→TACTICAL

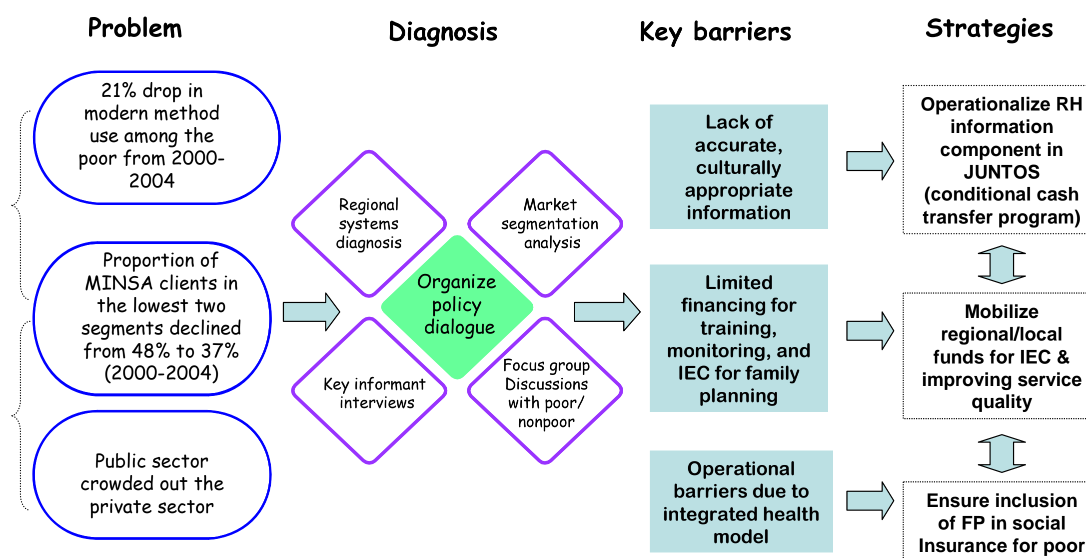
District Level: Micronetworks
Health Facilities
Service Delivery→OPERATIONAL

VI. Mobilization of Support for Selected Strategies at the Regional and National Levels

HPI first disseminated information from the analyses and proposed solutions to (1) generate awareness at the regional level regarding specific needs of the poor in Junin and (2) mobilize support for the proposed strategies and receive additional input on how to implement them. The regional authorities approved the strategies and provided important guidance for implementation. The authorities wanted to ensure that regional priorities—such as ensuring the rights of users of health services, reducing poverty, and addressing gender—would be integrated into the strategies.

HPI held additional meetings with relevant regional and national authorities at the beginning of strategy implementation to identify specific requirements and necessary steps to implement the strategies (see Figure 6). Each strategy required a careful consideration of the institutions involved, the institutional functions vis-à-vis the identified strategy, the individual actors, the level of influence of the individuals and the institutions, the actors' likely position along the continuum of "in favor of" or "against" the strategy, and the necessary steps to convince them of the proposed strategy.

Figure 6: Evidence-based Process of Designing Strategies to Address Access Barriers Among the Poor in Peru



VII. Testing and Implementation of the Selected Strategies

The planning and implementation of the selected strategies involved several processes: awareness raising among a broad range of stakeholders at national and subnational levels, building partnerships and support, tapping into multisectoral planning groups, building local capacity, mobilizing information for decisionmaking, and updating pro-poor monitoring and evaluation indicators. For each strategy below, we outline its background, aims, steps taken, and outcomes.

Strategy 1: Strengthen the FP/RH Educational Component of JUNTOS and Draft Culturally Appropriate FP Counseling Guidelines and Training

Background of JUNTOS conditional cash transfer program

In February 2005, to address poverty and implement a strategy proven to be successful internationally, the government of Peru launched JUNTOS ("Together"), a CCT program for the poorest families in rural and urban communities. The JUNTOS program has its roots in the country's efforts to achieve the Millennium Development Goals, as well as in national social strategies and the National Plan for Overcoming Poverty. In addition, similar to other country programs, JUNTOS institutionalizes civic participation in design, planning, and implementation processes to improve equity and social justice. The government placed the JUNTOS program within the multisectoral Roundtable for Poverty Reduction, a key body in social policy development. The JUNTOS advisory board uses a multisectoral approach to address poverty and includes the ministers of economics and finance, health, women and social development, and education; as well as representatives of nongovernmental organizations (NGOs), the commercial sector, and civil society. Local- and national-level committees supervise the JUNTOS program, which is carried out by civil society. JUNTOS is also included as one of the components of Peru's focused intervention to eradicate poverty, CRECER ("Grow"). CRECER aims to reach the poorest districts to reduce poverty, decrease malnutrition, and improve access to health and education benefits.

JUNTOS provides preventive and curative healthcare services and education on maternal and child health and nutrition, encourages children's enrollment and attendance in primary school among its beneficiary families, and promotes and facilitates the process of national registration and issuance of identity cards for children. The program works on the principles of voluntary participation and commitment in efforts to include households in addressing poverty. The program provides cash to female household members (mothers) upon meeting criteria related to seeking health services and enrolling children in school. The goal is to build human capital and provide economic opportunities and social protection for the most vulnerable segments of society. The program includes the poorest households that include pregnant women and/or children younger than age 14. Eligible households receive a fixed cash transfer of 100 soles (US$31.00) per month, irrespective of household size.

