Financing Contraceptive Supplies
in Developing Countries:
Summary of Issues, Options, and Experience

MEETING THE CHALLENGE

CONTENTS

The Interim Working Group on Reproductive Health Commodity Security (IWG) is a collaborative effort of John Snow, Inc. (JSI), Population Action International (PAI), the Program for Appropriate Technology in Health (PATH) and Wallace Global Fund. The IWG was formed in response to a meeting of the Working Group of the Global Initiative on Reproductive Health Commodity Management of UNFPA in January of 2000. At the meeting, UNFPA called on the participation of a wide variety of stakeholders to address the looming crisis represented by the shortfall in contraceptives around the world. The IWG's objective is to further the goals of the 1994 Programme of Action by raising awareness about the importance of securing reproductive health supplies. The IWG seeks to identify the causes of failures and weaknesses in commodity systems and to spur actions that will contribute to securing essential supplies for the delivery of reproductive health care.

The IWG understands the importance of addressing the full range of reproductive health commodities. The group is focusing on contraceptives first, however, due to the widespread lack of consensus within the population and reproductive health field regarding which commodities to include in an essential list of supplies. Moreover, there is little information on donor contributions for non-contraceptive reproductive health commodities. Through its efforts on contraceptive security, the IWG is working to bring together stakeholders to develop strategies for addressing the broader issues of reproductive health commodity supplies in the future.

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Financing Contraceptive Supplies in Developing Countries: Summary of Issues, Options, and Experience

The use of modern contraceptives is rising globally, driven by an expanding world population, by steadily increasing contraceptive prevalence rates and by a huge acceleration in condom use due to the HIV pandemic. As they enter the 21st century, few developing countries are self-reliant in providing reproductive health services (and procuring contraceptives) for their people.[1] In the mid-1990s, for example, donor funding for family planning programs in developing countries accounted for an average of 33 percent of program costs.[2]

With this heavy donor support, reproductive health programs have succeeded in increasing contraceptive use and generating demand for contraceptives—demand that could easily outpace available contraceptive supplies in the near future. A recent study of contraceptive commodity requirements concluded that, to ensure full supply globally, donor funding will need to increase sharply from $135 million in 1997 to $204 million by 2000.[3] After the year 2000, donor funding needs to increase at about 5.3 percent per year to meet global contraceptive requirements through 2010. Unfortunately, donor funding for contraceptive commodities has been shrinking, not growing, relative to the growing global requirements. For example, donors provided approximately $135 million for commodities in 1997, while an estimated $150 million was needed to meet full demand.

With donors increasingly forced to prioritize their limited resources, developing country governments face the daunting challenge of procuring more of their contraceptive commodities, and eventually replacing donor funding with government budget allocations. Government budget shortages for contraceptive procurement are likely throughout the developing world, especially in low-income countries that historically have relied heavily on donor funding for their contraceptive requirements. In the face of current and projected shortfalls of donor funds, many developing country governments will not be able to increase contributions to fill the commodity gap.

Clearly, there is an urgent need for governments to mobilize new sources of financing for contraceptives. Many developing country governments are looking to the growing commercial sector to help meet the projected contraceptive shortfalls. Indeed, the commercial sector is an increasingly important source of supply for lower middle and middle income groups who are able to afford contraceptives. However, in most developing countries, the commercial sector still plays a limited, and often ill-defined, role in helping the public sector achieve national reproductive health goals.

One final important point: The most popular contraceptive methods in use today—oral pills, condoms, injectables, and IUDs—are virtually generic and have low unit costs. This means that the major cost of a contraceptive is often not the commodity itself but the service delivery system required to get it to the client.[4] The guaranteed availability of contraceptives depends, in the long run, not only on securing contraceptive supplies but on assuring the sustainability of reproductive health services that deliver contraceptives to clients.

1.1 THE PURPOSE OF THIS PAPER

Because public treasuries alone cannot meet the impending funding shortfall for contraceptives, other sources of in-country finance must be identified and mobilized. Many financing approaches and interventions have already been tried. The purpose of this paper is to review these experiences and offer policymakers and donors financing options that will assist them in determining:

- Which financing options are the most promising for mobilizing resources to fund contraceptives;
- In what contexts these various options have been applied successfully;
- The potential of each financing option for broad application (that is, scaling up); and
- What technical assistance and other resources are needed to implement or expand each financing option.

1.2 THE FIVE FINANCING OPTIONS

This paper discusses five options for financing contraceptive commodities:

1. **Charging fees for contraceptives (and RH* services) in the public sector**
2. **Community financing of contraceptives**
3. **Expanding the role of the private sector in providing contraceptives**
4. **Covering contraceptives under a national health insurance or social security program**
5. **Exploring a Contraceptive Independence Initiative approach**

1.3 LIMITATIONS OF THE STUDY

Two important factors that affect the availability of government finance for contraceptives were beyond the scope of this study: 1) cost containment and efficiency measures, and 2) an investigation of the relatively low levels of central government allocations to health and how these allocations might be increased. In addition, this study draws on the results from extensive research documented in the family planning, reproductive health and health sector literature. The paper relies upon readily accessible research and resource materials and no field-based data collection or research was conducted. Nonetheless, sufficient data and experience were found to provide insight into which financing options have worked, where they have worked, and why. No single financing option is likely to ensure contraceptive availability for a developing country. Thus, the challenge is to identify which combinations of options are likely to be both feasible and effective in a particular country.

◄ PART II ►

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Each of the five financing options presented in this paper has the potential to fill the contraceptive gap. Implementing two or more options simultaneously is likely to have greater positive impact on ensuring long-term contraceptive availability than depending solely on one option.

2.1 FINANCING OPTION 1: Charging fees for contraceptives (RH services) in the public sector

Findings

National user fee systems in sub-Saharan Africa generate an average of 5 percent of total recurrent public sector health expenditure. In Latin America, the limited data suggest user fees can cover up to 18 percent of health expenditure. At facility level, user fees can cover as much as 100 percent of non-salary operating costs. However, means testing and other direct targeting mechanisms to protect the poor often do not work well. As a result, user fees can exclude the poor from receiving subsidized services while better off clients have access to them.

Recommendations for Option 1

Governments should:

a) Conduct market segmentation analysis to differentiate services for poor and wealthy clients and establish policies and procedures that target subsidies on the poor;
b) Introduce contraceptives into cash-and-carry drug depots and other publicly supported revolving drug funds;
c) Determine actual costs for contraceptive procurement, distribution and service delivery so that fees cover a predetermined percentage of these costs.

Donors and technical agencies should:

a) Support market segmentation and strategies to target subsidies on the poor;
b) Assist governments to strengthen revenue collection, accounting and resource management systems;
c) Strengthen contraceptive logistics and procurement systems, especially those undergoing integration with vaccine and essential drug logistics systems;
d) Fund research to better answer these important questions:
   - Is market segmentation and targeting an effective mechanism for transferring users from subsidized to non-subsidized sources of contraceptives supply?
   - Which contraceptive methods are most cost effective for governments to subsidize? For which income groups?
   - Is the "cafeteria" approach to contraceptive service provision in the public sector sustainable in view of available resources?
   - What mechanisms are most effective in targeting subsidies on the poor—characteristic targeting, self-selection, means testing or other mechanisms?

2.2 FINANCING OPTION 2: Community financing of contraceptives

Findings

Community financing (e.g., user fees, revolving drug funds, pre-payment insurance schemes) is able to cover a significant portion of non-salary recurrent costs, especially at lower level health facilities. Insurance arrangements (risk sharing) coupled with user fees are more likely than user fees alone to generate revenue and protect the poor, but such dual systems are more complex and more difficult to sustain. In almost all cases, community financing schemes backed by NGOs have been more successful than those initiated by the public sector.

* For a list of acronyms used in this study, see inside of back cover.

Recommendations for Option 2

Governments should:

a) Add contraceptives to existing community-level revolving drug funds and prepayment schemes;
b) Conduct costing and pricing studies to determine which contraceptives are the most financially viable to add to existing community programs;
c) Establish exemption mechanisms to protect the poor in communities where community financing is to be introduced;
d) Provide training and supervision for communities that intend to introduce community financing;
e) Establish policies and procedures to regulate community financing schemes;
f) Consider establishing a national umbrella organization to provide ongoing technical and management support to community financing schemes, particularly those involving pre-payment mechanisms.

Donors and technical agencies should:

a) Provide technical assistance in contraceptive/RH services costing and pricing;
b) Support training to upgrade community organizational and management skills;
c) Provide policy and regulatory assistance to support community financing schemes;
d) Fund research to better answer these important questions:
   - What are the costs of adding contraception to community financing schemes?
   - What effect do user fees and pre-payment insurance charges have on the demand for contraceptives and RH services?
   - Which targeting mechanisms are most effective in protecting poor clients? In minimizing leakage of benefits to the better off?
   - Are vouchers an effective mechanism for expanding provider and service choice in areas currently served only by public facilities?

2.3 FINANCING OPTION 3: Expanding the role of the private sector in providing contraceptives

Findings

Where government policies have encouraged the growth of the commercial health sector, there has been a shift of users from public to private services, effectively reducing the burden on government. In countries with relatively small commercial health sectors, even modest increases in contraceptive/RH service market share for the commercial sector is likely to result in significant reductions in public sector commodity costs. See Table 1 for an illustration of estimated savings in public sector commodity costs in 14 countries.

Recommendations for Option 3

Governments should:

a) Use market segmentation to shift to the private sector those users who can afford to pay for contraceptives;
b) Increase the private sector's share of the contraceptive market through various incentives (e.g., tax relief, eliminate or lower tariffs on imported contraceptives);
c) Encourage the commercial sector to offer more contraceptive methods and work in under-served areas; mandate private health insurance to provide minimum RH benefits;
d) Reduce legal and regulatory barriers, such as restrictions on brand advertising and prohibitions on paramedical practitioners providing contraceptives;
e) Foster an increase in the number of private practitioners and encourage the growth of professional associations to set standards and regulate their membership;
f) Set standards and monitor quality; provide training and other incentives to improve service quality in both the commercial and NGO sectors;
g) Increase the overall demand for contraceptives and direct new users to the commercial sector, including contraceptive social marketing programs and community financed revolving drug funds.

Donors and technical agencies should:

a) Foster and support public/private sector dialogue and partnership;
b) Assist governments to identify national reproductive health goals and contraceptive commodity requirements, and the appropriate role for the private sector in achieving them;
c) Provide technical assistance to segment markets and identify users who require continued government subsidies to ensure access to contraceptives;
d) Assist governments in identifying incentives to encourage commercial investment in the health sector and ways to reduce legal and regulatory barriers to private sector participation;
e) Fund research to better answer these important questions:
   - Do public-private partnerships have a measurable impact on achieving national reproductive health goals?
   - What is the magnitude of government resources "freed up" by expanding the private (particularly commercial) market share of contraceptives/RH services?
   - What is the impact of regulatory changes and incentives on the growth and market share of the private health sector?

2.4 FINANCING OPTION 4: Covering contraceptives under a national health insurance or social security programs

Findings

In some countries, national health insurance pays for employed workers' health costs, effectively removing them from subsidized public services. In middle and low income developing countries, social security expenditure as a percent of all public expenditure on health averages approximately 43 percent.[5] However, some social security systems still do not cover contraceptives, and even if they do, workers often continue to obtain them "free" from government facilities.

Recommendations for Option 4

Governments should:

a) Mandate social security systems to provide and/or pay for contraceptives;
b) Encourage the growth of national social insurance programs through policy and regulatory actions;
c) Implement policies and procedures to shift workers covered by social insurance away from subsidized public services.

Donors and technical agencies should:

a) Provide technical assistance in setting up/strengthening health insurance and social security systems that provide contraceptives;
b) Assist governments to identify which contraceptive methods can be covered by social insurance without jeopardizing the financial viability of these national programs;
c) Provide technical assistance in costing and pricing policies for social insurance programs, determining reimbursement policies, the need for co-payments, whether spouses/children should be covered, etc.;
d) Fund research to better answer these important questions:
   - Which are the most important contraceptive methods for a national health insurance or social security system to cover? For which clients?
   - What are the best mechanisms for ensuring that social insurance beneficiaries do not use subsidized government sources of contraceptives? RH services?

