

Contraceptive Security in Nicaragua: Assessing Strengths and Weaknesses

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



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AIM	Integrated Maternal Healthcare Program
CIDA	Canadian International Development Agency
CS	Contraceptive security
DFID	Department for International Development (United Kingdom)
DNIM	National Directorate of Medical Supplies
EMP	Private medical provider
ENDESA	Nicaragua Demographic and Health Survey
FP	Family planning
GTZ	German Technical Cooperation
IADB	Inter-American Development Bank
ICAS	Central American Health Institute
IMF	International Monetary Fund
INSS	Nicaragua Social Security Institute
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
JICA	Japan International Cooperation Agency
LAC	Latin America and the Caribbean
MAIS	Integrated Healthcare Model
MINSA	Ministry of Health
NGO	Nongovernmental organization
NORAD	Norwegian Agency for Development Cooperation
PAHO	Pan American Health Organization
PASMO	Pan American Social Marketing Organization
PROFAMILIA	NGO, IPPF-affiliate in Nicaragua
SILAIS	Local integrated health service systems
SPARHCS	Strategic Pathways to Reproductive Health Commodity Security
SWAP	Sector-wide approach
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

Although there will be many challenges to face in Nicaragua as the family planning (FP) program moves toward contraceptive security (CS), the results of the assessment conducted in February 2004 point to many positive elements that will facilitate the process. An important context for contraceptive security, Nicaragua has both a policy framework and a political environment favorable to family planning. There are no major obstacles from the legal or political perspective to future contraceptive security. The Constitution guarantees the right to reproductive health and universal access to basic health services.

Nicaragua's Ministry of Health (MINSAs), Ministry of Government (National Police), and Ministry of Defense all provide government-funded health services, including family planning. MINSAs is the country's dominant provider of primary and secondary healthcare as well as FP services and contraceptives.

One advantage for the Nicaraguan FP program is that it will benefit from several additional years of planned donor support in commodities. Currently, USAID and United Nations Population Fund (UNFPA) provide almost 100 percent of all commodity donations. USAID plans to reduce donations after 2005, and UNFPA will continue with donations until 2008 or 2009. The disadvantage, however, is that there is a general lack of awareness among MINSAs decisionmakers, nongovernmental organizations (NGOs), and other donors of USAID's planned phaseout. MINSAs and USAID have not yet prepared a phaseout plan, and MINSAs will need to give priority to contraceptive procurement in its annual budget (as it has with vaccines) to avoid a serious funding gap.

Nicaragua has achieved a high contraceptive prevalence rate and a relatively well balanced method mix, but there is still work to be done to guarantee that all Nicaraguans are able to obtain and use contraceptive methods that are consistent with their desires to limit or space future births. Overall, unmet need for family planning is lower than in many countries (15%), but gaps in contraceptive prevalence and unmet need are still wide between rich and poor, urban and rural, more educated and less educated, and younger and older women.

The segmentation of the Nicaraguan FP market also shows a heavy dependence on public sector facilities. Between 1992 and 2001, MINSAs's share of the FP market increased from 59 percent to 64 percent, and the private sector's share declined slightly from 37 percent to 33 percent, including

pharmacies, private providers, and NGOs. As donated contraceptives are phased out, the current overdependence on MINSA will make the contraceptive market extremely vulnerable both to changes in the government and to fluctuations in the national economy. Therefore, there is a need to shift at least some of the burden for contraceptive provision from MINSA to other government and private sector service providers.

Approximately 7 percent of MINSA's annual budget for operations goes into the purchase of pharmaceuticals and medical supplies, and its total medicine budget for the last year was approximately US\$8,750,000. Because of budget limitations, however, approximately 50 percent of that budget came from Inter-American Development Bank (IADB) and World Bank credits. MINSA has not yet begun to purchase contraceptives, but it has the systems in place and sufficient procurement experience to do so. MINSA works with UNFPA and USAID each year to estimate contraceptive needs and prepares both short-term and long-term procurement plans based on consumption and stock levels. To continue to meet the contraceptive requirements of its current market share, MINSA must begin purchasing contraceptives in 2005, increase its contraceptive budget each year by \$150,000–200,000, and purchase contraceptives at highly competitive prices every year from 2005 to 2015.