The JUNTOS targeting strategy is operationalized in three stages: geographic targeting, household targeting, and community validation of potential beneficiaries. The program's board identifies the selected districts, with the aid of a poverty map developed by the Ministry of Economy and Finance (MEF), which is also used for other national programs (Basic Unmet Needs, Poverty Gap, Extreme Poverty, and Chronic Child Malnutrition). JUNTOS has a contract with the National Institute of Statistics and Information (INEI) to conduct a census of households in identified poor districts. The census identifies eligible households based on composition—those households with pregnant women, with fathers who are widowers, and/or children younger than age 14. INEI then applies a socioeconomic evaluation of each household to classify it as extremely poor, poor, or not poor in order to identify the beneficiary and ineligible households. INEI provides the list of potential beneficiary households to JUNTOS, which compiles the information and verifies names and identification numbers of potential beneficiaries. Community Validation Assemblies, representing a social vigilance and transparency mechanism, provide an additional filter and enable community members to review and validate the list of potential beneficiary households.

Once validated as a beneficiary household, a representative of that household signs the commitment agreement with JUNTOS and completes the appropriate forms and documentation. The National Bank then creates savings accounts to deposit the cash transfers for the beneficiaries, generally in the name of the female head of household.

In 2005, Law No. 28562 provided 120 million soles (US$38 million) to finance the pilot phase in 110 districts in four regions. In 2006, the program expanded into 320 districts within 67 provinces of the 9 poorest regions of Peru: Ancash, Apurímac, Ayacucho, Cajamarca, Huánuco, Huancavelica, Puno, Junín, and La Libertad, reaching a total of 160,000 beneficiary households (800,000 people). Given the successes in 2006, Congress provided 400 million soles (US$121 million) in addition to a supplementary credit of 146 million soles (US$46 million) for the program. In 2007, JUNTOS began expanding into five more regions: Amazonas, Cusco, Pasco, Loreto, and Piura. By the end of 2007, the program will have grown to reach 638 districts of the 14 regions where extreme poverty is concentrated (JUNTOS website).

Strategy aims

While participation in FP/RH information sessions (*charlas*) is a component of the JUNTOS program, it has yet to be fully implemented. Focus group discussions in the region revealed poor women's interest in receiving more FP/RH-related information, and this program provides an opportunity to reach them with culturally appropriate information and materials. Additionally, should these *charlas* result in increased demand for family planning among poor women, providers must be prepared to conduct culturally competent individual or couple FP counseling and service provision. Providers should be trained in delivering these information sessions and in FP counseling for individuals—thus creating a cadre of professionals attuned to women's FP/RH needs. Ultimately, the strategy aims to incorporate both demand and supply components. On the demand side, addressing the lack of culturally appropriate and adequate

FP/RH information and counseling will likely increase the demand for FP products and services. An increase in demand requires preparation of the supply side of the equation, or the health providers, in being able to use culturally appropriate FP counseling techniques.

Steps

Two important steps in implementing the JUNTOS strategy included (1) securing the commitment of authorities at both the national and regional levels to approve and implement JUNTOS interventions and (2) receiving their technical input and guidance. HPI helped to achieve these objectives through policy dialogue and advocacy efforts. First, we met with national-level MINSA authorities. Because several divisions of the MINSA oversee JUNTOS and FP/RH service delivery, HPI had to meet with, share ideas, and convince three main stakeholders of the aims of the JUNTOS strategy: (1) the JUNTOS director, who makes decisions on the health content of JUNTOS and how to allocate the JUNTOS health budget; (2) the coordinator of the National Sexual and Reproductive Health Strategy within the Directorate of the People's Health, which makes decisions about FP/RH/MH care, including counseling for the MINSA and the JUNTOS; and (3) the director of health education within the Directorate of Health Promotion, which is responsible for all educational health activities and FP/RH *charlas*. At the regional level, HPI secured the commitment of the JUNTOS regional coordinator in Junin, the coordinator of JUNTOS within the Junin Regional Directorate of Health (DIRESA), which addresses the implementation of JUNTOS health activities; and the director of the Junin DIRESA, who makes decisions regarding content of health counseling, health information provision, and use of provider time.

After securing key stakeholder commitment to the JUNTOS program, HPI strengthened the RH information and counseling components of JUNTOS by integrating the cultural beliefs, practices, and relationships of the two main indigenous groups into the existing MINSA FP/RH counseling and information provision guidelines. We also designed a training-of-trainers (TOT) guide and approach for training health personnel. The guides aim to improve the cultural awareness of healthcare providers in Junin and ultimately increase health-seeking behavior among the poor, indigenous populations. HPI developed the guides in line with the needs and interests of the Junin DIRESA, as well as healthcare providers and indigenous women.

HPI used these guides to train trainers, who, in turn, trained health personnel in micronetworks in Junin districts. Having a cadre of experienced and well-trained health personnel in poor districts will ultimately help to build sustainability. HPI prepared a training program and guides to build trainers' capacity to use the adapted guidelines for educational FP/RH sessions and counseling. In April and May, HPI trained 19 health personnel in the Sierra and Jungle regions. These trainers, in turn, trained 83 health personnel, including medical doctors, nurses, midwives, and paramedical personnel in the Sierra (38 people) and Jungle (45 people). The TOT and the three-day training program included sessions on skills building (negotiation, communication, information sharing) and culturally appropriate counseling; and also field visits to rural health facilities for practical skills development. As part of the training, health personnel prepared an action plan for their health facilities and developed indicators for monitoring performance. HPI will conduct follow-up visits to evaluate the quality and appropriateness of the counseling sessions conducted by the trained health personnel.