◄ TABLE 1 ►
ESTIMATED SAVINGS IN PUBLIC SECTOR COMMODITY COSTS BY 2015 IF THE COMMERCIAL SECTOR'S SHARE OF THE FAMILY PLANNING MARKET INCREASES BY 20% OR 40% OVER 1998 LEVELS

Country	Commercial Market Share (1998) (Percent)*	Commercial Market Share in 2015 (assuming 20% increase) (Percent)	Commercial Market Share in 2015 (assuming 20% increase) (Percent)	MWRA in Year 2015 (000s)**	MWRA Served in Commercial Sector in 2015 With 20% Increase (000s)	MWRA Served in Commercial Sector in 2015 With 40% Increase (000s)	Public Costs Saved with 20% Increase in Commercial Share (US$) (000s)**	Public Costs Saved with 40% Increase in Commercial Share (US$) (000s)**	Projected Public Cost in 2015 (US$) (000s)	Savings as a Percent of Projected Public Costs (assuming 20% increase in commercial share)	Savings as a Percent of Projected Public Costs (assuming 40% increase in commercial share)
Low Income											
Bangladesh	15.10	18.12	21.14	35,427	6,419.37	7,489.27	4,277.47	6,041.51	23,466.50	18.23	25.75
Kenya	14.00	16.80	19.60	6,346	1,066.13	1,243.82	1,222.88	1,546.80	12,034.50	10.16	12.85
Nigeria	40.20	48.24	56.28	30,451	14,689.56	17,137.82	8,359.66	10,173.13	27,736.60	30.14	36.68
Ghana	47.80	57.36	66.92	5,228	2,998.78	3,498.58	2,095.65	2,559.35	4,905.20	42.72	52.18
Togo	26.30	31.56	36.82	1,126	355.37	414.59	275.56	331.47	1,541.50	17.88	21.50
Indonesia	28.30	33.96	39.62	45,651	15,503.08	18,086.93	12,317.92	18,086.05	86,293.60	14.27	20.96
Zimbabwe	12.70	15.24	17.78	2,412	367.59	428.85	21.85	99.68	5,106.50	0.43	1.95
Lower-Middle Income											
Sri Lanka	9.20	11.04	12.88	3,322	366.75	427.87	200.12	278.86	4,185.10	4.78	6.66
Philippines	26.20	31.44	36.68	15,537	4,884.83	5,698.97	3,669.24	4,688.86	19,482.50	18.83	24.07
Jordan	44.20	53.04	61.88	1,395	739.91	863.23	929.45	1,128.88	933.30	99.59	120.96
Morocco	33.40	40.08	46.76	4,985	1,997.99	2,330.99	1,022.60	1,579.28	7,102.90	14.40	22.23
Peru	38.10	45.72	53.34	5,102	2,332.63	2,721.41	1,366.94	1,863.80	6,000.30	22.78	31.06
Colombia	42.90	51.48	60.06	7,738	3,983.52	4,647.44	1,489.79	2,343.24	5,145.10	28.96	45.54
Upper-Middle Income											
Mexico	36.40	43.68	50.96	19,790	8,644.27	10,084.98	4,089.71	5,915.62	18,529.70	22.07	31.93
Savings/Costs						41,338.84	56,636.53	222,463.30	18.58	25.46	

*Data from Winfrey et al. *Factors Influencing the Growth of the Commercial Sector in Family Planning Service Provision*. Working Paper Series No. 6 (Washington, DC: The Futures Group International, POLICY Project, 2000).

** Based on data from Ross et al. *Profiles for Family Planning and Reproductive Health Programs* (Glastonbury, CT: The Futures Group International, 1999).

A "Contraceptive Independence Initiative" (CII) might be designed to facilitate contraceptive procurement and to fund contraceptive purchases by developing countries requiring hard currency and/or flexible credit terms.

2.5 FINANCING OPTION 5: Exploring a Contraceptive Independence Initiative Approach

Findings

Under the Vaccine Independence Initiative (VII), a hard currency loan fund of US$8 million leveraged and helped to finance and procure US$50 million worth of vaccines.[6] Learning from the VII model and other more recent initiatives aimed at vaccine financing, a "Contraceptive Independence Initiative" (CII) might be designed to facilitate contraceptive procurement and to fund contraceptive purchases by developing countries requiring hard currency and/or flexible credit terms.

Recommendations for Option 5

Governments should:

a) Estimate the country's long-term contraceptive requirements, the costs of these commodities, and the gap (if any) between needs and supplies;
b) Develop a long-term "Contraceptive Security Plan" that ensures nationwide contraceptive availability;
c) Evaluate potential new procurement and financing mechanisms;
d) Make a public commitment to eventually assume responsibility for purchasing all contraceptives used in the public sector.

Donors and technical agencies should:

a) Fund research to better answer these important questions:
   - Would a VII-type hard currency fund for contraceptive purchases contribute to long-term contraceptive security?
   - Has the VII resulted in increased government financial support for vaccines or decreased dependence on donor funding?
   - How much would be required to capitalize a CII fund? Which countries are likely to use the fund?
   - How much would contraceptives procured through a CII mechanism cost, and would this sum be lower than buying contraceptives directly from the marketplace?
   - What skills/expertise would be required by the global entity designated to manage a CII? Which organizations currently have these skills/expertise?
   - What lessons can be learned from the recent experience of the newer multisectoral partnerships promoting vaccine availability?
b) Assist governments in assessing all aspects of a potential Contraceptive Independence Initiative.
c) Contribute to a revolving hard currency fund for purchasing contraceptives;
d) Support the global entity established to organize and manage the CII fund;
e) Provide procurement and logistics technical assistance to countries using a CII mechanism.

◄ PART III ►

DESCRIPTION OF FIVE FINANCING OPTIONS

OPTION 1 Charging Fees for Contraceptives (RH Services) in the Public Sector

DESCRIPTION AND RATIONALE

Part of health reform. Although acknowledging that various forms of user fees have been used in many countries for decades, the World Bank set forth a more systematic approach in the 1980s as part of a proposed agenda for health sector reform.[7] Charging for services where subsidized health and family planning services are offered was strongly endorsed as one of four policy reforms to finance public sector health services (the others were decentralization, encouraging risk-coverage programs, and strengthening non-governmental provision of care).

◄ Box 1.1 ►
Using Charges for Services to Improve Resource Use

Since 1993, the Vietnamese government has made substantial investments in family planning services. There is usually no charge for contraceptive services. Poor women in Vietnam have embraced contraception as eagerly as their wealthier counterparts: contraceptive use among the poorest quintile (the poorest 20 percent of the population) is 66 percent while among the wealthiest quintile, 70 percent. Method mix and rates of modern contraceptive use are also similar. However, a disproportionate amount of public finance (subsidies) goes towards paying for the contraceptive services of the rich. The wealthiest quintile receives 28 percent of all government subsidies while the poorest receives only 15 percent. Behrman and Knowles (1998) attribute this to differences in where poor and rich women obtain their contraceptives. The rich more frequently use expensive hospitals while the poor use less expensive commune health centers. To better use government resources, they suggest that the government charge fees for services at high-cost hospitals to reduce subsidies per acceptor to the level received by users at less expensive facilities. They also suggest that this policy would likely shift some rich acceptors away from more expensive sources of family planning services and improve overall program efficiency.

Why charge. The rationale for charging for services in publicly financed health and RH programs is based on the need to raise more revenue to expand or improve services as well as concerns about existing inefficiencies and inequities. Box 1.1 gives an illustrative example of the poor use of government resources when there are no charges for public services. In this example, a large number of wealthy family planning users in Vietnam who can afford to pay for services receive them free from the public sector.

How much to charge. A key user fee issue is how to price each contraceptive method. Price obviously affects clients' choice of methods, and therefore, the relative prices of the various methods are likely to influence method mix and even contraceptive prevalence (CPR). Pricing contraceptives methods is perhaps a more important and complex issue than pricing drugs and other health services, because clients have a real choice and are often able to substitute a cheaper method for a more expensive one to achieve the contraceptive result they want.

How it works. Charging for services in the public sector involves setting up a system of user fees. Fees, which are paid directly by the client/patient or by an insurance provider for those who are insured, can cover:

- The cost of drugs/contraceptives/medical supplies;
- The costs of a consultation;
- The cost of a specific treatment or service (which includes all drug, contraceptive, consultation and auxiliary—such as laboratory—services);
- Charges for bypassing a level in the referral system;
- Registration charges during the initial visit (for outpatient services); and
- Hospital charges.

Fees can be set according to the actual cost of a contraceptive or service provided—with or without a mark-up. They can also be set on a "sliding scale" according to income and ability to pay (those who are wealthy pay for the full cost of a service, often plus a mark-up, while those who are poor pay only a fraction of the cost or nothing.) Strategic pricing decisions (such as increasing or decreasing subsidies) to affect the behavior of identified groups is known as targeting, and is a crucial aspect of user fee systems.

In theory, instituting charges for contraceptives in the public sector works as follows: with systems in place to protect the poor, charges for contraceptives are applied nation-wide. They are introduced first in more expensive tertiary facilities, then, accompanied by decentralization of resource use and control to regional or district levels, they are implemented downward to the primary levels of the health care system.

BENEFITS OF OPTION 1

Increasing cost recovery. Drug (including contraceptive) charges and user fees can increase revenue to cover recurrent expenditures and can be used to improve the quality and coverage of care. Charging for commodities/services has the potential to free up revenue that governments can then use to expand services in under-served areas or to subsidize care for low income groups. Box 1.2 illustrates efforts to improve cost recovery and equity with user charges for family planning services in Ghana.

Increasing efficiencies. Increasing user fees/decreasing subsidies has the potential to improve efficiencies by directing clients to lower-cost sources of contraceptives or—for those who can pay—to the unsubsidized private sector. Charging for public sector contraceptives reduces unfair competition and the "crowding out" of the unsubsidized private sector.

Increasing private sector participation and increasing equity. DHS data from the 1980s indicate that the public sector was the leading provider of modern contraception to couples in the developing world, dominating provision in North Africa (with Egypt being an exception), Asia, and Africa.[8] More recent DHS data on the public and private sector roles in contraceptive provision show a similar picture. Although in Latin America the private sector played a larger role in contraceptive services, the public sector was still the primary provider in all but two countries. Most importantly, for nearly all countries surveyed, the majority of clients living in urban areas and large numbers of higher educated women (indicators of an increased ability to pay) obtained contraceptives from the subsidized public sector. This suggests that a substantial number of higher income clients were obtaining their contraceptives at government expense. Thus, in addition to reducing unfair competition with the private sector, pricing decisions can also improve equity by charging higher prices to those who can afford it. To protect the poor, exemption mechanisms or other forms of targeting that maintain subsidized contraceptives for those who are unable pay must be put into place.

◄ Box 1.2 ►
Increasing Cost Recovery and Equity with User Charges in Ghana

A 1995 pricing study in Ghana found that government prices for family planning fees in public sector facilities had not kept pace with inflation, and were far lower than those charged in the private commercial and non-profit sector. Wealthier clients who could afford to pay more had switched to government sources of supply to take advantage of lower prices, and few costs were being recovered. The study recommended increasing public sector prices along two tracks: specific cost recovery targets as a guide to setting new prices in urban areas (where larger numbers of higher income clients live) and lower cost recovery targets for rural clients to reduce the negative impact of price increases. It was also recommended that a larger portion of revenue generated be kept at the facility level for service delivery and quality improvements. These recommendations—price increases and guidelines for the use of revenue generated by sales of donated contraceptives—were adopted by the Ministry of Health (Smith et al., 1998).

DISADVANTAGES OF OPTION 1

Negative impact on demand and access. The main concern for policymakers and program managers is the negative effect that charging for contraceptives (and reducing subsidies) may have on demand and contraceptive prevalence. Reducing subsidies on more costly methods may deny some women and men access to a preferred method (which indicates a reduced level of quality) and could even result in higher drop out rates.[9] Exemption systems and other targeting mechanisms have not always been effective in ensuring that the poor have continued access to contraceptives. At the same time, higher income groups who can afford to pay and are therefore not targeted for subsidies often manage to take advantage of free or subsidized contraceptives.

Potential political problems. Restricting the benefits of free contraceptives to the poorest (and least politically powerful) may result in a loss of political support for reproductive health programs. It may also contribute to the development of a two-tier health system of high quality, largely privately funded care for the middle and elite classes and under-funded, low quality public services for the poor.[10] Another problem is the potential for political backlash in countries where contraceptives traditionally have been provided for free. Policymakers are often reluctant to institute charges in such situations.[11]

Managerial difficulty. The technical feasibility of collecting and accounting for fees may be a problem, particularly in government clinics where there has been little experience with revenue generation. The resulting administrative costs could be higher than revenue collected.[12]

DISCUSSION OF OPTION 1

A broad ranging discussion of several issues inherent in financing Option 1, charging for contraceptives in the public sector, is included in Annex A. The issues include:

- The difficulty in assessing the impact of revenue generated at the national, district, and facility levels, due to scanty and unreliable data, most of which are for non-FP health services;
- The major challenges involved in improving managerial and administrative capacity to make cost recovery/revenue generation schemes work in the public sector; and
- The effect that charging for services has, or may have, on demand, and the prospects for mitigation by improving quality.
- The most critical issues, however, are discussed here:
- Potential revenue generated from charging for contraceptives and services;
- Protecting the poor by effective targeting;
- Conducting market segmentation analysis and developing effective policies and segmentation strategies; and
- Scaling up strategies for charging fees for contraceptives.

Limited revenue potential of fees

National user fee systems in sub-Saharan Africa generate an average of 5 percent of total recurrent health expenditure in the public sector.[13] More limited data available from Latin America suggest user fees can cover a much higher level of health expenditure—up to 18 percent in Colombia.[14] National cost recovery levels from user fees can fluctuate over time and be greatly influenced by factors such as fee increases, improvements in collection and administrative practices, inflation, economic recession or war. No current data on revenue generated from user fees for public sector contraceptives could be found in the literature. More discussion of revenue generated from user fees at the facility level, and the inherent difficulties of collecting and interpreting user fee data, is found in Annex A.

Protecting the poor by targeting

Policymakers can use targeting as a way to provide a "safety net" to protect the poor (and other vulnerable groups) when introducing or raising fees in public facilities. There are several different targeting mechanisms:

Characteristic targeting is directing benefits (subsidies) to people in target groups defined by various social, geographic and/or demographic criteria; for example, "free" contraceptives for women living in shanty townships, subsidized preventive services in rural areas, or "free" vaccines for all children under five years. In these examples, economic status, geographical location and age are the characteristics being used for targeting health resources.

Self-selection targeting involves segmenting the health care market by, for example, price, provider, facility or type of service, and then having clients choose the services and providers they want. Self-selection targeting is based upon clients' preferences and willingness/ability to pay.