The Nicaraguan CS Committee, which is made up of representatives from public and private sector organizations and international donor agencies, is well positioned to raise awareness about the issues related to contraceptive security. The role of civil society organizations and consumer advocacy may also be important in achieving contraceptive security.

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

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

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

These activities were initiated in July 2003 during a regional CS conference in Nicaragua designed to raise awareness about contraceptive security and stimulate dialogue. During this meeting, representatives from each participating country formed a Contraceptive Security Committee designed to take the lead on CS issues and serve as a liaison in the CS assessment in those countries that formed part of the regional study. The CS assessment was conducted in Nicaragua in February 2004.

With an estimated population of 5.5 million in 2003, Nicaragua is the third most populous country in Central America.¹ Most of its population is concentrated along the Pacific coast, and over 60 percent of Nicaraguans now live in towns and cities. The population growth rate decreased to 2.7 percent in 2000 according to the 2001 Nicaragua Demographic and Health Survey (ENDESA). The current growth rate is estimated at 2.2 percent, which translates to more than 110,000 new inhabitants each year. The total fertility rate has also declined from 4.6 in 1992 to 3.2 in 2000. Despite these improvements, internal migration has had a negative impact on the overall economy. According to the National Survey on Measuring Lifestyle, 48 percent of the population is poor, and 17 percent suffer from extreme poverty.

Nicaragua has both a policy framework and a political environment favorable to family planning. There are no major obstacles from the legal or political perspective to future contraceptive security. The Constitution guarantees the right to reproductive health and universal access to basic health services. The National Development Plan calls for reducing the unmet need for family planning and includes unmet need as a performance indicator. The new National Sexual and Reproductive Health Program is an extremely important and timely document that will serve as a guide for the future delivery of quality reproductive health services. Because it is being published during a period of health sector reform, it may also help to protect FP services and resources in the face of expected structural changes inside of MINSA. Registration of pharmaceuticals and legal representation of manufacturers in Nicaragua are required, as they are in most countries. The registration process is relatively simple and not excessively costly or time consuming. Import regulations are also conducive to future contraceptive security, as all medicines may be imported duty free.

In the last 10 years, almost all countries in Latin America have approved some level of health sector reform, and Nicaragua is no exception. MINSA is currently in the process of implementing some important changes, including adoption of a new Integrated Healthcare Model (MAIS), the recently approved Law of General Health, and the integration of critical support functions, including the supply system for essential medicines and contraceptives. These reforms will have important repercussions for contraceptive security in Nicaragua.

¹ Population estimates for Nicaragua do not agree. The government of Nicaragua's estimate of 5.5 million in 2003 is used in this report. Likewise, estimates of urbanization vary from 56 percent (U.S. Bureau of the Census) to 65 percent (World Bank 2003).



Family Planning Services in Nicaragua

MINSA, the National Police, and the Ministry of Defense all provide government-funded health services, including family planning. MINSA is the country's dominant provider of primary and secondary healthcare as well as FP services and contraceptives. Five contraceptive products are provided free in MINSA's health posts, health centers, and hospitals—Lo-Femenal and Norigynon (an oral contraceptive and a monthly injectable donated by UNFPA), and Depo-Provera, Copper-T intrauterine device (IUD), and condoms (donated by USAID).

Within MINSA, the Integrated Maternal Healthcare Program (AIM) makes FP policy and oversees the delivery of reproductive health services nationwide. AIM is located in the Primary Health Division of MINSA and manages contraceptive logistics and a variety of subprograms, such as family planning, safe motherhood, adolescent reproductive health, violence prevention, and cervical cancer and breast cancer screening. AIM recently developed a new National Sexual and Reproductive Health Program policy and a new strategy for community-based distribution of contraceptives through volunteers that is expected to increase the number of FP users by approximately 10 percent.

The Nicaraguan Social Security Institute (INSS) contracts with HMO-style private medical providers (EMPs) to provide medical care to its beneficiaries and dependents. EMPs function as private businesses, but they are located in both private and public health establishments. Private sector FP providers include NGOs, private hospitals and clinics, and commercial pharmacies. PROFAMILIA is the largest NGO provider, followed by Ixchen, Si Mujer, Marie Stopes Nicaragua, and several others. The Pan American Social Marketing Organization (PASMO), the regional condom social marketing organization, has the status of a nonprofit NGO in Nicaragua as well.