Outcomes

Increased access to culturally appropriate information among the poorest populations.
Operationalization of the RH *charlas* component of the CCT program has been successful in removing barriers to access caused by a lack of culturally appropriate information (see Figure 7). This strategy resulted in an increased number of educational sessions held, an increased number of poor women attending counselling sessions, and the improved quality of culturally appropriate counselling. HPI developed indicators to assess the increase in access to high-quality FP counseling among the poorest women in Junin. A comparison of baseline and endline data shows that weekly attendance in counseling

sessions at the selected health facilities increased from 568 to 1,000 women (see Figure 8). The average number of RH *charlas* held per month increased from 1–3.

Figure 7: Operationalizing RH Information Component in JUNTOS – a Conditional Cash Transfer Program

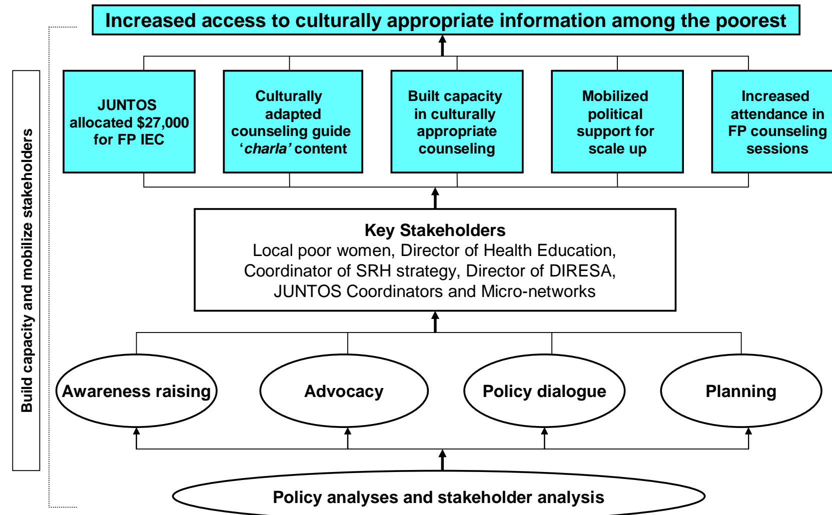
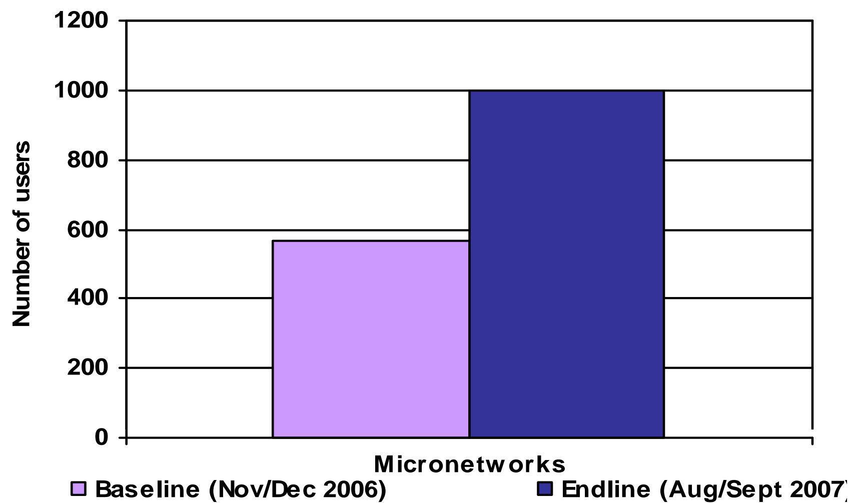


Figure 8. Number of Poorest Women Attending FP Counseling Sessions, Weekly



JUNTOS funds mobilized for strengthening the FP/RH component. JUNTOS (via the MINSA's Health Promotion Division) allocated 82,500 soles (US$27,000) to produce culturally appropriate, FP/RH IEC materials designed by UNFPA for use in health facilities countrywide. This allocation of resources signifies a commitment to FP/RH and an interest and capacity to respond to regional/local needs and interests. It also represents an important example of intergovernmental collaboration to ensure that poverty reduction and FP/RH efforts are integrated and maximize each program's potential impact. The MINSA will distribute the materials to health facilities in Junin (and other regions). JUNTOS will also fund training for MINSA providers on culturally appropriate, FP/RH information sharing in facilities where the program is operating.

MINSA approves culturally adapted counseling and information provision guidelines. The director of the MINSA's General Directorate of the People's Health approved the guidelines, signifying the government's commitment to reaching underserved indigenous groups with FP/RH information and interest in using the training materials. It is hoped that the guidelines will be used in other regions of Peru as well.

Strategy 2: Mobilize Regional Resources for IEC and Quality Improvement Strategies for FP/RH Through Public Investment Funding

Background of the National System for Public Investment

The National System of Public Investment (*Sistema Nacional de Inversión Pública* or SNIP), created in 2000 as an administrative system, establishes standards and procedures for ensuring the quality and sustainability of public investment projects. Overseen by the Office of Planning and Investment (OPI) of the MEF, SNIP's objectives are to (1) allocate resources to public investment activities that will have a positive 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. National-level, public sector entities began implementing SNIP in 2001. As part of the decentralization process, in 2003, the national government mandated the implementation of SNIP in regional and local governments—stating that the distribution of funds for public investment (approximately 10% of the regional budget) must involve a participatory process (government and civil society), which includes jointly setting priorities.