Although there is "leakage" of benefits to the non-poor with both characteristic and self-selection targeting, service coverage tends to be fairly good. Box 1.3 gives an example of two successful programs in Bangladesh that use self-selection targeting.

Direct targeting provides benefits only to clients identified as belonging to a specific target group, which is usually based on income. In programs where poor people are the target group, **means testing** is required to classify potential clients as eligible or ineligible for benefits according to their income levels. The purpose of means testing is to protect the truly poor by wholly or partially exempting them from paying for services.

Although a good deal of research has been conducted on the effectiveness of means testing in health care programs, little of it has been focused on contraceptive services. However, the experience with means testing has been more successful in Latin American countries, which tend to have the infrastructure and higher literacy levels needed to implement means testing programs.[15] Means testing seems more likely to succeed when decision-makers can make use of more formal, centrally-located information such as wage and tax records, or other social service records, to exempt those who are unable to pay for services. A review of means test experience in 15 countries (four in Latin America, six in Africa, and five in Asia and the South Pacific) found serious operational problems in all but two: Jamaica and South Korea.[16] In both of these cases, officials were able to rely on formal records and administrative systems to successfully identify and exempt the poor. In sub-Saharan Africa, means tests usually lack formal,

◄ Box 1.3 ► Successful Self-Selection Targeting in Bangladesh

Two programs in Bangladesh demonstrate how user fees can raise revenue and protect poorer patients without resorting to costly direct targeting methods such as means testing. The approach used in each case was self-selection targeting. Under the right market conditions, poorer patients were able to identify themselves as poor without having to be tested, and were able to obtain the most affordable health care or family planning service option available in the market. Self-selection allowed authorities to cross-subsidize the market choice of the poor by charging higher fees to the non-poor.

One program in district hospitals offered in-patients either a non-paying or paying-with-extra-amenities option. The differentiation of the market was based on additional "hotel"-type extras, not a difference in the quality of services. Revenue generated from in-patient fees covered 12 percent of district hospitals' running costs in 1995. Another program involved condoms sold through the Social Marketing Company, which were highly segmented by brand. Consumer choice was based on the valuation of the 'extras' against the increased price. Although essentially the same product, higher-priced brands offered higher status, and revenue generated from these brands subsidized the nearly free condoms sold to low-income consumers. Commodity charges covered 60 percent of in-country recurrent costs plus a 25 percent mark-up for retailers. (Thomas et al. 1998)

written, or centralized procedures, and programs that employ means testing suffer both from serious leakage of exemptions to the non-poor and from large numbers of deserving poor who are excluded from benefits.

In light of these shortcomings, characteristic and self-selection targeting may have more practical and political advantages over direct targeting. Practical because characteristic and self-selection targeting are easier to implement and more likely to be effective in protecting the poor, and political because self-selection helps guard against the development of a two-tier health system. Characteristic and self-selection targeting also have advantages when used in family planning programs. Family planning programs are more effective when a range of contraceptive methods and service provider choices are offered to clients. Under self-selection, this "cafeteria" of choices is available: clients select a method and provider source (public or private) that best meets their needs and ability to pay. Since the more costly, long-term clinical methods may be beyond the means of many clients, even those who are not poor, governments could subsidize them to bring net costs to users more in line with those of re-supply methods.[17] Full subsidies would be reserved only for users who are unable to pay at all.

Market segmentation analysis and strategies

Market segmentation analysis. To help minimize the problems associated with instituting user fees and other charges for contraceptives, policymakers can take advantage of market segmentation analysis. Traditionally used by the private commercial sector to divide or "segment" their client market by characteristics such as income, age or gender, market segmentation analysis is an important tool for developing effective marketing and pricing strategies for different market niches. For public goods such as contraceptives, market segmentation analysis can be used by policymakers to identify different consumer groups and the characteristics that describe them, such as income, gender, and geographic location, including each group's family planning provider and method choice.[18]

Market segmentation strategies. In a well-segmented market, most consumers within a specific group will behave similarly with respect to price, service provider and method choice. Consumer group behavior will also be consistent with national program goals and make efficient use of both public and private resources.[19] Market segmentation strategies involve matching segmented consumer groups with appropriate sources for contraceptives, based on their need and their ability to pay. Thus, effective market segmentation strategies can make it possible for the public sector to target subsidies to those most in need while minimizing the "leakage" of such benefits to those who can afford to pay. Market segmentation analysis can also help policymakers develop strategies for achieving contraceptive self-reliance in the future when supplies of donor-funded contraceptives may no longer be available. And it can help define and foster appropriate roles for the public and private sectors in the contraceptive market.[20]

Market segmentation analysis can also help policymakers develop strategies for achieving contraceptive self-reliance in the future when supplies of donor-funded contraceptives may no longer be available.

Market segmentation for policymaking. As a diagnostic tool for targeting, market segmentation analysis can be used to identify distortions in consumer markets. In Indonesia, for example, the consumer market for contraceptives was well segmented by price, as high income consumers of IUDs, implants, and sterilization paid a much higher price for these methods than the poor.[21] Higher income consumers also paid somewhat more for oral contraceptives and injectables. However, in terms of free contraceptives, the market was not well segmented. Higher income consumers of implants and orals more often received free services than poor consumers did. And, higher income injectable users were as likely to receive free services as poorer users. Similarly in the Philippines, more than 40 percent of high- and middle-income women obtained contraceptives in the subsidized public sector.[22] On the other hand, in Egypt, the contraceptive market was efficiently segmented: consumer market segments for the three most popular methods (pills, condoms, and IUDs) were clearly differentiated according to price, income, convenience, and/or other amenity characteristics. The public sector was able to effectively target users with low ability to pay. Segmentation analysis revealed that consumers were willing to pay more for pills and IUDs and that there was considerable room for increasing cost recovery (without disrupting the market) by relaxing price controls.[23]

To date, policymakers have not yet had the opportunity to extensively use market segmentation analysis as a policymaking tool. Thus, its effectiveness as a catalyst to shift users from subsidized to non-subsidized sources

◄ Box 1.4 ►
Using Market Segmentation Analysis to Increase Contraceptive Self-Reliance in Turkey

Turkish policymakers use market segmentation analysis to reduce subsidies to family planning consumers who can afford to pay for contraceptives, and to define a public-private sector partnership that will help meet the country's contraceptive needs without donor support. In 2000, Turkey will be financing and procuring nearly all contraceptives used in its public sector program, as contraceptive supplies donated by USAID will have ceased. From spending nothing on contraceptives in 1996, government contributions for contraceptive purchases totaled almost $1.8 million by 1999. Dialogue and linkages between the Ministries of Health and Finance have increased significantly so that a broader base of support for financing contraceptives could be generated.

In spite of increased government contributions, as early as 1997 officials realized that budget allocations for contraceptives were falling—and would continue to fall—short of actual need. Discussions about targeting as a component of the country's program for contraceptive self-reliance began. Dialogue with the private sector (both non-profit and commercial) also began, so that a public-private partnership could be fostered to efficiently apply the resources of each sector.

A market segmentation analysis was conducted showing that large numbers of well-off clients were using MOH services for free; these clients could "crowd out" poorer clients if contraceptive supplies became less available. The analysis gave policymakers information about the family planning market structure and client population characteristics and was used to identify groups most in need of subsidized contraceptives. A targeting strategy labeled "Insurance/Ability to Pay Model" was adopted, under which the social insurance organization would reimburse the MOH for their clients' contraceptive services, the poor and near-poor would receive free services, and all other uninsured clients would make a recommended donation.

Market segmentation analysis played an important role in changing the attitudes among major stakeholders (including the social insurance sector) about supporting new sources of finance to meet the government's contraceptive needs. And, it increased the acceptability of the idea of generating revenue for contraceptives by charging the well-off while reserving subsidies for the poor (Berg 2000 and Sine 1999).

of contraceptives in a variety of country contexts needs further study.[24] Box 1.4 describes the efforts of policymakers in Turkey to use market segmentation analysis as a tool for both more effective targeting and developing a national strategy for contraceptive self-reliance.

■ Scaling up

Implementing national (as opposed to pilot) public sector programs that charge for contraceptives involves a lengthy and complex series of policy and program actions that requires effective strategic planning.[25] Actions needed for introducing fees for contraceptives/RH services nationally include:

- *Ensuring effective advocacy* before, during, and after implementing fee systems to garner political support, needed legal and regulatory modifications, and continued government contributions for contraceptive supplies and services;
- *Establishing strong leadership* from the central Ministry of Health throughout a rationally phased design and implementation process;
- *Involving key stakeholders* such as service providers and clients so that they can inform the implementation and policy development process and support it;
- *Setting achievable financial goals and developing and implementing financial management and accounting systems* that track the amount of revenue generated from charges and how/where revenue is used;
- *Conducting and using market segmentation analysis and strategies* to guide policy, planning and implementation processes;
- *Implementing charges in more expensive tertiary facilities* before doing so in the lower, primary levels of the health system;
- *Phasing implementation to allow for new policies and systems (such as those aimed at protecting the poor) to be tested* and adjusted based on experience and regional differences;
- *Phasing implementation to develop the financial management capabilities* needed for implementation and long-term sustainability;
- *Improving the quality of reproductive health services and facilities* so that clients feel they are getting value for their money.

CONDITIONS FOR SUCCESS OF THE FEES OPTION

Experience shows that charging for contraceptives is more likely to be successful when:

- **A significant share of revenue collected is reinvested at the provider/facility level** so that quality improvements can be made;
- **There is an explicit link between fees and improved quality of services.**
- **The costs of quality improvements and their likely effect on demand compare favorably** to potential revenue generated from increased fees;
- **Prices for contraceptives and services mirror those of affordable household items and other necessities** in low income countries;
- **Self-selection and characteristic targeting is used** to protect the poor;
- **There is an array of public and private price, provider, and method choices for family planning client market segments to select** according to their ability and willingness to pay;
- **Fees are one part of a wider public sector contraceptive financing strategy** that includes other components such as:
  - Encouraging the private sector to play an active role in providing RH services;
  - Risk-sharing mechanisms;
  - Maintenance of government subsidies for core products/services;
  - Cost containment, e.g., bulk purchasing, reduced waste and leakage from more efficient logistics management, increased staff productivity and facility utilization, and establishing/enforcing standards that reduce unnecessary or poor service and prescription practices.

◄ Box 2.1 ► A Community-Government-NGO Partnership for Health Financing in Guatemala

Community financing programs that involve a mix of government and NGO facilities and services are rare. In Guatemala, however, a grassroots NGO (Associacion por Salud de Barillas) entered into an agreement with the government health ministry for primary care services (through its health posts and centers) on behalf of the communities living in Barillas municipality and its rural environs. Primary care services were covered by a prepaid health plan financed by community members. For tertiary care, a capitation contract was entered into with a private non-profit hospital owned by a religious organization. (Ron 1999)

OPTION 2 Community Financing of Contraceptives

DESCRIPTION AND RATIONALE

Community financing is a mechanism for increasing the availability of resources to pay for primary health care, reproductive health care, and other preventive and curative services. Services financed by communities are typically provided by lower level, primary care facilities, although some programs may also include hospital care located some distance away. Community financing programs tend to be initiated in rural areas where access to high quality health care is more limited, but they are by no means restricted to these areas; urban-based communities may also organize, finance, and manage such programs.

Community financing partnerships. Most often the ministry of health is the catalyst for the organization of community-financing programs and provides the health and RH services.[26] However, in some communities, nonprofit NGOs are the catalyst and service provider.[27] Box 2.1 describes a community financing partnership in Guatemala that uses a mix of public and NGO services. Rural cooperatives, such as the dairy farmers' association in India or the coffee growers group in Colombia, also organize and manage health financing arrangements—usually prepaid plans—for members.[28]

Why community financing? The goal of community financing programs is that communities will raise and use revenues in ways that will meet their specific health care needs, including expanding access to services, improving their quality, and ensuring their sustainability. Ideally, communities will also ensure that members who use these services are held accountable as responsible participants—that they will pay their share of costs and will not over-utilize health services for frivolous reasons (the so-called "moral hazard").

In reality, actual community participation in the organization, financing, and management of their health care varies from nonexistent (with the entire responsibility resting with the service provider) to total control. In the former, there is little to distinguish community financing from traditional models of public- or NGO-sponsored health care systems that charge their users (communities) for services provided (see discussion under Financing Option 1.) In the latter case, "communities" (which could be cooperative-based, large in size, and cover population segments from different parts of the country) hire professional managers who often adopt management techniques from the private sector. These are more rarely found outside of middle and higher-middle income countries. Most community financing mechanisms documented in the literature fall in between these two extremes.

Revenue raised by community financing typically covers non-salary recurrent expenses in lower level health facilities. Recurrent costs covered include pharmaceuti-

cals, equipment, medical supplies, maintenance (for facility and equipment), and, occasionally, bonuses for health staff. The facility owner, whether government or NGO, usually covers salaries (by far the largest recurrent cost of a health service.)

TYPES OF COMMUNITY FINANCING MECHANISMS

Community financing involves generating revenue by two basic mechanisms.