USAID and UNFPA are Nicaragua's two largest donors in reproductive health. USAID is currently supplying 60 percent of MINSA's contraceptive needs and providing technical assistance to MINSA, PROFAMILIA, and NicaSalud through JSI/DELIVER (logistics management), MSH/Management and Leadership Project (organizational strengthening, decentralization, and community-based distribution of contraceptives), and URC/Quality Assurance Project (quality assurance mechanisms and quality of care). UNFPA administers its own funding as well as funding from United Kingdom's Department for International Development (DFID) and others. In 2002 and 2003, UNFPA covered 40 percent of MINSA's contraceptive needs with funding received from UNFPA's emergency fund. The German Technical Cooperation (GTZ), JICA, NORAD, DFID, CIDA, the World Bank, the IADB, and the embassies of Holland and Finland all provide financial and, in some cases, technical assistance to MINSA for work that is either directly or indirectly related to future contraceptive security. Several of these groups are beginning to work in a coordinated fashion and pool their funding in the style of a sector-wide approach (SWAP).

Findings from the Contraceptive Security Assessment

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

Environment

The current environment in Nicaragua is extremely supportive of family planning. By including a target for the reduction of unmet need for family planning in the new National Development Plan, the President's Office has also shown support for family planning and reproductive health. Within MINSA, the national FP subprogram has had consistent support from the Minister of Health and from the Director of Primary Care Services. Prior to the CS assessment, there appeared to be no knowledge of the planned phaseout of USAID contraceptive donations among these groups. All expressed the government's commitment to family planning. At the same time, however, they also expressed concern that MINSA may not be able to assume the full cost of contraceptives quickly enough to avoid shortfalls, particularly given the country's current economic situation and restrictions imposed by the International Monetary Fund (IMF) and World Bank on the growth of the government's recurrent cost budget.

In other countries in the region, as contraceptive donations and technical assistance budgets have declined, so have leadership, staffing, and other forms of tangible support for family planning. MINSA is planning further integration of functions at the central level and greater decentralization of authority and responsibility to the departments and local integrated health service systems (SILAIS). These are changes that should be anticipated. If decentralization includes decentralized control of the contraceptive supply, informed leaders and advocates for family planning will be required not only at the central MINSA level where they currently reside, but also in the SILAIS and at the departmental levels of government. Furthermore, if key support functions such as contraceptive logistics are integrated, a similar effort will be required to make sure that those who assume responsibility for these key functions at each level of the health system understand the importance of family planning and their role in its support.

Client Demand and Use

Nicaragua has achieved a high contraceptive prevalence rate and a relatively well balanced method mix, but work still must be done to guarantee that all Nicaraguans are able to obtain and use contraceptive methods that are consistent with their desires to limit or space future births. Acceptance of all contraceptive methods increased 18 percentage points between 1992 and 2001, growing from 50 percent to 68.6 percent for the country overall, and from 32 percent to 62 percent in rural areas. Use of modern methods also increased, from 45 percent in 1992 to 66 percent by 2001, with similar trends in rural and urban areas.

Overall, unmet need for family planning is lower than in many countries (15%), but gaps in contraceptive prevalence and unmet need are still wide between rich and poor, urban and rural, more educated and less educated, and younger and older women. Prevalence among those in the lowest socioeconomic quintile is 50 percent, compared with 70 percent in the highest segment, and unmet need for family planning in the poorest quintile (25%) is more than double that in the wealthiest (10%). There is also considerably more unmet need for long-term and permanent contraceptive methods among the poor than among the wealthy.

Nicaragua's method mix is relatively well balanced, with equal proportions of pill and injectable contraceptive users and a slight decline in female sterilization over the last decade from its high of 39 percent in the early 1990s. However, the method mix is becoming more and more expensive per couple-year of protection because of the increased use of injectables, particularly Mesigyna and Norigynon, which have the same formulation, but Mesigyna is used for commercial distribution, and Norigynon is used for public sector facilities. These monthly injectables are significantly more expensive than the three-month injectable, Depo-Provera. Declining IUD use rates have also contributed to increased costs per couple-year of protection. As in most of the LAC region, the use of male methods—condoms and vasectomy—is still extremely low and should be increased.