Although this funding is available for local government and civil society to finance public investment activities, accessing these funds has been difficult, particularly for the social sector. In general, one main problem is that government entities lack the capacity and information required to develop winning proposals for SNIP funds. For example, consultants prepared the proposals for the regional government of Junin to implement infrastructure activities. Within the DIRESA, few staff have the technical capacity to prepare proposals or conduct problem analysis to justify the public investment. Furthermore, the proposal writing process is extensive and time consuming (minimum of two months). Although the MEF and OPI-MINSA have trained DIRESA staff on formulating SNIP proposals and managing SNIP projects, the trainings did not include an applied or practical component and staff did not feel adequately prepared to write proposals. These factors contribute to the DIRESA's inability to prepare viable proposals for the funding of health-related activities.

Moreover, OPI is unfamiliar with the area of health, limiting its ability to evaluate health-related proposals. This situation is problematic given that OPI is singly responsible for evaluating the feasibility of proposals, thereby pre-selecting them for the participatory budget process during which civil society and government actors help to make the award decisions.

Strategy aims

Building the capacity of local groups to prepare proposals will enable them to articulate the role of health as a social investment and to ultimately obtain important funds for improving access to and the quality of FP/RH services. The Junin DIRESA requested assistance with helping to prepare technically strong proposals for much needed health activities, which are aligned with the region's health priorities. In response, HPI strengthened the capacity of the DIRESA and regional government (i.e., Division of Social Development Management and OPI) staff in the identification, formulation, and evaluation of proposals for public investment activities. Emphasis was placed on health and improving access to and the quality of FP/RH services that reflect regional health plan priorities.

Steps

HPI first gathered information on the process for mobilizing social investment funds and the perceptions of key informants on barriers to accessing the funds in general and specifically for health activities. The assessment included interviews with regional government and regional health authorities and thus helped to determine who to reach out to and where to attain commitment and approval.

Next, HPI gained intra-governmental interest in accessing public investment funds for health activities and collaboration from multiple groups. We met several times with government officials to convince them that greater efforts are needed to access additional funds for health. HPI contacted three main governmental stakeholders: the social development manager**,** who decides which types of programs should be created and implemented from the Social Development Management office and in the health and education sectors; the director of the Office of Planning and Investment (a division of the MEF), who evaluates the public investment project proposals from a technical perspective; and the director of the Junin DIRESA, who identifies regional health priorities and which types of health project proposals should be developed.

HPI also fostered collaboration with nongovernmental actors, including a university. HPI collaborated with PRODES, a USAID-funded project implemented by Associates for Rural Development, which implements a proposal writing training course for infrastructure projects. With the support of PRODES, we adapted its training modules to focus on health and education activities and learned how to conduct the course. The National Central University agreed to provide credit and diplomas to participants (in conjunction with the Regional Health Directorate) and waive the 10 percent fee usually charged for an external course credit. HPI, PRODES, and the university worked together to structure, prepare materials for, and conduct the course. Local university involvement and support ensures sustainability and replicability of the process and a greater likelihood that public investment funds will be accessed and used for health activities.

The DIRESA and Social Development Management office each selected staff to participate in the course to increase their capacity to prepare proposals and access funds for social development/health issues. The two entities worked together to define course objectives, identify participants, and pre-select proposal topics based on regional priorities. The DIRESA assumed the costs of travel and lodging expenses for its staff participants, as necessary.

With PRODES, HPI facilitated the intensive six-month course, which included both distance learning and classroom components. The training had three main modules: problem identification, proposal development, and evaluation design. Twenty-nine participants from the DIRESA, Social Development Management office, and OPI attended the course and drafted six comprehensive funding proposals, including a description of the problem and a costing of the interventions. All the proposals passed the first round of approval.

Outcomes

Courses adopted to increase capacity to access funds and sustain health activities. The National Central University provided credit and diplomas to participants (in conjunction with the Regional Health Directorate) and waived the 10 percent fee usually charged for an external course credit. Several regions contacted the university and expressed interest in the course. The university now offers a proposal writing course for policymakers and implementers from different regions.

Strategy 3: Include Family Planning in the Package of Services Offered to Poor Women Through Social Insurance

Background of 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 MINSA, targets MINSA healthcare resources to the most vulnerable population segments, 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 scheme. SIS defines and adheres to criteria, designs benefits plans in coordination with the MINSA, and distributes financial resources. As of December 2006, SIS was serving 10,389,607 beneficiaries, reflecting steady annual increases in the number of beneficiaries since 2002, when SIS was serving 5,863,687.

To reach the poorest subgroups, SIS identifies and categorizes potential beneficiaries through geographic targeting or individual targeting. To begin the registration process, all potential beneficiaries, including children, must have a national identification card or other form of identification. Potential beneficiaries either express interest in registering, or a health provider might suggest that they register. Pregnant women and children are not required to register, because they are automatically considered beneficiaries due to life-cycle status, regardless of poverty status. In particular regions, SIS officials conduct only geographic targeting, as some districts have more than 65 percent of residents living in poverty or extreme poverty. In districts not characterized as predominantly poor, SIS requires the application of an individual socioeconomic evaluation survey to be conducted with the potential beneficiary (or head of beneficiary household) in the health facility. A SIS social worker or other designated facility member completes the evaluation survey. If possible, the SIS representative conducts a home visit to determine household living conditions and to confirm whether the applicant meets the requirement of being poor or extremely poor. If confirmed, the beneficiary and the SIS representative sign an Affiliation Contract Form (Defensoria del Pueblo, 2006; Petrera 2006).