1. **User fees** include payments for drugs, payments for consultations, payments for each visit to the health facility, payments per illness episode (which includes both drugs and services provided to treat an illness), or a combination of these. Fees can be used to cover a facility's recurrent expenses and/or to capitalize a revolving drug fund for re-supplying the facility (in Kenya, community financing has been used to establish and operate community pharmacies.)
2. **Risk-sharing arrangements** include pre-payment (by household or individual) of a fixed amount for health coverage. Known under such names as solidarity funds, social insurance, or mutual aid societies, this mechanism spreads the risk of being burdened by high health costs among a larger pool of individuals or households. Participation in community risk-sharing funds can be involuntary (where a tax is imposed on all households) or voluntary. Some studies indicate that community (as well as provider-based) prepayment schemes—although an improvement in many cases over out-of-pocket payments—may be more difficult to sustain because of their higher level of complexity.[29]

Community prepayment programs are usually organized around either the direct provision of services (the health maintenance organization or HMO-type arrangement) or indirect provision (the preferred provider organization or PPO-type of arrangement). With the HMO arrangement, the prepaid plan owns health facilities (which have salaried staff) that provide services directly to members. With the PPO arrangement, the prepaid plan contracts with a number of facilities and practitioners that are paid either a fee for service or a fixed amount per participant per year (capitation). Members can choose among participating facilities and professionals. Many community-financed risk-sharing arrangements reviewed for this paper—particularly those that fall under the Bamako Initiative—are a sort of hybrid of these two types.

The concept of risk sharing is not new to many traditional cultures where extended families and clan organizations have long provided a system of mutual aid to members facing catastrophic illness. In sub-Saharan Africa (where formal experience with non-profit social insurance is relatively new and coverage limited), Atim has identified a useful typology of social insurance organizations that can be applied to community financed social insurance experience elsewhere in the world.[30] The most common are:

- *Traditional social security networks,* which are comprised of members belonging to a particular ethnic or clan group;
- *High or low participation community financing models,* which are organized by health providers and the community;
- *Medical Aid Societies,* which are organized on a large scale (usually unrestricted by ethnicity or similar factors), highly developed and usually run by professional staff.

Community-financing mechanisms have been introduced in a variety of countries, including Thailand, Guatemala, Colombia, China, Philippines, Indonesia, India, Bangladesh, and in many parts of sub-Saharan Africa (often under the rubric of the Bamako Initiative.) For example, in Niger, prepayment mechanisms are combined with user fees to finance services provided by the public sector.[31] In Bangladesh, co-payments are charged (along with premiums for social insurance) to cover the costs of health and family planning services provided by two NGOs.[32]

In terms of scale and longevity, Thailand has one of the most active community-financing programs. By 1987, drug funds were operating in 45 percent of all villages, and covered 50 to 60 percent of the rural population (see Box 2.2). Since 1983, Thailand has also widely experimented with social insurance that currently covers about 20 percent of the rural population.[33]

As a region, sub-Saharan Africa has the widest experience with community financing as a result of the Bamako Initiative (BI), which commenced in 1987. Under the initiative, policymakers hoped that the more formal participation of communities in the management and financing of their health services would help halt the steady deterioration of primary health care infrastructure and service provision. At first BI only focused on creating revolving drug funds that were managed at the community level and financed by user charges. Over time more flexibility in terms of community financing mechanisms and types of health care-related expenses covered were built into country programs. Typically, while the community finances most non-salary recurrent costs and some of the investment costs of government health facilities (NGO-sponsored initiatives are less common), the government covers a portion of vaccine costs and the salaries of health staff, including their training and supervision. Donors often finance many start-up costs and the replacement costs for such critical expenses as vaccine transportation and cold chain.

◄ Box 2.2 ►
Drug Funds in Thailand

Thai villages have a tradition of mobilizing and pooling savings for social good; feelings of obligation to the community and respect for authority are strong. In addition to expected services, drug fund shares are purchased by villagers in expectation of profits that are distributed according to the number of shares purchased. The viability of drug funds is maintained by profits on drug sales (the typical markup is 30 percent) as well as the sale of other goods. Drug funds tend to be much more profitable when other goods are sold and work best when fund managers are compensated based on their performance.

An evaluation found that compared to other community funds (such as social insurance, nutrition, water and sanitation funds) drug funds were the most successful single purpose health care fund. (Myers 1987) This was measured in terms of viability, profitability, capital appreciation, diversification of income sources and services, and numbers of households contributing to and benefiting from fund activities. At the time of the evaluation, 20,000 drug funds were operating in close to half of all rural villages in Thailand; these had an average net return of 50 percent. The drug funds were most successful when: fund management committees provided strong, active leadership; fund managers were compensated according to fund profits; the local health officer was active; the fund was supported by a geographically compact village of a least 60 households; the village met a minimum standard of development as measured by electrification; and there was limited competition from retail outlets.

BENEFITS OF OPTION 2

Fosters community participation and increases sustainability. In contrast to financing Option 1, discussed above, where communities do not participate in revenue management, and where financing, pricing, and targeting decisions are made by the government, community financing emphasizes that revenue should be raised and controlled by the community. This process fosters community participation in service provision and helps to ensure that members are not just passive recipients of services. Community financing builds a better understanding of risk-sharing and instills confidence in the insured. Better understanding of and ability to control revenue collection and distribution systems can build capacity at the community level and increase prospects for long-term sustainability.

Positive impact realized from community financing. Among the various impacts attributed to community financing, studies have found:

- In Zimbabwe, the Commercial and Industrial Medical Aid Society added family planning benefits in the late 1980s and other social and private insurance groups have followed suit. About 700,000 beneficiaries have family planning services as a covered benefit although there is evidence that most still obtain free services from the public sector.[34]
- In Guinea and Benin, community financing has led to overall improvements in vaccine coverage and health status.[35]
- On Java, where local family planning services are financed by an insurance-type fund capitalized by payments from community members (part of Indonesia's KB-Mandiri initiative), women have a sense of ownership in the program and feel more willing to use family planning.[36]
- In Niger, community financing has helped to improve access to quality services among the poor.[37]
- Community financed prepayment schemes have helped control the costs of basic outpatient care in 20 poor Chinese counties—consultations are reimbursed more highly than drug purchases and members are encouraged to adhere to the referral chain.[38]
- In Kenya, community financing has greatly improved access in rural areas to emergency transport for medical care.[39]

DISADVANTAGES OF OPTION 2

Effect on demand and contraceptive prevalence. One of the main concerns with community financing is that client fees and/or risk-sharing arrangements may reduce the demand for family planning and result in lower contraceptive prevalence. However, because of the dearth of available experience in community financing for contraceptives and services, this effect is impossible to document with any certainty.

The experience of community financed health services indicates that in most countries, community financing did not reduce demand; it improved the accessibility, quality, and affordability of health services for the majority of the population. However, communities may be more willing to accept price increases for health services, particularly for curative care, than for contraceptive or other preventive services. More documented experience with the community financing of contraceptive and other reproductive health services is urgently needed.

Equity considerations. In spite of the improvements in affordability that community financing has brought to most members, research indicates that very poor and vulnerable groups (such as widows) still do not have access to health care. The problem lies in both the inadequacy of exemption mechanisms used by communities and in the structure of the community management and administrative committees set up to manage financing.[40] How financing decisions are made and the degree to which local management committees represent and are held accountable to their communities is not clear. Another problem may be that many community financing management committees operate without a clear framework for resource allocation and management, resulting in ad hoc decisions about which services are supported.[41]

Lack of provider choice and accountability. Revenue generated by the community most often goes toward supporting the public sector health services, particularly in sub-Saharan Africa where the public sector is often the sole provider of services outside of urban areas. Consequently, in some countries community financing tends to perpetuate the government's monopolistic hold over health care. The result is little or no choice of provider, price, or service; the inability of the health/RH market in communities to segment itself through self-selection; and a lack of accountability of service providers to their communities.

- Scaling up community financing interventions from local, pilot efforts to a national strategy to improve long-term contraceptive availability for all.

Approaching financial sustainability

The data for this discussion are drawn largely from health programs, not contraceptive programs; furthermore, the information systems that produce these data are weak in most developing countries. Nevertheless, they provide a starting point for discussion on the potential of community financing for contraceptives through user fees and risk-sharing, and the general prospects for cost recovery for contraceptives and RH programs. Their deficiency also clearly highlights the need for additional research.

Cost recovery at the facility level. Results from health sector studies in a number of countries indicate that community financing can cover most if not all non-salary (including drug) expenditure for preventive and curative services provided in lower level health facilities. Covering *all* recurrent costs, including the salaries of health providers, is another matter. Recovering all recurrent costs (including salaries) would require generating significantly more revenue by both sharply increasing utilization rates and raising user fees. Neither solution is simple: achieving the former entails implementing measures such as increasing staff productivity and making large quality improvements, while implementing the latter would probably adversely affect demand—particularly in poorer communities.

In terms of cost sharing with public sector or NGO providers at the facility level, community financing has demonstrated its potential to generate significant amounts of revenue, even in poor countries.

DISCUSSION OF OPTION 2

Annex B includes a discussion of several important issues involved in community financing, such as:

- The importance of community participation, the role of external "catalyst" organizations, and especially, the importance of separating the financing and provision of services;
- The prospects for achieving quality, equity, and efficiency goals with community financing; and
- The need for significant improvements in specific management and administrative skills at local and oversight levels.

The issues of most crucial importance to the success of community financing for contraceptives and RH services are discussed below:

- Achieving financial sustainability through cost recovery for contraceptives and services; and

Nevertheless, in terms of cost sharing with public sector or NGO providers at the facility level, community financing has demonstrated its potential to generate significant amounts of revenue, even in poor countries:

- In Guinea-Bissau, Senegal, Cameroon, Cote d'Ivoire, and Mali user fees from community financing programs covered 200 percent of local drug costs, 100 percent of local non-salary operating costs, and half of total local recurrent costs (which includes salaries of government health staff). In Guinea, user fees generated from community financing covered 300 percent of local drug costs and 40 percent of total (including salary) recurrent costs.[42]
- In Benin, fees covered 350 percent of drug costs and half of total recurrent costs. Impressively, revenue generated from user fees in community financing programs was the equivalent of about 20 percent of overall public expenditure on health.[43]

◄ Box 2.3 ►
Testing Alternative Financing Mechanisms in Niger: Which Have the Best Outcomes?

Niger is one of the few countries to actually test alternative community financing mechanisms to see which work best in terms of increasing access and sustainability. Two different mechanisms were tested in two districts: a user fee system (a fee-per-episode of illness) was tested in one while a prepayment scheme financed by a tax levied on all households plus a small fee (co-payment) to reduce frivolous use was tested in the other. Representatives of local health committees managed revenues generated from fees and taxes at each health facility and at the district level. Revenues were also pooled at the district level to finance the solidarity (insurance) fund that was managed by a district health committee comprised of delegates from local health facilities. Revenues generated by fees and taxes primarily financed drug supplies for facilities.

Results from the test indicated that access to health care for women, children, and the poor was higher with the tax plus nominal co-payment mechanism (social insurance) than with the fees alone. In addition, revenue generated by taxes-plus-fee was two times higher than fees alone. (Diop et al. 1995).

- In Niger, tax payments (to fund social insurance) plus fee revenue covered 149 percent of drug costs and 89 percent of drug and management costs; user fees alone covered 52 percent of drug costs and 35 percent of drug and management costs. (See Box 2.3.)
- In Uganda, Nigeria, Kenya, and Burundi one-half to nearly all facilities studied (the variation is due to differences in how costs were counted) were able to cover non-salary recurrent expenditures. Facilities generating the most revenue had the highest utilization rates. Uganda's health facilities fared least well, and Kenya's community pharmacies have also not done well due to competition from private drug stores. In Nigeria, only one out of 155 village drug funds lost capital and other revenue generating activities are supplementing drug sales.[44]
- In Nepal, drug fund schemes operating in very poor communities covered from about 19 to almost 60 percent of costs. NGO-coordinated funds were better able to recover costs than those managed by the public sector.[45]
- In the Philippines, a community-financed prepayment program covered 110 percent of recurrent expenses, not including salaries of medical staff that were covered by the NGO provider.[46]

Cost recovery prospects for contraceptives and services. What does this experience mean for financing contraceptive and other reproductive health services at the community level? What magnitude of contraceptive costs can be recovered? Experience with drug funds has demonstrated that these are highly valued by the community and that revenue generated—even in poorer communities—can more than cover the costs of pharmaceuticals. Thus, if fees charged could cover the costs of selected contraceptive commodities and yet remain relatively affordable then a significant share of contraceptive program costs could be recovered at the community level. At the national level this could result in a considerable savings for governments. Adding relatively inexpensive methods such as pills, condoms, and perhaps injectables to community-financed drug funds should not pose an insurmountable challenge in countries with sound financing, procurement, and distribution systems. But it should be noted that in most developing countries, contraceptives—unlike many essential pharmaceuticals—are not locally manufactured and access to foreign exchange is required for international purchasing. Given the paucity of financial data on community financing of contraceptives and services, this assessment of the potential for community financing to reduce the contraceptive "gap" is largely conjecture. Thus, research is urgently needed on:

- Logistical feasibility of adding various contraceptives to community-financed drug funds;
- Incremental costs of adding different contraceptive methods and services to community financing arrangements;
- Effect these costs may have on user fees and/or fees charged for social insurance; and
- What effect these fees may have on the demand for contraceptive services.