Services

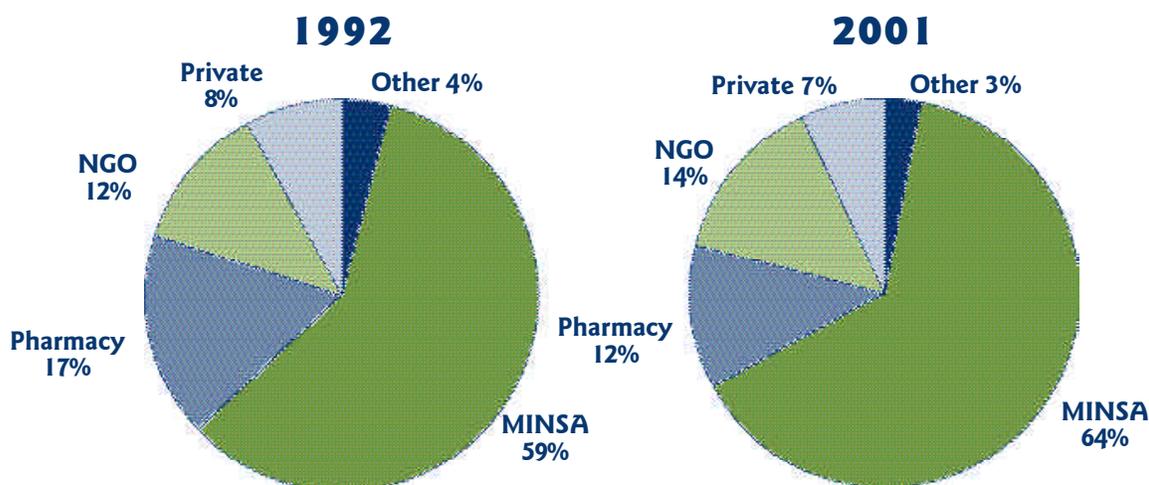
MINSa is the primary provider of FP services. The availability of contraceptives in health establishments was found to be very good. Although there are still geographic and cultural barriers for poor and rural populations, adolescents, and young adults, there are significant numbers of programs that aim to expand access to these groups, including MINSa's new strategy of promoting community-based distribution of contraceptives as well as multiple other strategies supported by NGOs and international donors. There were no serious issues with the quality of FP services. However, inadequate supervision from the central to SILAIS level and from SILAIS to municipalities and health establishments was mentioned as a continuing problem for MINSa—one that is exacerbated by the lack of AIM staff and resources at the central level.

The INSS provides limited access to FP services for its beneficiaries and their dependents. INSS contracts with HMO-style EMPs to provide medical care to its beneficiaries and dependents. Although the EMP service package includes family planning for enrollees, INSS dependents do not have the right to this care. Also, most EMPs simply do not promote or provide FP services, even to their enrollees.

Market Segmentation

The segmentation of the Nicaraguan FP market shows a heavy dependence on public sector facilities (see Figure 1). Between 1992 and 2001, MINSa's share of the FP market increased from 59 percent to 64 percent, and the private sector's share declined slightly from 37 percent to 33 percent, including pharmacies, private providers, and NGOs. As donated contraceptives are phased out, the current overdependence on MINSa will make the contraceptive market extremely vulnerable both to changes in

Figure 1. Changes in Sources of Contraceptives and Condoms



Source: ENDESA 2 years

the government and to fluctuations in the national economy. Therefore, there is a need to shift at least some of the burden for contraceptive provision from MINSAs to other government and private sector service providers.