The SIS targeting strategy is more effective in identifying the poor and providing services to them than the MINSA. About 94 percent of SIS beneficiaries are poor or extremely poor. About 50 percent of beneficiaries reside in rural areas and 28 percent reside in marginalized urban areas, reflecting the success of SIS in reaching those who are traditionally underserved or hard to reach with health services. The MINSA does not have a targeting strategy for preventive services, such as family planning, that do not require user fee payments; as a result, wealthier women are often more likely than poorer women to receive the benefits.

SIS also has an arm called Semi-Contributive Insurance, or Plan G, which targets populations with some ability to pay—those earning less than 1,000 soles (US$317) per month. This group will pay a small, monthly premium for healthcare, between 10 and 20 soles (US$3.17–6.34) for an individual, depending on annual income, and 30 soles for families (US$9.52). The plan reflects an attempt to distinguish between the poor and those with some ability to pay.

SIS receives its annual budget directly from the MEF and then funnels its resources through regional health directorates to reimburse government health facilities for services rendered to SIS beneficiaries, which ultimately increases the amount of resources in the health facilities. In 2006, SIS received approximately 271 million soles (US$8.6 million). For 2007, the budget will be approximately 267 million soles (US$8.5 million). Since 2004, the SIS budget has not increased despite increases in the number of affiliates. An Ombudsman report highlighted that more resources are required for SIS to meet the demand for services.

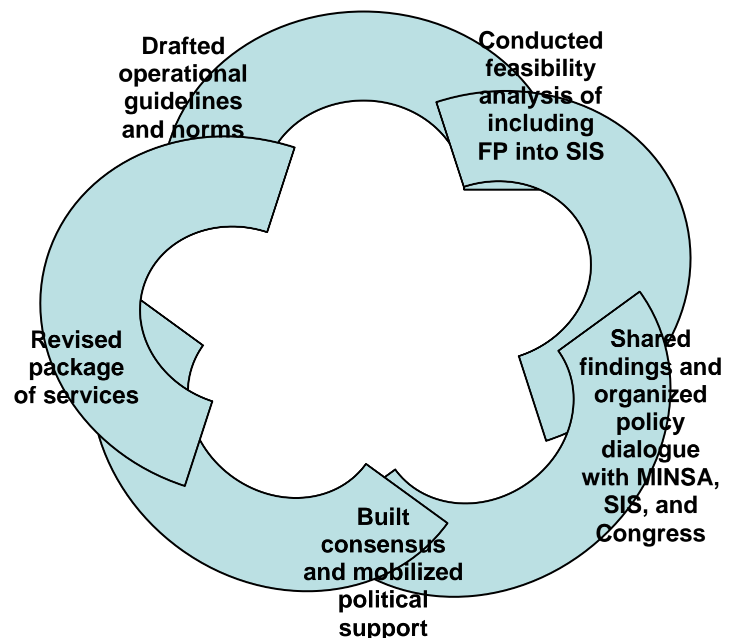
Strategy aims

SIS represents a potential financing source for family planning and operates a relatively effective targeting strategy that identifies the poor. As such, including family planning in the benefits package for social insurance beneficiaries would increase national-level commitment to and financing for family planning, ultimately facilitating access to FP products and services among the poor. Prior to 2007, the SIS service package only 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. It would be beneficial to increase the number and type of services in the benefits package, particularly FP counseling and method provision.

Steps

First, HPI assessed the feasibility of including family planning in the SIS. We reviewed MINSA facility-level data, legal documents, SIS program documents, market segmentation information, and case studies of experiences including FP services in social insurance in Bolivia, Chile, and Colombia. With this information, HPI prepared a technical document, "Evaluación de inclusión de atenciones de PF en los planes de Beneficios del Seguro Integral de Salud" (Evaluation of Including FP Services in the Beneficiary Plans of Integrated Health Insurance), which supported adding FP counseling, services, and commodities to the SIS benefits package.

Figure 9: Including FP in Social Insurance: A Continuous Process of Advocacy and Policy Dialogue



HPI then designed and implemented an evidence-based advocacy plan aimed at central-level health authorities to convince them of the cost savings and added value of including family planning. The plan included political mapping of key stakeholders and opportune moments for sharing the information. HPI/Peru presented and discussed the technical document in meetings from January–March 2007 with key stakeholders of the MINSA, including members of the Executive Directorate of SIS, the General Directorate of People's Health, and those implementing Peru's Sexual and Reproductive Health Strategy; as well as other key stakeholders at USAID and UNFPA. Ongoing advocacy was essential given that four different SIS directors served during December 2006–May 2007.

Following the meetings, an inter-ministerial commission was formed to prepare a proposal for Universal Health Insurance to ensure access to healthcare among those who require subsidies. Commission members included several key stakeholders who had attended the meetings about expanding the SIS benefits package. The commission held multiple meetings with high-level decisionmakers, including the Minister of Health and the President of Peru, to discuss establishing two packages under Universal Health Insurance: full subsidy for the extremely poor (SIS) and a partial subsidy for those who could pay a small monthly premium (Semi-Contributive Insurance Program). The discussion also focused on expanding the number and type of services offered, including HIV/AIDS/STI screening and prevention; FP products, counseling, and services; and other services.