Cost recovery prospects for high cost contraceptive methods. Covering the costs of contraceptive services such as IUD insertion, sterilization, and NORPLANT that require clinical settings are unlikely with community financing, based on the experience with health services provided in more expensive clinical facilities. With community financing there are limits to the amount of potential revenue that can be generated and prices that can be charged to offset the higher costs of tertiary services. For example, in Bangladesh where two NGOs currently operate community financed solidarity funds and

provide health care and family planning services (family planning is provided free), one (Gonosasthya Kendra, GK) offers hospital services while the other (Grameen Bank, GB) does not. GK covers 36 percent of its costs from income earned from the community while GB covers 66 percent. On the other hand, offering hospital services is a real "draw" for GK's subscribers, and this NGO has far fewer program dropouts. (Concerned about participants' complaints and long-term program sustainability, GB also plans to offer hospital services.) Clinical settings need a mix of other forms of finance to cover costs in addition to what might be earned directly from the community. For example, hospitals in China, the Democratic Republic of Congo, Brazil, and South Korea have been able to cover nearly all recurrent expenditure by implementing relatively high fees and having access to fairly widespread insurance systems which reimburse hospitals for patient claims.[47]

Factors influencing sustainability outcomes. Certain factors seem to positively influence the sustainability outcomes of community financing for services provided by primary care facilities and prepaid arrangements:

- Larger community population sizes;
- The confidence of the client population;
- Higher utilization rates (which also may be attributed to having better quality services);
- A range of curative as well as preventive services;
- Higher per case treatment revenue;
- Fewer price subsidies and higher profit margins built into fee structures;
- A trained midwife working in the health facility so that high margin obstetrical services can be offered; and
- More antenatal care and a larger number of deliveries.[48]

Because of the negative impact of adverse selection (where lower risk and higher income individuals opt out) and moral hazard (frivolous use) by subscribers, protecting the financial viability of prepaid plans calls for additional measures. In Niger, in addition to a tax imposed for insurance coverage, a co-payment is charged for every visit to reduce moral hazard.[49] In Bangladesh, co-payments are also imposed.[50] In Ghana, a three-month probationary period is required before members can collect benefits.[51] Nonetheless, there is still clear evidence of moral hazard in Ghana's program (hospital utilization among the insured is far higher than for the uninsured). Adverse selection undermines the social insurance programs of Burundi and Thailand.[52] The authors of one study in Zambia strongly recommend user fee systems over social insurance because of the latter's potential for being abused; examples of abuse were use of member cards by non-members, visiting more than one center with the same card to obtain more medicines, and not joining until sick.[53]

Scaling up

Scaling up community financing interventions to countrywide programs that integrate contraceptives and other reproductive health services will involve a series of actions, focused attention, and potentially large resource inputs. Gradual expansion of community financing nationwide is recommended to allow for new policies to be developed, implemented, and adjusted in response to experience. At the same time, local capacity needed to assure long-term sustainability has time to develop.

Actions needed for disseminating community financing countrywide include:

- *Conducting action-oriented research on the incremental costs of adding contraceptives and RH services* to community financing interventions and what effect these may have on demand;
- *Developing information strategies* to inform communities, expand their awareness, and involve them in the process of developing and implementing community financing interventions;
- *Involving key stakeholders* such as service providers early in the policy development and implementation process in order to better inform that process and ensure support;
- *Establishing (or designating) an umbrella-type organization* to provide technical assistance for human resource development at the community level;
- *Ensuring that other key countrywide support systems are in place,* and if needed, strengthened (e.g., banking, logistics, MIS);
- *Instituting standards of care and best practices* and strengthening monitoring and supervisory capability at all levels of the reproductive health system to track service provider performance and assure quality;
- *Instituting government fiscal policies* to enable central level resource transfers and the equalization of resource availability between richer and poorer areas within countries in order to ensure continued access to contraceptives and services for the poor;
- *Developing a central government regulatory framework* for the management of prepayment funds that includes defining the membership of fund management committees and instituting routine monitoring of fund performance; and

Scaling up community financing interventions to countrywide programs that integrate contraceptives and other reproductive health services will involve a series of actions, focused attention, and potentially large resource inputs.

- *Designating a government agency with authority and oversight responsibility* to ensure these new regulations are enforced.

CONDITIONS FOR SUCCESS FOR OPTION 2

The vast majority of documented experience with community financing has not been implemented on a national scale but has been pilot tested in limited areas of a country. Little community financing experience has been documented for contraceptive or other reproductive health services, and we must rely on the extensive experience of community financing for health care to extract lessons learned. Key factors that seem to be necessary for the development of successful community financing programs include:

- **Communities understand and accept the advantages of taking responsibility** for their health services, including RH services;
- **Community participation is broad-based** and does not reflect only the biases of the providers and/or the elite;
- **Communities participate in the financial management** of their services in a meaningful way;
- **There is clear separation between the financing and provision of health/RH services;**
- **Communities have access to the necessary support systems,** such as skilled administrators, outside help to strengthen their managerial skills, secure banking facilities, well-run pharmaceutical procurement and distribution systems, and strong management information systems;
- **Communities have confidence in the quality of reproductive health services** provided by health facilities and feel they are getting value for money;
- **Communities use characteristic targeting to identify and exempt poor and vulnerable members from paying for services and/or prepayment mechanisms** to protect them from the high cost of some health/RH services;
- **Prepayment mechanisms are protected** from adverse selection and frivolous use;
- **Health/RH service providers understand that community financing will not cover the full costs of services,** and that community financing is a form of cost-sharing that must be supplemented by other revenue sources;
- **Health/RH service providers are accountable to their clients/patients** (the communities) and not just to their employer's chain of command; and
- **Cost containment is used by health providers to lower the cost of service provision to communities** by, for example, efficiently procuring, distributing, and prescribing pharmaceuticals/contraceptives; reducing contraceptive wastage and leakage; increasing staff productivity and facility utilization; and enforcing standards.

OPTION 3 Expanding the Private Sector's Role in Providing Contraceptives

DESCRIPTION AND RATIONALE

For well over a decade in many developing countries, and over two decades in some, innovative public-private partnerships have been formed to help meet people's RH service needs. These partnerships benefit both sectors. For the public sector, the amount of government financing required to meet the contraceptive requirements of a country's population can be lowered if an active private sector is providing contraceptives to clients who can pay. An active private sector that serves clients who can afford competitively priced services allows a government to focus its resources on providing contraceptives to the poor and under-served populations. From the standpoint of the private sector, public-private sector partnerships have allowed private providers to compete more fairly in a less distorted marketplace and develop successful businesses.[54]

Little community financing experience has been documented for contraceptive or other reproductive health services, and we must rely on the extensive experience of community financing for health care to extract lessons learned.

Private sector partners. With and without the assistance of outside donors, the public sector is already forming beneficial partnerships with the private sector, e.g., non-profit and NGO organizations and commercial providers such as:

- Private practitioners (physicians, midwives, nurses) in single or group practices;
- Private hospitals;
- Private pharmacists and chemists;
- Pharmaceutical manufacturers who sell contraceptives and RH commodities;
- Employer-provided health service programs;
- Informal contraceptive vendors (kiosks and street vendors);
- Commercial health insurance.

Market share. The commercial sector's share of the family planning market ranges from 10 percent to 65 percent in countries that have conducted a Demographic and Health Survey (DHS).[55] The developing country

average is approximately 30 percent market share,[56] although it should be noted that the private sector's market share varies significantly by method (generally higher for supply methods and lower for clinical methods).

The NGO sector has a relatively small market share compared to the commercial sector—less than 10 percent of the family planning market in most of the 45 DHS countries, the exceptions being Haiti, Colombia, Guatemala, Jordan, Liberia, and Madagascar where the market share is greater than 10 percent.[57]

Commercial Sector Market Share for Family Planning by Region

Latin America	40%
North Africa	38%
Asia	26%
Sub-Saharan Africa	20%

Factors influencing commercial sector growth. The commercial sector usually plays an important role in providing contraceptives in low prevalence countries. However, as prevalence increases and family planning programs mature, the private sector often does not develop at the same rate as the public sector for several reasons:

- Untargeted free or heavily subsidized contraceptives in the public sector limit demand for private sector contraceptives and "poach" potential clients.[58]
- When commercial sector providers cannot compete in price, and when demand is low for their services, they will not offer them.[59]
- Government regulations may:[60]
  - Require medically unnecessary prescriptions for oral contraceptives;
  - Limit where contraceptives can be sold;
  - Prohibit NGOs from charging for contraceptives;
  - Ban the use of certain contraceptives;
  - Restrict which family planning practitioners may operate private practices and provide contraceptives; e.g., in many countries nurses and midwives are not allowed to operate in private practice or provide contraceptives;
  - Delay product registration, licensing, and certification.
- Government policies may:[61]
  - Impose high sales and value added taxes on commercially sold contraceptives;
  - Impose high tariffs on imported contraceptives sold commercially while donated ones are exempt, thus putting commercial products at a price disadvantage;
  - Restrict brand advertising and promotion;
  - Impose price controls (such as in Egypt and Jordan) to keep prices low;
  - Threaten intellectual property rights; e.g., South Africa's weak patent protections led one pharmaceutical company to suspend local production plans.

Other external factors may also constrain the expansion of the private sector:[62]

- Low per capita income and resulting low purchasing power;
- Low rate of urbanization and low population density;
- Low demand and small market size for contraceptives;
- Lack of trained medical personnel operating in the commercial sector who can prescribe contraceptives;
- An unfavorable political climate, corruption, and lack of knowledge about market conditions in both the government and commercial sectors.

The commercial sector usually plays an important role in providing contraceptives in low prevalence countries. However, as prevalence increases and family planning programs mature, the private sector often does not develop at the same rate as the public sector.

Effect on commercial sector growth. As subsidized programs grow, the commercial market often shrinks; for example, in Senegal commercial market share fell from about 50 to 25 percent as the number of donor-provided contraceptives increased during the late 1980s.[63] Likewise in Mexico, from 1979 to 1995 the commercial sector's share of the family planning market declined from 50 to about 25 percent as a result of large donor support for Mexico's subsidized public sector programs.[64]

PRIORITY APPROACHES TO EXPANDING THE ROLE OF THE PRIVATE SECTOR

Successful private sector experience. Behrman and Knowles (1998) suggest that under certain circumstances it is appropriate for donors to subsidize the private sector as a way to increase/maintain access for lower income groups. In fact, donors—particularly USAID, and to a lesser extent UNFPA—have been actively supporting programs aimed at expanding the role of the private sector in providing contraceptives. See Annex E for a brief overview of major USAID-funded private sector projects that have developed and refined tools and approaches, and experienced success, in the following areas:

1. PUBLIC/PRIVATE SECTOR PARTNERSHIPS

- Developing partnerships with pharmaceutical companies to increase the demand for, and the availability and sustainability of low-priced family planning products;
- Changing legal and regulatory policies affecting the delivery of RH services to foster increased private investment in the health sector;
- Integrating private practitioners into government referral systems;
- Inviting private sector representatives to participate in national health policy formulation, and publicly acknowledging the private sector's contribution to achieving national health goals.

2. PRIVATE SECTOR STRENGTHENING

- Promoting corporate social responsibility that includes support for health services;
- Expanding and strengthening private provider networks;
- Promoting the integration of RH into various health financing alternatives (such as commercial health insurance, social insurance, and managed care organizations);
- Developing new cadres of private RH practitioners, e.g., private midwives;
- Strengthening NGO sustainability by developing NGO capacity as facilitators of employer programs, as managers of franchise-type programs with private doctors and midwives, and as direct providers of services;
- Working with commercial sector employers to add family planning benefits for their workers;
- Providing credit and other support for private practitioners;
- Training for private practitioners (doctors, nurses, pharmacists and retail staff to improve their RH knowledge and skills).

3. SOCIAL MARKETING

- Expanding markets and consumer demand with subsidized products and services;
- Using commercial techniques and retail outlets to market low-cost contraceptives to low income consumers;
- Segmenting markets using market segmentation analysis techniques.

Mobilizing the private sector. Based on these private sector experiences, UNFPA now recommends that six key approaches for mobilizing the private sector should be supported by donors, governments, and private sector partners:

- *Stimulating demand for family planning*. Initiatives to stimulate demand include organizing communications campaigns and removing advertising restrictions on family planning as well as brand-specific messages.
- *Improving access to contraceptives*. Initiatives to improve access include expanding (beyond pharmacies) the types of outlets where contraceptives are sold; improving product distribution through social marketing; removing regulatory barriers preventing non-physician providers from offering some contraceptive methods; and introducing new methods.
- *Improving the quality of services*. This includes providing training to providers and undertaking product testing.
- *Using market segmentation*. This involves analyzing the effect of untargeted government programs on national budgets, on commercial sector participation, and on overall program impact, and using the results to improve segmentation in the family planning/RH market.
- *Reducing the price of contraceptives*. This includes entering into social marketing partnerships to reduce contraceptive prices, direct price subsidization by donors through social marketing initiatives, and removing duties, price controls, and regulatory restrictions that tend to increase prices.
- *Promoting commercial sector financing*. Initiatives include encouraging employers to cover the cost or provide contraceptives to employees, and private health insurance to cover family planning and contraceptives as a benefit to subscribers.[65]

Under certain circumstances it is appropriate for donors to subsidize the private sector as a way to increase/maintain access for lower income groups.

Regarding the last approach, evaluative research indicates that further investments that support employer-based programs and private insurance are likely to have limited impact due to 1) the relatively small number of clients—particularly women and populations living in sub-Saharan Africa—actually employed in the formal sector or covered by private insurance; 2) employed family planning clients are more likely already to be obtaining contraceptive services in the commercial sector; and 3) private insurance investments are relatively high risk, and there are few financial incentives for insurers to cover family planning services.[66]

◄ Box 3.1 ►
Positive Policy Changes Increasing the Availability of Contraceptives

Zimbabwe reduced tariffs on imported condoms from 10 to 5 percent while Senegal eliminated taxes on condoms. Morocco and Jamaica lifted advertising restrictions on socially marketed contraceptives while Egypt lifted regulatory barriers to permit general practitioners (rather than only OB/GYNs) to provide Depo-Provera. All of these policy changes decreased contraceptive prices for consumers, increased contraceptive supplies for clients, and/or increased the utilization of private sources of supply. (UNFPA 1998b; Smith et al. 1998)

Examples of some of the approaches and supportive policy initiatives recommended above that are having a beneficial effect on contraceptive supplies and prices are found in Box 3.1.