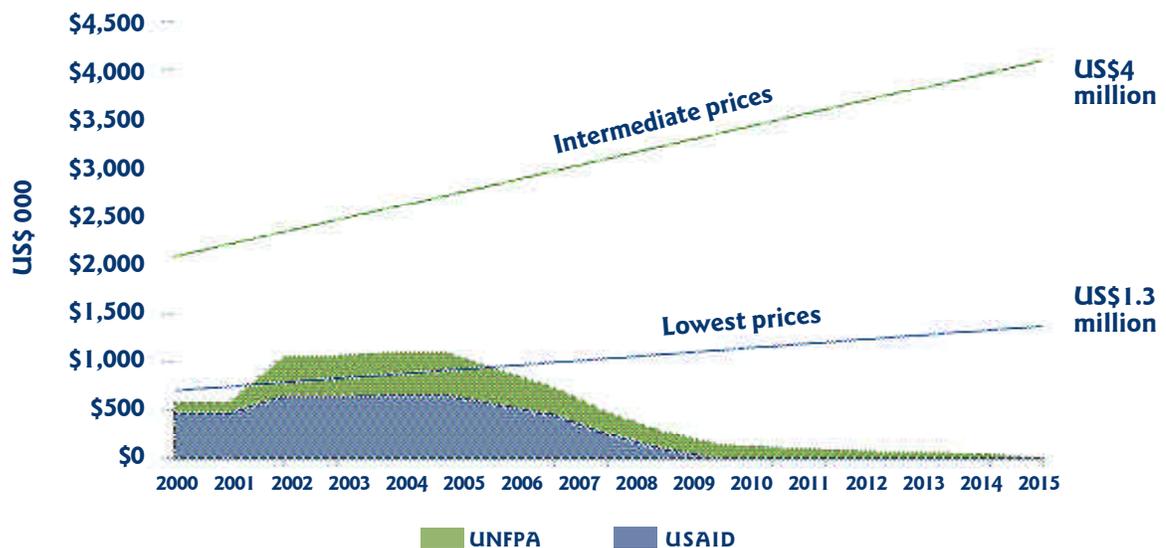
There is a need to further segment the mix of FP clients receiving products and services from MINSAs. Currently, MINSAs is the predominant supplier of contraceptives to all socioeconomic quintiles, except the wealthiest. MINSAs's services are not focused on the poor to the degree that might be expected. Only 33 percent of all MINSAs's contraceptive clients are from the lowest two quintiles (which make up 40 percent of the total 2001 ENDESA sample) while 45 percent are from the two wealthiest socioeconomic quintiles. MINSAs also serves more INSS enrollees and beneficiaries than it should—43 percent obtain their contraceptives from MINSAs.

Financing

Approximately 7 percent of MINSAs's annual budget for operations goes into the purchase of pharmaceuticals and medical supplies, and its total medicine budget for the last year was approximately US\$8,750,000. Because of budget limitations, however, approximately 50 percent of that budget came from IADB and World Bank credits. For contraceptives, however, MINSAs receives all its supplies through donations. MINSAs's ability to begin purchasing contraceptives and increase its contraceptive budget to cover the growing funding gap will depend on Nicaragua's economic situation and competing demands for MINSAs's limited recurrent cost budget.

USAID has been the principal supplier of contraceptives to the country since 1995. USAID's contraceptive donations to MINSAs in 2004 and 2005 will be at the same levels of the past few years (US\$650,000 per year), but its donations will decline rapidly after 2005 and end in 2008 or 2009. UNFPA was able to more than double its contraceptive donations to MINSAs in 2002 and 2003—donations in both years were valued at over US\$400,000 per year. UNFPA will continue to provide contraceptives at this level through 2005, with donations expected to decline thereafter.

Figure 2. MINSA Contraceptive Funding Gap, 2000-2015



Based on financial projections using SPECTRUM software, MINSA’s annual funding requirement almost doubles between 2000 and 2015, and the potential gap in funding created by USAID’s planned phaseout and UNFPA’s probable phase-down of contraceptive donations reaches US\$1.3 million per year by 2015 using low prices (see Figure 2). At intermediate prices (those paid by NGOs and others purchasing contraceptives from national suppliers), this gap increases to US\$4 million per year. In order to continue to meet the contraceptive requirements of its current market share, MINSA must begin purchasing contraceptives in 2005, increase its contraceptive budget each year by \$150,000–\$200,000, and purchase contraceptives at low (UNFPA) prices every year from 2005 to 2015.