HPI also assisted the MINSA with determining and revising specific, itemized costs for the provision of FP counseling, methods, and services to strengthen the operationalization of the policy change. Costing took into account the inclusion of all types of contraceptive methods, measures to ensure quality of care, and provider time.

Outcomes

Government publishes decree to include FP services within SIS. On March 17, 2007, the President of Peru and Minister of Health published Supreme Decree N°004-2007-SA, which establishes "a prioritized list of obligatory health interventions that must be conducted in [health] establishments that receive financing from SIS." The decree lists reproductive health (counseling and family planning as established in MINSA norms), as one of eight preventive priorities, with 100 percent coverage. The policy promotes equitable and affordable access to high-quality FP/RH services by adding FP services and supplies to the list of priority interventions that all facilities receiving SIS funding are required to provide.

The decree presents the following opportunities for family planning and reproductive health:

- Ensures adequate financing for FP services within the SIS.
- Provides financing and supplies for voluntary male or female sterilization—services for which, prior to this policy change, had no funds available within the SIS.
- Protects, by law, the budget for FP services, as the SIS budget is protected by law.
- Enables healthcare providers at the facility level to provide FP care in conjunction with the other SIS services.
- Enables the financing of FP counseling for first-time users, thereby officially recognizing the lack of information as a barrier facing the poor.
- Expands the number and type of services offered, including HIV screening and prevention.

HPI worked closely with the MINSA to inform and facilitate the operationalization of the FP component of social insurance, actively participating in the development of technical norms and a costing package.

Next Steps

These policy changes cannot remove *all* barriers to accessing FP/RH services. SIS has several remaining problems to address. For example, an Ombudsman report commented that SIS should give further priority to poor, rural populations by launching registration campaigns in rural areas with high levels of poverty—to ensure that they are indeed program beneficiaries. SIS should also periodically supervise the socioeconomic qualification process to ensure a minimum number of nonpoor participants in the program. The Ombudsman report recommends highlighting to beneficiaries which health services are included in the SIS, so that they understand that particular services are not covered and could require some payment. Given the stigma and discrimination in MINSA health facilities experienced by SIS beneficiaries, the Ombudsman also recommended training providers in cultural sensitivity and stigma and discrimination reduction.

As the poor are eligible for SIS benefits, the new FP funding will be targeted toward the poor. MINSA health facilities are reimbursed for services rendered to SIS beneficiaries, increasing the amount of resources in that facility. In addition, SIS tracks facility reimbursements according to beneficiary plan (e.g., children 0–4, pregnant women, poor adults), making it possible to monitor subgroups' receipt of services.

VIII. Conclusions and Lessons Learned

Understand the Dynamic Policy Environment

Peru's experience reveals that well-intentioned policies can have adverse outcomes on the people they are designed to help. As a result, policymakers and planners must think through both the short- and long-term consequences of alternative policies prior to implementation. The country's experience also underscores the importance of monitoring policy implementation and governments' willingness to make midstream corrections.

Policy challenges and opportunities vary depending on the policy environment of a particular country. Before policy reforms can occur, policymakers must recognize that a problem or potential problem exists and must understand the implications of the problem for program effectiveness. Involvement of multiple stakeholders at different levels and from different sectors can accelerate the decisionmaking process and often improve the quality of decisions made. In a dynamic policy environment, the stakeholders involved and their positions and interests frequently change; continuous advocacy and targeted actions are thus needed to keep the policy issue high on the policy agenda and to influence policy decisions, funding streams, or programs. HPI organized policy dialogues and planning meetings to gather stakeholders and reach a consensus on taking action to improve access among the poor and to define and debate the merits of emerging strategies. Policy dialogue helped build consensus, ownership, and commitment within the MINSA and, more broadly, within national and regional governments.

Support an Evidence-Based, Country-Driven Process

Planning is the iterative process of assessing a situation; setting short-, medium-, and long-term goals; identifying priorities; understanding the feasibility of options; knowing the resource requirements of each; and developing strategies and policies. Peru followed a systematic, evidence-based, country-driven process to select effective strategies for addressing key barriers to access among the poor in Junin. These strategies were selected and implemented in the broader context of sectoral reforms, including decentralization. HPI evaluated each strategy for feasibility, challenges, opportunities, and key steps in the implementation process with the leadership of regional and national government. The MINSA was fully involved in the process and provided insights on the broader context of health, development, and policy reforms.

Use a Comprehensive Approach Involving Multiple Stakeholders

Multiple strategies ensured that these financing interventions would meet the needs of different segments of the poor population and would be sustainable in the long run. Instead of relying on one mechanism, using a combination of three mechanisms ensured better odds of reaching the poor and that the mechanisms would be effective. Involving multiple ministries (health, planning, economics, education), a university, and other local organizations ensured that addressing the barriers to access by the poor was a truly multisectoral approach and built on the strengths of each institution. Each financing mechanism draws on a different source of funding—JUNTOS has its own budget, MINSA (MEF), and SIS (regional funds). We used a comprehensive approach to address priority regional issues—protecting the rights of users of health services, reducing poverty, and addressing gender dynamics.

Involve the Poor in Identifying Problems and Designing Solutions

Recognizing that policies and programs are often developed *for* the poor but not *with* the poor, HPI involved the poor from the start of the process. Involving the target population in identifying the barriers

to seeking and receiving healthcare and how to resolve those barriers ensured that the solutions would ultimately address their needs.