BENEFITS OF OPTION 3

Better use of scarce public resources. By reducing the number of wealthier clients served in public facilities, the government is no longer forced to support the massive infrastructure needed to serve the needs of the entire population in all areas of the country. Instead, it can focus its resources on the poor and on areas of the country where there are no private providers offering services.

Mobilizing the commercial sector can benefit even the lowest prevalence countries. Even in countries of sub-Saharan Africa with low levels of contraceptive use that have small commercial sectors (such as Uganda, Burkina Faso, and Tanzania), governments should use the commercial sector as a partner to expand access to contraceptives. The commercial sector can be leveraged even during the earliest stages of a family planning program to foster program growth for both contraceptive prevalence and sustainability.[67] Since family planning users in low prevalence countries are highly motivated and better off, they are, in fact, good potential clients for the commercial sector.

Market segmentation and self-selection benefits. In an environment where the private sector is allowed to compete freely for clients, governments can reap the benefits of market segmentation and self-selection. That is, clients of all income levels will segment themselves and select the services and providers that best meet their needs in terms of price, method, and desired amenities.

DISADVANTAGES OF OPTION 3

The commercial sector will not provide contraceptives to everyone. Governments must be realistic in their expectations about the commercial sector. Because commercial sector providers do not receive subsidies or donations, they must charge for goods and services. Actual costs plus profit margins that meet reinvestment and other needs are the basis for calculating prices charged. Moreover, since the profitability of contraceptives is low, commercial providers must also provide a range of other services. For example, private practitioners must provide profitable curative services along with preventive services. In addition, commercial sector providers usually must operate in areas of higher client density to ensure a sufficient number of clients who can access and afford their services. Thus, most commercial sector providers find it more viable to work in urban and peri-urban areas and not in sparsely populated rural areas.

Moreover, the income expectations of service providers will differ and will influence where they target their services. For example, physicians have higher income expectations, tend to charge more for services and tend to target their practices to higher income and privately insured urban dwellers. The same holds true for the larger pharmacies. Non-physician medical personnel such as midwives and nurses, whose income expectations are lower and who consequently can charge less for services, are more willing to operate in poorer communities, less densely populated small towns, and even in rural areas. Smaller stores and informal sector vendors selling contraceptives are more readily found in these areas as well. Two successful projects in the Philippines and in Indonesia that have trained and helped set up private midwifery practices offering family planning to middle and lower-middle income communities are good examples of commercial sector programs that target less well-off clientele.[68] Box 3.2 describes the Philippines example.

Since family planning users in low prevalence countries are highly motivated and better off, they are, in fact, good potential clients for the commercial sector.

DISCUSSION OF OPTION 3

Annex C contains a discussion of several topics relevant to expanding the role of the private sector in providing contraceptives. These include:

- Assuring quality of care in the private sector; and
- The pros and cons of governments contracting with the private sector.

Three critical issues are discussed in further detail below:

- The impact of mobilizing the private sector on government resource use;
- Market segmentation analysis and strategies for public-private partnerships;
- Contraceptive social marketing; and
- Scaling up interventions that expand the private sector.

■ The impact of mobilizing the private sector on government resource use

Intuitively, expanding the role of the private sector in providing contraceptives helps "free up" government resources, but there are no data to prove or disprove this claim.[69] Likewise, there are no reliable data on how governments are using resources freed up by private sector expansion. For example, government policies helped to expand commercial market share of family planning services in Indonesia from 12 to 40 percent,[70] but no one knows if this has allowed the Indonesian Government to redirect health resources to lower income groups. Furthermore, falling incomes and rising prices during the recent economic crisis in Indonesia may have forced many consumers to switch back to low-cost subsidized contraceptives, possibly temporarily reversing any redirection of government resources.

As governments constantly face competing priorities for resources, an action-oriented research agenda is needed to help governments redirect resources to the poor and under-served.

■ Market segmentation analysis and strategies for public-private partnerships

Market segmentation analysis provides information that can encourage and guide public and private sector dialogue about opportunities for collaboration in the financing of contraceptives. Public, non-profit, and commercial sector partners can use market segmentation analysis to coordinate and use resources more efficiently. Each partner has a different but complementary objective.[71]

For the commercial sector the objective is to maximize profits. The commercial sector aims to target the market segment comprised of clients with a high ability to pay, with a high level of need, and who are readily responsive to (that is, want) services from commercial providers. To minimize commercial sector costs, target market segments must be readily accessible.

For the non-profit private sector the objective is to maximize equitable access to services while remaining sustainable. Desired target client market segments have a high level of need to meet equity objectives but have sufficient responsiveness, accessibility, and ability to pay to meet sustainability objectives.

For the public sector the objective is to maximize equity. Desired target market segments' ability to pay is not imperative for survival. Thus the public sector is able to focus on client market segments with low accessibility and high need without being overly concerned about responsiveness and ability to pay.

In Morocco, market segmentation analysis has been used to develop a strategy for public-private partnerships to increase access to long-term methods.[72] The analysis identified a greater role for the private sector in serving market segments comprised of (1) older women (2) wanting no more children (3) with medium to high socioeconomic status (4) living in urban areas. For market segments comprised of (1) poorer (2) older women

◄ Box 3.2 ►
Expanding Midwife-Provided Family Planning to Low Income Populations in the Philippines

Since 1997, family planning NGOs, professional midwives associations, the government Department of Health, and USAID have collaborated to extend midwife services to poor communities. Midwives are given training in family planning, marketing, and business; basic equipment; and advertising support (under the Well Family Midwife Clinic network logo). In exchange, they are responsible for providing and furnishing their own facilities and must provide family planning services (all methods except sterilization) in their practices. Eight NGOs provide technical assistance and supervisory support (with funding and technical assistance from the USAID-sponsored TANGO II project).

Nearly 200 midwives located in most regions of the country are providing family planning services to low income clients; nearly all midwife practices are profitable and most are reinvesting earnings into their businesses for expansion. All have developed partnerships with physicians who supply emergency back-up services for high-risk patients. Many midwives invite pediatricians or family practitioners to hold clinics within their facilities a few hours a week as an additional service for clients (Fort et al. 1998).

◄ Box 3.3 ►
Using Market Segmentation Analysis to Expand the Private Sector in Brazil

Findings from a market segmentation analysis conducted in Brazil helped guide reproductive health finance discussions between USAID and the Depo-Provera distributor, Pharmacia & Upjohn/Brazil (P&U). The findings from the analysis and supporting sales projections convinced P&U to change its strategy from targeting a high-priced product to a narrow market of upper-income breastfeeding women to one that focused on a broader market with a lower price. USAID agreed to support P&U's sales force with an advertising program and helped it develop strategic partnerships with key government, professional association, and non-profit groups. P&U cut the price of Depo-Provera in half and within a year of launching of the new strategy, sales exceeded original projections by 30 percent (Allman 1998).

(3) living in rural areas (4) wanting no more children, the analysis identified a clear opportunity for public sector expansion. The strategy targeted a 50/50-public/private service mix by 2005. Another example of market segmentation analysis being used to develop a donor-private sector partnership to introduce socially marketed injectables in Brazil is found in Box 3.3.

■ Contraceptive social marketing

Contraceptive social marketing (CSM) applies commercial marketing techniques to the sale of contraceptives for a social purpose. Socially marketed contraceptive products expand accessibility and family planning use because they are lower in price and widely available as they are sold in commercial retail outlets. NGOs also manage social marketing programs and offer products through their distribution points and service centers. Two country governments, India and Jamaica, have actively supported and managed social marketing programs as well, but these are exceptional cases.

Benefits and drawbacks of social marketing programs. In addition to accessibility and price advantages, additional potential benefits of social marketing include privacy (anonymity), increased male involvement (condom programs), and increased cultural acceptability of family planning. Drawbacks include difficulties assuring quality of care (since contraceptives are sold in retail markets), limited method choice, and vulnerability to cutbacks in donor funding/subsidies.[73]

The subsidized CSM model. Although social marketing programs sell products through commercial and other private channels, most cannot be considered truly commercial because they receive at least some donor funding and supplies of donated contraceptives. A few social marketing programs are entirely self-sustaining and no longer depend on outside support for contraceptive supplies, distribution costs, or advertising. These are considered to be "graduated" in USAID parlance, and include programs in the Dominican Republic (for oral contraceptives), Morocco (for condoms and orals), and PROFAMILIA's social marketing program in Colombia.[74]

The commercial CSM model. Although subsidized social marketing programs will remain the norm in low-income countries for the foreseeable future, the commercial (also called manufacturers) contraceptive social marketing model is becoming increasingly common in higher income countries. Under this model, a formal agreement is reached between commercial pharmaceutical distributors, governments, and donors to sell contraceptives at prices that are affordable to middle and lower-middle income groups. The objective is to encourage them to switch from the free or more highly subsidized contraceptives of the public sector to socially marketed products. Donors provide advertising support for the products, with the expectation that these costs will eventually be assumed by companies. The USAID-supported Commercial Market Strategies (CMS) Project is actively promoting and negotiating these commercial model partnerships with pharmaceutical companies on a regional basis in West Africa and Latin America, as well as in India, Brazil, Kazakhstan, Morocco, and Uzbekistan.[75]

Impact on program costs, donor funding, and the commercial sector. Findings are inconclusive with respect to some important questions concerning social marketing programs: whether they reduce overall program costs, whether they reduce dependence on donor funding, and what effect they have on the unsubsidized commercial sector.[76] For example, a 1992 study of a CSM program in Honduras[77] found that when socially marketed pills were introduced, the market share of commercial brands fell. The cost of providing the pills which was previously borne by pill users was now being at least partially carried by donors. However, these are results from only one study. More research is needed.[78]

■ Scaling up

Facing scarce resources and the need to close the contraceptive commodity gap as quickly as possible, government policymakers and donors need to focus on priority actions to scale up private sector expansion in contraceptive services that will have the most impact in the shortest time period.[79]

For scaling up private sector involvement, governments should give priority to:

- *Increasing demand for contraceptives* with more effective information, education and communication strategies and by effectively collaborating with contraceptive social marketing programs that are moving toward financial sustainability;
- *Using market segmentation strategies* to facilitate access to markets, reduce government subsidies to those who can pay, and increase the commercial sector's share of the family planning market;
- *Assessing the potential impact of donated contraceptives before introducing them and reducing contraceptive product leakage from government programs,* to minimize undermining of the commercial marketplace;
- *Reducing legal and regulatory barriers* such as restrictions on brand advertising and restrictions that prohibit paramedical practitioners from providing some contraceptive services;
- *Providing incentives* to encourage the commercial sector to provide more contraceptive services and to work in under-served areas;
- *Providing soft loans* to help practitioners start up or expand their practices—particularly in under-served areas. One important caveat is offered, however: lack of access to capital and credit seems to be more of a constraint for physicians since they face higher start-up costs than paramedical personnel; many paramedical practitioners are also more cautious about the financial risks of borrowing.[80] Thus, governments need to assess the costs and benefits of supporting loan programs that may favor the expansion of physician practices.

At the same time, donors will need to assist governments in fostering policy dialogue to identify:

- *National reproductive health goals and actions* that the public and private sectors will work together to achieve;
- *Market segments* that each partner will focus on to maximize family planning access and coverage;
- *Incentives* that will most likely mobilize private sectors partners; and
- *Legal and regulatory barriers* that need to be changed.

Action-oriented research is urgently required to ascertain:

- *The potential impact of regulatory changes and incentives* on the growth and size of the private sector;
- *The magnitude of government resources "freed up"* by expanding private sector market share in family planning;
- *Whether or not "freed up" government resources are being redirected* to the needy and underserved; and
- *What impact* these public-private sector partnerships are having on achieving reproductive health goals.

Box 3.4 illustrates the positive impact that some of these actions have had in Indonesia, where the government has actively supported policies and programs to increase the commercial sector's share of the family planning market.

CONDITIONS FOR SUCCESS

In sum, mobilizing the private sector to provide more contraceptive services is more likely to be successful when:

- **Market segmentation analysis and strategies are used to develop public-private sector partnerships** to increase access to contraceptives and services;

◄ Box 3.4 ►
Government Policies in Indonesia Expanding Commercial Sources for Family Planning

Facing economic problems in the mid-1980s, the Indonesian Government implemented policy reforms and other actions to expand the commercial provision of family planning services. These included: implementing legal and regulatory reforms related to pharmaceuticals to increase local investments; supporting generic advertising for contraceptives (under the "Blue Circle" logo); authorizing midwives to provide all family planning methods but sterilization and providing them with training; encouraging wealthier clients to pay for contraceptive services and instituting means tests to protect the poor; and encouraging private health insurance to cover family planning.

As a result of these actions, from 1987 to 1997 the commercial sector's share of the family planning market grew from 12 to 40 percent (Rosen and Conly, 1999).

- **A healthy balance exists** between the need for minimum standards and regulations to assure quality care in the private sector with the need to not stifle growth by over- regulating the industry;
- **Carrots (incentives) are used more frequently than sticks (regulations) to influence private provider and insurer behavior**—particularly where the capacity to enforce minimum standards is low;
- **Demand creation strategies** for contraceptives and services are being implemented;
- **Government contracting with the private sector is used cautiously** and only where capacity exists for adequate contract procurement, management, and monitoring.