Procurement

MINSA has not yet begun purchasing contraceptives; however, it has the systems in place and sufficient procurement experience to do so. MINSA works with UNFPA and USAID each year to estimate contraceptive needs and prepares both short-term and long-term procurement plans based on consumption and stock levels. MINSA’s procurement department manages a large yearly procurement of medicines, medical supplies, and reagents for its primary and secondary health establishments and laboratories, and an estimated savings of 10–12 percent has been achieved in the last two years by making this annual procurement more transparent and systematic. MINSA also purchases vaccines and other medicines under two different Pan American Health Organization (PAHO) procurement mechanisms—the revolving vaccine fund and program of reimbursable procurement for member states. National Treasury funding is used for vaccine purchase each year, and this purchase appears to be managed directly by the immunization program.

The most cost-effective contraceptive procurement option for MINSA would be reimbursable procurement at the global level, either through UNFPA, the International Planned Parenthood Federation (IPPF), or PAHO. However, because national procurement regulations may make

reimbursable procurement through one of these groups difficult (i.e., the Contraloría Nacional does not accept MINSA's proposal to purchase through one of these mechanisms and/or a national distributor registers a complaint that delays procurement), preparations for procurement through national channels are advisable. Organizations that purchase contraceptives and medicines from Nicaraguan distributors pay much higher prices than those offered by UNFPA or IPPF. Therefore, if national procurement is required, additional budget will also be required.

As INSS coverage increases and EMPs begin to provide FP services to their enrollees, EMPs will become one of the country's important purchasers of contraceptives. At present, EMPs purchase pharmaceuticals, but not contraceptives. In 2003, the majority of the registered EMPs purchased at least some of their pharmaceuticals through a combined purchase that was coordinated by the EMP Camara. Because the Camara is not yet a legal entity and has no financial reserves of its own, this purchase was more complicated than it might be in the future.

Logistics Management

Oversupply of some contraceptives and frequent stockouts of others became serious problems for MINSA in the late 1990s. The use of population data and contraceptive prevalence estimates to project commodity needs was a cause of these problems, as was inadequate donor coordination. In 2000, to improve the population's access to the full range of contraceptives, MINSA launched a new contraceptive logistics policy and an accompanying logistics information and administration system. Unlike the old system, the new one estimates contraceptive needs on the basis of consumption data and inventories at each level of service. It also applies minimum and maximum stock levels and is built around close donor coordination. USAID (through JSI/DELIVER) and UNFPA provided technical assistance for the design and launch of this new system.

In 2003, an important new challenge was proposed by MINSA to eliminate redundancies and reduce costs—the integration of MINSA's existing supply systems. The merger of the contraceptive logistics and essential medicines systems began in 2003 with the creation of a single system for storing and distributing contraceptives and essential medicines. Other steps toward integration have included providing training for the in-charges of medical supplies in the 17 SILAIS and personnel in the Health Resources Directorate at the central level in the use of Pipeline software; making the frequency of reporting and requisitioning the same for essential medicines and contraceptives; evaluating the two information systems to determine similarities and differences; and making decisions about how to integrate the two. Through these activities, AIM's knowledge and skills in contraceptive logistics are being transferred to the personnel of the Provision of Technical Material (Abastecimiento Técnico Material), who are responsible for managing the logistics of all other medicines and medical supplies. These first steps toward integration have proceeded smoothly although there is still some resentment being addressed between those responsible for AIM and medical supplies (part of the National Directorate of Medical Supplies (DNIM)).

(14)

There is much good will and agreement on the part of AIM and DNIM to work together on the design of the new integrated supply system. This is a positive sign for the future, but the complications of integrating supply systems should not be underestimated. For example, a single supply system based on consumption (one of the strengths of the contraceptive logistics system) may prove difficult to design.

This is because medicines are currently requisitioned and procured by MINSA on the basis of fixed budgets at each management level. It was not clear to the assessment team that DNIM and AIM have sufficient control or influence over drug budgets at lower levels of the health system to make necessary changes in allocation formulas and/or to allow greater flexibility in moving budget allocations between management units. Other tasks that must be undertaken by AIM and DNIM include the design of an information and administration system that combines the two existing systems and agreement on a single system for monitoring, evaluating, and supervising contraceptive and essential medicine use.