Build on Existing Mechanisms

Building on existing financing and social assistance mechanisms targeting the poor sets the stage for scale-up to more districts of Junin and other regions of Peru. The National Central University will offer the SNIP proposal writing course to individuals and government staff from other regions; and because all regions have some available funds for public investment and social participation in the distribution of those funds is mandated, the potential for replicating the course in other regions is great. The JUNTOS program, including FP/RH *charlas* and culturally competent communication approaches, will be scaled up in 27 districts of Junin. All JUNTOS beneficiaries will be registered under the SIS to ensure receipt of the full package of benefits. Because family planning is included in the SIS, JUNTOS beneficiaries will have access to a complete package of FP services. As the SIS is a national effort, it could reach a large number of poor women with FP counseling and services.

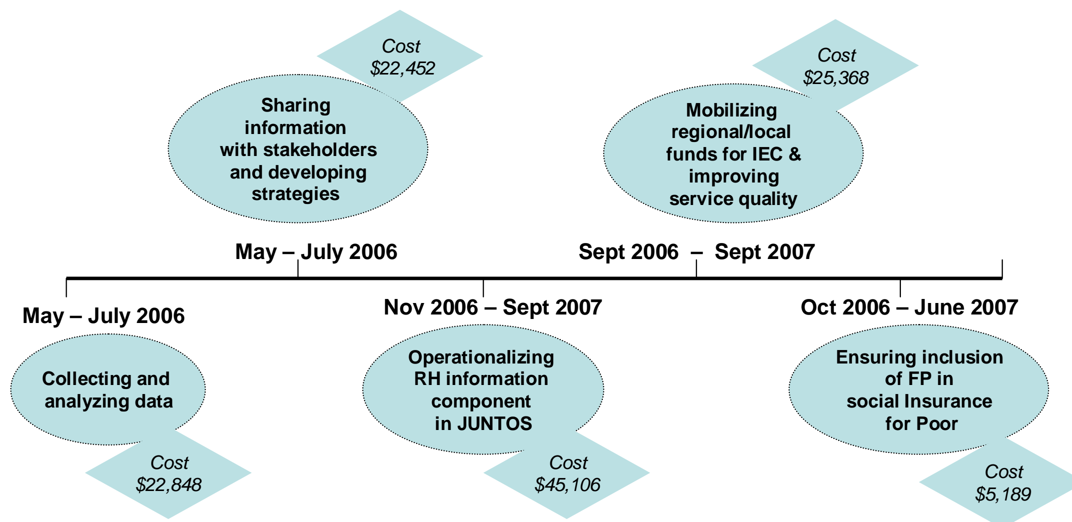
Conduct Equity-Based Monitoring and Evaluation

In most countries, ministries are not held accountable for meeting equity objectives, largely because disaggregated information on income does not exist. There are no monitoring indicators that measure and demonstrate the poor are, in fact, benefiting from various policy and financing interventions. Developing FP indicators by wealth quintiles and rural/urban categories can help measure the achievement of equity goals and reduce inequalities in FP service use. Facility-based indicators could include use of services by the poor and the application of exemption and waiver mechanisms for the poor, and population-based indicators could include contraception prevalence rates or unmet need among the poor. For example, we evaluated the effectiveness of JUNTOS in terms of the number of RH *charlas* organized, the number of poor women who attended *charlas*, and the number of JUNTOS beneficiaries who attended FP counseling at the facility, and whether the counseling was culturally appropriate.

IX. Recommendations for Scale-Up and Replication

The key aim of this innovative approach is to remove barriers to FP use and ensure that providers are delivering high-quality and culturally appropriate counseling and services. Now the challenge is how to expand the benefits achieved in the successful pilot to serve more people, more quickly and more equitably. Scaling up requires active sponsorship and concerted efforts from multiple stakeholders and the adaptation of innovations to local conditions (WHO, 2006). HPI designed the innovative approaches and strategies to reach the poor with scaling up in mind (see Figure 10). The estimated financial resources presented in Figure 10 are only indicative, as many factors can influence the scale up of selected strategies at the regional level. It provides the information on cost of designing, testing and evaluating selected strategies and can form the basis for discussions regarding scale up. Estimation of the cost of scaling up must take into account the available resources (tools, instruments, and manuals) and additional resources needed to implement selected/adapted strategies at the regional level. The success of the pilot generated interest and mobilized support for scaling up.

Figure 10: Timeline and Cost



In Junin, equity-based monitoring and evaluation is ongoing to assess the improvements in access to culturally appropriate counseling. The USAID-funded Healthy Municipalities strategy included cultural appropriate counseling in five of the 11 districts: San Luis de Shuaro in Chanchamayo, Junin; MR Chazuta, in San Martin; MR las Palmas, Aucayacu, Pumahuasi, Supte, and Las Palmas in Huanuco; and MR Neshuya in Ucayali. These districts are achieving increased use of counseling, as reported in the pilot sites. We will train providers on culturally appropriate counseling for these districts to improve the supply-side response.

The CRECER program, which aims to address chronic malnutrition and poverty among children under 5, currently covers 330 poor districts and 219,000 children. The Presidency of the Council of Ministers/JUNTOS and MINSA/DIRESA implement the health component of CRECER. JUNTOS and the MINSA are responsible for the promotional education component regarding the prevention of early pregnancy, suitable birth spacing, demonstration sessions, and nutritional counseling for the beneficiary population. The Institute for Human Resources of MINSA has asked HPI to share with selected health professionals our work on reaching the poor with culturally appropriate information and counseling. This is an excellent opportunity to get involved and help the CRECER program with the implementation of strategies on culturally appropriate counseling and family planning.