OPTION 4 *Covering Contraceptives under National Health Insurance or Social Security Programs*

DESCRIPTION AND RATIONALE

Who benefits from risk-coverage? Outside of China, no more than 15 percent of people living in developing countries take part in any form of risk-coverage (other than free health care covered by tax revenue).[81] Of people covered by some form of risk-coverage in many middle-income countries of Latin America and Asia, most are covered by national social health insurance programs (national or state health insurance or social security). Coverage by private insurance, prepaid plans (community or provider-based) and employers—although growing—is still relatively rare in developing countries.

Using national social insurance to cover contraceptive methods and services may be a suitable option where national/state health insurance or social security systems are well established and fund a significant share of health care expenditures.

Using national social insurance to cover contraceptive methods and services may be a suitable option in the middle and higher-middle income countries where national/state health insurance or social security systems are well established and fund a significant share of health care expenditures.[82]

Expanding access to risk-coverage. The higher-middle income countries of Latin America (especially Brazil, Mexico, Costa Rica, Uruguay, and Argentina) have been able to broadly expand social security coverage for health care for some low-income groups. On average, the percent of people living in these countries who are covered by national social health insurance is an impressive 70 percent.[83] Although payments vary according to income, benefits received are the same—whether one is rich or poor. Any inequities arising from national social insurance, then, are from incomplete population coverage. National social insurance in higher-middle income countries has demonstrated its ability to generate revenue for health care; outside of some government subsidies to extend social insurance coverage to rural areas, these systems are largely self-financed from payroll taxes.

Family planning market share of the social insurance sector. DHS data analyzed for 45 developing countries[84] show Latin America as the only region where national or state employee insurance schemes and social security systems cover a significant share of the family planning market.[85] But even in this region the numbers are relatively small. Family planning market share is only 10 percent or higher in Brazil (where national social insurance covers about 25 percent of the market), Peru and El Salvador (where it covers about 20 percent), and Guatemala and Bolivia (where it covers about 10 percent). Mexico's national and state insurance/social security system serves around 8 percent of the family planning market, Colombia's about 5 percent, the Dominican Republic's about 3 percent, and Ecuador's about 2 percent. Only two countries outside of Latin America (Egypt and Nigeria) are mentioned as having national social insurance that covers family planning, and their family planning market share is less than 2 percent.

Which contraceptive methods should be covered? Contraceptives and services covered by national social insurance usually include at least oral contraceptives, condoms, and IUDs. Mexico's national social security system offers a full range of methods including sterilization (male and female), several choices of IUDs and pills.[86] To reduce contraceptive costs where insurance participation is not compulsory, governments may want to limit these entitlements.

To lower contraceptive costs under compulsory insurance schemes only the more expensive clinical methods (injectables, IUDs, sterilization) should probably be included. According to Akin (1987), many countries have adopted compulsory insurance because it is easier to manage, especially where national administrative and management systems are not as strong and where there are lower levels of literacy. But to be viable, compulsory insurance systems need to be kept simple. This means excluding low-cost and routine contraceptive services (such as condom and pill provision) since the cost of collecting payments and administering reimbursements for these kinds of services is very high. More affluent beneficiaries are already likely (or have the capacity) to routinely purchase these low-cost goods and services in the commercial sector. To protect the poor, however, low-cost methods could be given to them free. Exemption mechanisms protecting the poor are more likely to work where record keeping and administrative systems are developed.

What about low-income countries? For the foreseeable future regions such as sub-Saharan Africa will have limited ability to broadly expand national social insurance.[87] This also holds true for covering contraceptive

and other reproductive health services. There are a number of challenges involved with expanding insurance coverage to poor and hard-to-reach populations in any country—low or middle income. Kutzin (1998) notes that expansion of coverage may result in more government subsidies for people who are already better off. And Shaw and Griffin believe that formal health insurance may not significantly increase the welfare of individuals living in the rural areas of low-income countries. They note that in more traditional rural settings, charging user fees for relatively inexpensive services (financing Option 1) is more appropriate, reserving insurance coverage only for more expensive inpatient care. To better target resources for the poor and underserved, governments can also mandate that employers provide health/reproductive health services or insurance coverage for their employees.

TYPES OF PUBLICLY FINANCED OR MANDATED SOCIAL INSURANCE SYSTEMS

Government financed versus mandated coverage. Government financed insurance schemes that provide benefits to eligible populations are at least partially supported with general revenues or taxes earmarked for health services. This differs from government-mandated insurance (or medical care), which is not publicly financed. Government-mandated insurance is a set of laws or statutes requiring formal sector employers to provide insurance coverage (or services) to employees. All insurance systems, whether publicly financed or mandated, involve the collective pooling of resources (usually through the payment of premiums, taxes or payroll deductions) to protect covered members from financial loss due to illness and accident. Preventive services may also be covered to keep beneficiaries healthy and costs down.

There are pros and cons of each approach. A highly regulated or managed system requires extensive government involvement and may create inefficiencies. Where there is competition between providers, insurance plans, and insurers there is greater likelihood of higher quality (to attract people's business), efficiencies (to keep costs down), and choice. Differently priced plans with different benefit, co-payment, and deductible options can foster market segmentation and self-selection targeting. On the other hand, an entirely private and unregulated insurance market may not adequately provide insurance for the poor, high risk and/or hard-to-reach populations.

National social insurance models. Countries typically follow one of two models:[88]

1. *The national health system model.* Health care is financed by taxation, controlled by the government, free for citizens or residents, and managed and often delivered by public facilities staffed by government employees. Sometimes, private providers also may provide services and co-payments may be paid.
2. *The health insurance system model.* Health care is financed by compulsory contributions paid by employers and employees, and by general taxation. Funds go to a non-governmental statutory finance and management entity that owns provider networks or purchases services from external providers (public and/or private). Co-payments and deductibles may also be paid.

Box 4.1 describes Colombia's successful efforts to transform its rather inequitable health care system based on a mix of the national health system and health insurance models into a more equitable one based on the health insurance system model.[89] As a result of these reforms, funds channeled into the new system almost doubled as a percent of GDP over only a four-year period. Financing is now separated from the provision of care. In order to provide more health, family planning, and other RH services for the poorest, government subsidies and other revenue have been increased and are being rigorously targeted through the management of a special fund.

For the foreseeable future regions such as sub-Saharan Africa will have limited ability to broadly expand national social insurance.

Government roles in social insurance. Depending on the country, governments play different roles in organizing and regulating health insurance. For example, governments can:

- Encourage and even subsidize social insurance or solidarity funds for health care financed by communities (as discussed under financing Option 2);
- Directly manage social insurance systems
- Highly regulate a purely private insurance market;
- Allow private insurance systems to be largely shaped by market forces.

BENEFITS AND DISADVANTAGES OF OPTION 4

Government investments in risk-sharing arrangements that pool resources to cover contraceptives and other reproductive health services can make sense if these arrangements also extend benefits to the poorer popula-

tion segments that cannot afford or do not have physical access to services in the private sector. But relying on publicly financed health insurance or social security to expand access to contraceptives and RH services has several disadvantages:[90]

- Organizing, administering, and financing national/state insurance or social security systems is a complex undertaking, and particularly difficult in low income countries where management, administrative, and record keeping systems are weaker and the number of people employed in the formal sector is smaller.
- A relatively small number of people are covered by these programs and those covered—salaried employees in the formal sector—are the most able to purchase contraceptive methods from the commercial sector.
- Expanding coverage to low income and hard-to-reach populations can be costly and administratively difficult in any country, rich or poor.
- National social insurance programs can crowd out the private insurance sector, reduce competition, create inefficiencies and increase costs.
- Designing national social insurance programs that protect the economic interests of major provider professional groups can be difficult (pharmacists defeated a national health insurance model proposed in Nigeria that allowed clinics to dispense non-emergency drugs).
- Management capacity in the social insurance sector may be insufficient to guard against
  - Adverse selection that occurs when lower-risk and healthier population segments opt out (not possible under compulsory insurance), thus reducing the positive effect of risk-pooling and increasing costs; and
  - Moral hazard that occurs when the insured overuse expensive services and cause costs to rise (this can be avoided with co-payments and deductibles).

DISCUSSION OF OPTION 4

Annex D includes a discussion of several important issues related to publicly financed social health insurance and contraceptives/RH services, including:

- The impact of extending risk-coverage on government resources and the "reach" of government services; and
- Mandating employer-provided coverage and/or services.

Two key issues are discussed below:

- Targeting subsidies using market segmentation analysis; and
- Scaling up national social insurance to more widely expand benefits to the disadvantaged.

◄ Box 4.1 ►
Reforming Colombia's National Social Insurance System to Increase Contraceptive and Other Health Services to the Poor

In 1993, Colombia completely restructured its national social insurance and health care system that had been segmented into three parallel systems. The first was a social insurance program run by the Social Security Institute, which covered employed workers. The MOH provided free health services to those outside the social security system, and the private sector provided services to its clients.

With regard to family planning and other RH services, Colombia's dynamic family planning NGO, PROFAMILIA, dominated (and still dominates) the private sector market. The MOH (whose family planning program historically had been weaker) targeted the indigent for government family planning services. The Social Security Institute referred its covered clients to PROFAMILIA for family planning services.

Three main features distinguish the new health system: health insurance is now compulsory; everyone is guaranteed a universal package of curative and preventive (including family planning) services with free access; and there is regulated competition between insurers and between the public and private providers contracted by insurers. To help finance the new system, worker and employer contributions have been increased from 7 to 12 percent. All funds including earmarked revenue from the government, worker/employer contributions, and other rents, taxes, and revenue go into a Solidarity Fund which is responsible for financing and managing the system. As a result of these reforms, there has been a significant increase in funds for the social insurance system, rising from 2.73 percent of GDP in 1993 to 4.71 percent in 1996. Subsidies from government transfers, municipalities and a solidarity payment of 1 percent of worker/employer contributions go into a special fund where payments for health and preventive services such as family planning are targeted strictly to the poorest 30 percent of the population. (Puig-Junoy 1999; Gomez 1993)

Targeting subsidies using market segmentation analysis

Family planning subsidies are often not targeted. Although social security systems are intended to be largely self-financing, many rely on government subsidies to extend coverage for family planning services. These subsidies do not discriminate between wealthier and poorer beneficiaries. However, because populations covered by national social insurance tend to be more affluent, the better off disproportionately benefit from these subsidies. In order for governments to allocate more resources to expand contraceptive services for the disadvantaged, governments need to eliminate social insurance subsidies for the relatively wealthy. Market segmentation analysis can be used to achieve this goal.

In order for governments to allocate more resources to expand contraceptive services for the disadvantaged, governments need to eliminate social insurance subsidies for the relatively wealthy.

Market segmentation analysis as a targeting and policymaking tool for social insurance. One example of market segmentation analysis being used to reduce subsidized coverage of family planning services is in Turkey. Currently, the Ministry of Health provides free family planning services to any beneficiary of the country's three largest social insurance schemes. In fact, these beneficiaries make up 60 percent of the MOH's family planning clients. Thirty-seven percent of the MOH's family planning clients come from largest of these schemes, the SSK (Sosyal Sigortalar Kurumu) which covers most workers employed in the formal sector.[91] Market segmentation analysis was used to identify this subsidized population segment as a group that should be paying for family planning services since they are more affluent.[92] However, thus far SSK has been unwilling to reimburse the MOH for family planning costs incurred by its members and is instead advocating for larger central government allocations for the health sector.[93] As a result of the market segmentation analysis a sustainable self-reliance strategy is being developed by policymakers and social insurance scheme managers to ensure that their beneficiaries have continued access to contraceptives.[94]

Scaling up

National social insurance schemes have the potential to be scaled up to a level where they contribute significantly to ensuring reliable access to contraceptives for large numbers of clients. However, to successfully scale up a national social health insurance scheme to reach more of the disadvantaged, governments will want to:

- *Use market segmentation techniques to reduce/eliminate current subsidies for the relatively well off* who are able to pay for their own contraceptives and RH services;
- *Invest in action oriented research* to examine the financial costs and benefits of (1) offering low-cost, less comprehensive RH benefits packages to lower income groups, and (2) restricting contraceptive benefits to clinical methods under compulsory insurance systems;
- *Offer access to cheaper commodities from bulk purchases made by the public sector to employers* providing contraceptive services or coverage under government mandated insurance systems;
- *Engage in government-donor-insurer dialogue to ascertain if resources saved from self-financing systems are being redirected* to provide more contraceptives and services for the poor and under-served.

CONDITIONS FOR SUCCESS

In sum, expanding access to contraceptives and RH services with national social insurance is more likely to succeed when:

- **It is integrated into an already established system** that funds a significant share of health expenditure;
- **There are large numbers of workers employed in the formal sector to enroll** and thus spread risk more widely and make the system more financially viable and fair;
- **There is a mix of insurance, benefit package, and provider options** to avoid crowding out the commercial sector and to foster self-selection targeting;
- **Insurance packages are offered with more limited choices of contraceptive methods** to reduce costs and thereby increase affordability;
- **Contraceptive prevalence rates are relatively high** so that little investment is needed for demand creation;
- **Market segmentation analysis is used** to identify family planning market segments and target family planning subsidies to the poor and under-served;
- **Low income countries without mandated social insurance coverage** channel the more affluent into the private sector.