Policy

The Law of General Health and the new MAIS both open the door for increased targeting of MINSA's scarce resources to vulnerable populations. In the minds of many, however, there is potential conflict between the law and MAIS and the universal rights to reproductive healthcare that many believe are guaranteed by the Constitution and the earlier health laws. The new law establishes three levels of government service—free care, care covered by individual and employer contributions, and care that goes beyond the basic service package and is provided based on fees for service. Most of those interviewed during the CS assessment agreed that any future attempt by MINSA to ration or limit its distribution of free contraceptives to only vulnerable populations would encounter problems because of the belief that the Constitution guarantees universal access. This is clearly an area that will require additional study and a strategic approach in the future if rationing of scarce contraceptive supplies becomes necessary.

The INSS law establishing the EMP service package includes family planning, but only INSS enrollees and not their beneficiaries (spouses) are covered for FP services. This could be a problem in the future, but the current reality is that in the majority of EMPs, FP services still are not promoted nor provided, even to enrollees. Also, most of the contraceptives that are currently used by MINSA appear on the Essential Drugs List, but Norigynon must still be added. Finally, there are restrictions on access to permanent contraceptive methods in the public sector because the signature of the husband is required prior to the procedure, even though this is not a feature of the current Health Law or National Sexual and Reproductive Health Program.

Leadership and Commitment

The Nicaraguan CS Committee, which is made up of representatives from public and private sector organizations and international donor agencies, is well positioned to raise awareness about the issues related to contraceptive security. The role of civil society organizations and consumer advocacy may also be important in achieving contraceptive security. NGOs such as PROFAMILIA, Marie Stopes, Ixchen, and ICAS have worked in reproductive health and family planning for years and will be important advocates for contraceptive security in the future. As an NGO network that includes a wide variety of members from both reproductive health and family planning as well as NGOs working in other sectors, NicaSalud is positioned to play an important role in creating support for and awareness of the importance of contraceptive security. NicaSalud may begin to increase awareness among its own members of the importance of contraceptive security and the need to develop a strategic plan to stimulate public support.

Coordination

There is an increased need for central-level coordination within MINSA as a result of recent structural changes. Coordination appears to be relatively good between MINSA and other governmental and nongovernmental organizations at the department level. Coordination also seems relatively good between the individuals in charge of AIM and medical supplies at the SILAIS level. There has been an obvious effort made to work together since the integration of supply functions. There appears to be little coordination between MINSA and the INSS in terms of populations being served.

There are many donor agencies working in Nicaragua to improve reproductive health and implement the health sector reforms that could have important implications—good and bad—for future contraceptive security. The relationship between MINSA’s principal contraceptive donors—UNFPA and USAID is positive. Since 1997, UNFPA and USAID have coordinated contraceptive procurements and, for the most part, they have been able to reduce overstocking as well as stockouts. Although there appears to be some level of coordination among the other groups, there is also obvious frustration that there has not been more. A number of the donors have begun to pool their resources and to work with MINSA through a SWAP, under which their funding is pooled. This SWAP, or pooled funding approach, has the potential to improve donor coordination and is thought to be reducing MINSA’s management burden by eliminating redundant planning, administrative, and reporting requirements. Although USAID is prohibited from pooling its resources with those of other donors, USAID is an active member and has been able to play an important role in SWAPs in many different countries.

Recommended Strategies and Next Steps

Strategy 1.

Allocate the national budget and raise funding for contraceptives to cover the funding gap created as USAID and UNFPA donations end.

- Make structured presentations to key MINSAs decisionmakers and donor representatives to raise their awareness about contraceptive security and the implication of USAID's phaseout.
- Negotiate a phaseout plan. Clarify USAID's and UNFPA's commitments from 2005 through at least 2008, define MINSAs funding targets for contraceptives through at least 2010, sign and disseminate an official phaseout plan, and use this plan to lobby for a budget.
- Lobby for a protected budget line item and/or a minimum annual budget for contraceptives. Determine how the vaccine budget is protected and lobby for the same protections for contraceptives.
- Raise stop-gap funding from new sources. Make funding needs known to those inside MINSAs and to other donors and include contraceptive funding in plans and proposals to the World Bank, IADB, SWAP group, and other donors.
- Evaluate and take steps to control the cost of MINSAs contraceptive method mix. Study the cost implications of recent changes in MINSAs method mix and establish guidelines for programming of contraceptive purchases that ensure both contraceptive choice and financial sustainability.
- Reduce MINSAs market share through improved targeting of free contraceptives (see Market Segmentation below).