Finding and implementing the right policy solutions to reach the poor is an ongoing challenge in LAC. While no single solution exists, the process of identifying and understanding the barriers to access among the poor, identifying a more equitable structure, and putting in place policies that foster needed change has begun. For example, many Latin American countries—including Brazil, Chile, Honduras, and Mexico—are implementing conditional cash transfer programs. Peru's experience can inform the design, implementation, scale up, and evaluation of pro-poor strategies in LAC and other countries. It is important that policymakers consider both the short- and long-term consequences of alternative policies on the poor prior to implementation. All countries should continuously monitor and evaluate how policies are being implemented and be willing to make adjustments or revisions based on evidence that indicates that a policy is not achieving its equity outcomes.

Annex: Matrix 1: Addressing Key Problems through Potential Financing Strategies

		Financing Mechanism			
Problem	**Reason**	**Strengthen FP component of JUNTOS**	**Mobilize regional and local resources for IEC and quality improvement strategies**	**Ensure that SIS package finances FP counseling, service provision, home visits**	**Facilitate introduction of social marketing for nonpoor**
Negative perceptions of the effects of modern methods	Lack of accurate, culturally appropriate information about modern methods Misinformation campaigns about family planning	Will reverse misinformation and misperceptions with couple counseling and educational materials	Will improve availability of accurate information with community-based IEC	Will reduce misinformation through Including counseling in the SIS package	
Poor quality of care for family planning	Lack of availability of FP information Lack of time with providers Long waiting times Low number of providers Lack of provider training on counseling, FP methods	Will improve availability of FP info and provider training for counseling	Will improve the quality of provider training, IEC materials with more resources available	Will ensure reimbursement as an incentive to provide better services	Redirects those who are willing to pay away from MINSA, but with appropriately priced modern methods, thereby potentially reducing burden on MINSA
Operational barriers due to the integrated health model, affecting the provision of services	No financing for training, supervision, monitoring, and IEC in integrated model SIS has used much of the MINSA budget SIS's removal of cost barriers increased demand for MH Providers have made prenatal care a priority SIS does not include family planning	Will reposition family planning and increase resources for family planning	Will result in more resources available to focus on family planning	Will increase recognition of importance of family planning	

Matrix 2: Opportunities and Challenges for Each Financing Strategy

	Financing Mechanism			
	Strengthen FP component of JUNTOS	**Mobilize regional and local resources for IEC and quality improvement strategies**	**Ensure that SIS package includes FP counseling, service provision, home visits**	**Facilitate introduction of social marketing for nonpoor**
Opportunities	Existing scheme is starting in Junin Provides opportunity to reach the extremely poor FP information component exists in package, but could be strengthened	Unspent funds at regional and local levels New government is open to changes in health service delivery Evidence that poor quality of FP services and lack of information are barriers to access Multisectoral participatory diagnostic in Junin highlights need for attention to teenage pregnancy and maternal mortality Potential to involve business sector that has been involved in social programs	In February 2006, government declared that all poor will be covered by SIS SIS has clearly identified inclusion criteria via geographic and individual targeting SIS is defining the package of care SIS already covers women of reproductive age, including adolescents Reimbursement will be an incentive for providers to serve SIS clients	Potential to reduce burden of increased demand on MINSA Involves private sector Provides alternatives, specifically for those who are willing to pay Contributes to reducing prices of modern methods
Challenges	Cash incentives are sensitive in FP Unclear whether health facilities have capacity to provide information Must influence at very high level and regional level to ensure that this component is addressed, carried out	Competing demand for limited resources Convince authorities that investment in health and social programs is worthwhile Lack of sufficient skills in proposal writing to access regional funds	Opposition groups could launch campaigns against this effort At first, FP was included in SIS but was removed by former Minister of Health Short-term costs of including FP could be prohibitive Health system may not be able to support increased FP demand	

Matrix 3: Implementation Requirements for Each Financing Strategy

	Financing Mechanism			
	Strengthen FP component of JUNTOS	**Mobilize regional and local level resources to organize IEC and quality improvement strategies**	**Ensure that SIS package includes FP counseling, service provision, home visits**	**Facilitate introduction of social marketing for nonpoor**
Implementation Requirements	Understand how JUNTOS is being implemented Organize meeting with Presidencia de Consejo de Ministros Organize meeting with JUNTOS committee in MINSA Examine and adapt existing protocol for FP counseling to take into account cultural, language, male involvement, and educational requirements Determine if other organizations are offering provider training for potential collaboration (i.e., PHRPlus/PRAES) Develop/locate indicator to determine whether participants have satisfied FP requirement Ensure that those involved in JUNTOS (extremely poor) are exempt from all charges Help to develop guidelines	Conduct advocacy at the regional level to convince officials that family planning is important and requires increased funds (links to maternal health, infant, environment, economy) Conduct political mapping to identify key stakeholders Form core group of local people and train them in proposal development according to the MEF's specifications/methodology Prepare and submit a proposal	Assess the political, financial, legal, and operational implications of including family planning in SIS Prepare a cost-benefit analysis presentation on including family planning in the SIS Organize evidence-based policy dialogue with high-level officials (MINSA, SIS, Congress) Help to draft operational guidelines to determine the package of services and rate of reimbursement	Facilitate meetings with PRISMA and the university and municipality of Huancayo

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