Strategy 2.

Enable MINSAs to procure contraceptives at the lowest possible prices through international procurement.

- Advocate to exempt contraceptives from the requirements of the State Contracting Law, which favors national purchase. Use the government's annual purchase of vaccines through PAHO as the precedent for this action.
- Submit a formal request to the Contraloria Nacional to purchase contraceptives through UNFPA or PAHO and to exempt such purchases from the regulations that require national procurement.

- Establish agreements with UNFPA and/or PAHO that may be used in the future for reimbursable contraceptive procurement.
- Test the purchase of contraceptives in conjunction with MINSA's 2005 and 2006 procurements of medicines, medical supplies, and reagents. Include funding for contraceptives in MINSA's 2005 budget, prepare specifications, determine price ceilings, issue the solicitation, evaluate bids, and award contracts. If no acceptable bids are received, issue a second solicitation. If this is not successful, see Strategy 3.

Strategy 3.

Reduce dependence on MINSA by targeting the free contraceptives it currently provides to vulnerable populations only and encourage an expanded role in contraceptive provision for the private sector.

- Develop a policy and mechanisms for targeting MINSA's scarce contraceptive resources to only vulnerable populations. Review/clarify laws, regulations, and program norms. Investigate targeting options, define criteria, develop practical mechanisms, and implement them.
- Encourage the expansion of FP coverage for INSS affiliates (spouses) and direct beneficiaries (workers). Provide technical assistance and other incentives to the EMPs for their promotion and provision of FP services. Provide technical assistance to the EMP Camara to improve procurement and contraceptive logistics.
- Expand and make more sustainable the social marketing of hormonal contraceptives. Analyze the impact that PROFAMILIA's transition to commercial procurement of hormonal contraceptives will have not only on PROFAMILIA but also on small NGOs that buy from PROFAMILIA.
- Reinforce the role of the private sector—commercial and NGO—through strategic alliances, incentives, technical assistance, and financial support. Promote the establishment of a buyers' consortium for NGOs. Work with the commercial sector to establish social marketing ventures that depart from the traditional donor-funded model.

Strategy 4.

Ensure the sustainability and maintain the effectiveness of MINSA's contraceptive logistics system as it is integrated with the essential drug management system.

- Finalize the specifications and plan for integrating the two supply systems. Establish guiding principles, develop specifications, and prepare a detailed work plan that spells out the responsibilities and expectations of all parties.
- Design and carefully test the integrated supply system before introducing it countrywide, including revised policies and procedures, registers and reports, databases, reference and training manuals, and guidelines and tools for supervision and monitoring and evaluation.

- Lobby the Committee on Rational Drug Use to include all contraceptives on the Essential Drugs List.

Strategy 5.

Strengthen the CS Committee and work through it to influence policy.

- Increase the visibility and influence of the CS Committee through presentations to MINSA leadership and donors (described above) and by proposing to the Minister or Vice Minister that the CS Committee be established as one of MINSA's official working groups.
- Define the CS Committee's mission, structure, and norms of operation (professional facilitation recommended), agree on modus operandi, appoint/elect leaders, and assign responsibilities.
- Expand CS Committee membership by determining which organizations and projects with related reproductive health missions are not currently part of the committee and invite them to join.
- Develop and implement a CS Committee Action Plan. Prioritize issues raised in this assessment, form subcommittees based on interests and expertise, develop subcommittee action plans, and combine them into an overall CS plan. Implement the action plan with support from organizational members.
- Continue to raise awareness about contraceptive security among decisionmakers within MINSA and among other government agencies, the NGO and EMP communities, and international donors.
- Acknowledge leaders who support concrete actions to protect the rights of all couples to choose, obtain, and use the contraceptives of their choice, whenever and wherever they need them.