OPTION 5 Exploring a Contraceptive Independence Initiative Approach

DESCRIPTION AND RATIONALE

The Vaccine Independence Initiative (VII) vs. a Contraceptive Independence Initiative (CII). While Financing Options 1-4 are mechanisms for generating in-country revenue and "freeing up" government resources for contraceptives and RH services, Option 5 is an exploration of the feasibility of a new approach for facilitating procurement of contraceptives and moving toward self- reliance in contraceptive financing. The experience of UNICEF's Vaccine Independence Initiative (VII) and the more recent multisectoral initiatives such as the Global Alliance for Vaccines and Immunizations (GAVI) and the Global Fund for Children's Vaccines warrants careful study, as it may be highly relevant to contraceptive security efforts. The VII itself is modeled after a similar fund managed by the Pan American Health Organization that successfully operated in Latin America for more than 10 years. The core of VII is a revolving fund, initially capitalized by nine major donors and managed by UNICEF, which is currently valued at over $8 million. Since its inception in 1992, over $50 million worth of vaccines have been procured by 23 developing countries using the VII fund.[95]

Based on the VII model, a CII mechanism would facilitate the purchase of contraceptives in local currency for developing country governments that are facing a phase-out of donated commodities and must finance the shortfall with their own revenue. However, the VII has its limitations, is not suitable for every country, and is best viewed as an interim measure (see below under **Disadvantages**).

Which countries need the CII fund? Not all countries will need help with commodity procurement. In the case of vaccines, an increasing number of country governments purchase directly from manufacturers with hard currency (for example, the governments of Egypt, Sri Lanka, Nepal, Pakistan, Syria, and Zimbabwe). However, many governments choose to purchase through the VII. Assuming it operates like the VII, governments will prefer to use the CII fund if they:

- Wish to pay in local currency;
- Are small countries with small contraceptive supply needs or are larger countries financing only a part of contraceptive supply needs;
- Have complex and lengthy international procurement processes and procedures which make direct tendering difficult;
- Want to purchase through the CII's procurement and delivery system assuming that prices are lower and delivery is reliable (an important role that UNICEF plays under the VII).

TYPES OF SERVICES OFFERED BY THE CII

Because of its complexity and the current lack of available evaluative information, this paper cannot propose a "commodity independence initiative" for contraceptives. However, this paper can describe the four basic types of services being offered by the VII, and each of these could potentially be adapted and incorporated into the design of a Contraceptive Independence Initiative.

- **Planning and budgeting.** Technical assistance from the fund organizer/manager can be given to national Ministries of Health to strengthen local logistics management capability as well as to develop multi-year national commodity supply and budgetary plans for contraceptive purchases. Plans will take into account contraceptives available through local production as well as quantities required through international procurement. Once procurement, budgeting, and financing issues are resolved a schedule will also be developed for gradual assumption of all projected commodity costs by governments. Under the VII some higher income countries have planned to assume total responsibility for costs after only a few years while other, lower income, countries pledge to finance anywhere from 10 to 50 percent of supply needs.
- **Assistance with fostering inter-ministerial cooperation.** Advocacy and fostering dialogue between national Ministries of Health and Ministries of Finance and Planning are key to assuring adequate budgetary resources and a payment system for contraceptives over the long term. Based on the experience with the VII, the CII will have to ensure that the fund's budgeting and payment system is in agreement with country regulations. This can be tricky since each country has different procedures for advancing and disbursing funds to its Ministry of Health.
- **Flexible credit terms,** including the option to pay for contraceptives in local currency and to delay payment until after the contraceptives are received.

The experience of UNICEF's Vaccine Independence Initiative (VII) warrants careful study, as it may be highly relevant to contraceptive security efforts.

- **Access to an international procurement system** that buys in bulk to ensure that the lowest price possible will be paid for contraceptives.

BENEFITS OF OPTION 5

Experience with global vaccine initiatives has demonstrated that these benefits could be expected:

- **Increased access to hard currency for contraceptive purchases** with flexible credit terms that make it easier for governments to meet country commodity needs;
- **Increased funding support** from government ministries of finance for contraceptive procurement as a result of increased advocacy and better budgetary planning.
- **Increased capacity to do budgetary planning, forecasting, and procurement** that moves governments toward contraceptive self-reliance;
- **Increased ability to access contraceptives more cheaply** by being part of a larger pooled procurement mechanism;
- **Increased international capacity** to build commercial sector-government-donor partnerships by increasing the global managing entity's capacity to provide technical assistance and negotiate, procure, and distribute contraceptives on behalf of governments;
- **Increased leveraging for contraceptive commodity purchases.** As of mid-1999, the $8.2 million VII revolving fund has purchased more than $50 million in vaccines.

DISADVANTAGES OF OPTION 5

Policymakers must weigh the possible negative effects before embarking upon the design of a CII mechanism. Based on available data, a CII mechanism—like its VII counterpart—is probably best viewed as only an interim measure, implemented in conjunction with programs designed to strengthen budgeting, planning, and procurement capabilities. These data have also highlighted some weaknesses in the VII model.[96] For example:

- **A CII needs to include firm commitment by the government to increase funding for contraceptives.** Some VII programs have been criticized for lacking "teeth" in terms of actually increasing government funding, and thus contributing to long-term vaccine dependency.
- **Very precise timing is required to make all the program elements work and there is little room for error.** Administrative delays from either the procuring country or the fund organizer/manager can disrupt the system. In Morocco, for example, billing and funds transfer delays caused major administrative slowdowns and subsequent problems with local currency absorption. In addition, UNICEF/Rabat had need for local currency at almost exactly the same time the government made its payment; and the revolving fund had to be replenished in time to support procurement consistent with the re-supply schedule. These conditions were not always met.
- **The financial policies of the procuring government and the requirements of the fund organizer/manager are not always compatible.** In Morocco, unresolved tax issues on the imported vaccines procured by the VII and whether or not to fix prices in local or hard currency were not resolved before start-up.
- **Focuses too narrowly on supply issues.** The VII program in Kazakhstan focused on supply issues while ignoring other key concerns such as the inadequate cold chain, the need for key inputs such as vaccine commodities (needles, syringes, transport equipment) and technical assistance to improve logistics. An EU evaluation of programs in West Africa found that more capacity building in supply planning and inventory controls was crucial for the fund to work.
- **Undermines local private sector producers, importers and distributors of contraceptives.** A CII mechanism has the potential to distort the marketplace. One local producer/importer in Morocco felt that the VII fund competed unfairly for government business, and undermined the ability of the private sector to compete (and survive) in the marketplace.
- **There are hidden costs in CII arrangements that raise overall contraceptive commodity costs.** Hidden CII costs include interest lost on prepaid funds, the possibility of a local currency devaluation between commitment and payment, high import duties and taxes, interest paid on borrowed funds, freight and handling costs, and management fees charged by the fund organizer/manager. In Kazakhstan, for example, UNICEF would not accept local currency as payment, thus requiring a large input of hard currency from a donor. These funds had to be locked into a vaccine procurement account that could not be used for any

A CII mechanism—like its VII counterpart—is probably best viewed as only an interim measure, implemented in conjunction with programs designed to strengthen budgeting, planning, and procurement capabilities.

other purpose. An evaluation of the arrangement found that if the country's vaccine fund had been able to revolve (which was not the case) and be paid in local currency, the donor contribution to vaccine procurement could have been reduced by two-thirds and the same quantity of vaccines procured.

Many questions need to be addressed before serious consideration can be given to the design or initiation of a CII arrangement. These include:

1. **How much would be required to capitalize the fund?** Investigation is needed on which countries would need hard currency from a CII mechanism and how much would be required. Further work is also required on how much hard currency is needed to seed a revolving fund to meet this requirement and its potential "leveraging" power.
2. **How much would contraceptives cost when procured through a CII mechanism?** Taking into account fees that would have to be charged to cover program costs, interest payments, import duties and local taxes, would the cost of contraceptives procured through a CII mechanism actually be lower than buying them directly from the marketplace?
3. **Who would run a CII?** A CII requires an organization with global reach and appropriate technical skills to run it successfully. Would a new organization have to be created or a consortium built from existing organizations to meet the myriad of needs and technical capabilities? What levels of staff and kinds of expertise would be required? How much would it cost?
4. **How will contraceptive logistics costs be covered?** CII may be able to procure contraceptives at low prices, but if an adequate logistics system is not in place to distribute them effectively, contraceptive availability will not be achieved. Will CII be willing and able to invest in ensuring an adequate contraceptive supply chain?
5. **What has been the more recent experience in global efforts to promote vaccine availability, and how is it relevant to contraceptives?** The Global Alliance for Vaccines and Immunization (GAVI) is a multisectoral partnership that has revitalized, even revolutionized worldwide vaccine programs, along with the Global Fund for Children's Vaccines. While quite new, these efforts deserve careful examination for findings and approaches that may be applicable to enhanced contraceptive security.[97]

CONDITIONS FOR SUCCESS

A Contraceptive Independence Initiative approach to achieving self-reliance in contraceptive procurement and financing is more likely to be successful when:

- **The benefits of doing business with a CII mechanism outweigh the costs,** meaning that countries are not harming the capacity of their private sectors to meet supply needs; an unhealthy dependence is not created; and the costs of contraceptives procured through a CII are substantially lower;
- **Strong technical assistance in advocacy, logistics management, contraceptive forecasting, and budgetary planning are available** to strengthen central and local capacity and foster higher government funding for contraceptive supply purchases;
- **Procurement and supply chain management capacity are available** for accurately estimating contraceptive supply needs, making advanced purchases, and consolidating procurements;
- **Government funding for contraceptive purchases** (including projected growth in government funding) are clearly understood and spelled out;
- **The CII Agreement clearly describes credit terms and the amount of soft and hard currencies** that will be involved in fund transactions.

A Contraceptive Independence Initiative may be able to procure contraceptives at low prices, but if an adequate logistics system is not in place to distribute them effectively, contraceptive availability will not be achieved.

◄ PART IV ►

CONCLUSIONS

4.1. ENHANCING THE PROSPECTS FOR ACHIEVING CONTRACEPTIVE SELF RELIANCE

The most important immediate problem is that surprisingly little data exist on financing options for contraceptives in developing countries; therefore, the first priority is extensive operations research to answer the many policy questions surrounding the vital issue of long-term contraceptive self-reliance.

Key Policy and Program Tools: Market Segmentation and Targeting

Embedded in all five financing options are the key policy and program tools of market segmentation and targeting. These two tools stand out in their potential impact on financial sustainability, and dramatically improving access to contraceptives for the poor and under-served. Market segmentation and targeting are most effective at the *national* or macro-level, but are also powerful tools within a given service program. National level market segmentation refers to the evolution of a national policy that results in a clear identification of citizens requiring a "safety net," and then targeting public resources to the poor and disadvantaged who have no place to go other than the public sector for contraceptives. The remainder of society (or other market segments) can, by definition, pay for all or part of their contraceptives, meaning the commercial sector can serve these people and reduce the burden on government.

The "downside" of this approach is that for most developing countries, it will require a major restructuring of roles, capacities, and interests, as well as making policy changes and providing financial and other incentives. Given the fundamental nature of the changes involved, implementing these changes will not happen quickly, even in the best of circumstances. Inevitably, market segmentation and targeting on a national scale will require years of work, firm commitment from governments, serious and creative efforts to overcome obstacles, and sustained assistance from donors and technical agencies.

The Need for Multiple Financing Approaches

Policymakers must seek to finance contraceptive commodity needs in a comprehensive way because no single financing option is likely to succeed on its own. In addition, some options can be implemented—or expanded—almost immediately, whereas making serious progress on others (such as national market segmentation and expanding the private sector) is more likely to require a longer-term effort. Government policymakers must also be aware that even a single financing option—whether it is charging for contraceptives, providing subsidized contraceptives only for the poor, or lowering the sales tax on contraceptives—will have a ripple effect throughout the public and private sector marketplace with perhaps unanticipated effects on contraceptive self-reliance.

Important Steps towards Contraceptive Self-reliance

Countries that have made the most progress toward contraceptive self-reliance have undertaken some or all of the following steps. Note that these steps are taken with the support and encouragement (and sometimes at the insistence) of the major contraceptive donor(s) supplying the country's commodity needs.

- Country policymakers have developed a good understanding of the amount of funds required to meet national contraceptive requirements (and the amount of the estimated shortfall);
- Realistic financial goals have been set (including cost recovery targets with finance leveraged from communities or directly in the public sector) and a timeframe and plan to meet these goals have been put into place for reducing this shortfall;
- Market segmentation analysis has been used to identify and target clients who will continue to need subsidized contraceptives and those who can purchase contraceptives;
- Segmentation policies and strategies have been implemented that encourage clients who do not need subsidized contraceptives to seek them in the private sector;
- Policies, legislation (e.g., tax breaks, import incentives, loan opportunities) and regulations are in place to encourage commercial sector growth;
- Legislation has been enacted mandating social security systems to cover contraceptives;
- Systems have been developed to collect data on costs, revenues, and expenditures to track how well contraceptive financial goals are being met; and
- People have been trained at all levels of the service delivery system to increase financial management and administrative capacity for contraceptive self-reliance.

◄ Table 2 ►
Potential Savings in Contraceptive Commodity Costs by Restricting Subsidies to Clients below the Poverty Line

Country	Population Below Poverty Line (%)*	Source of Supply for Contraception (%)**		% Able to Shift to Private Source	Total MWRS in Year 2015 (000s)**	MWRA Able to Shift to Private Source in 2015 (000s)	Amount Saved (US$) (000s)**	Projected Public Costs in 2015 (US$) (000s)**	Savings as a % of Projected Public Costs
		Public	Private						
Low Income									
Bangladesh	35.6	74	26	35,427	16,883	47.7	27,837	23,467	118.6
Kenya	42	58	42	6,346	2,135	33.6	3,892	12,035	32.3
Nigeria	34.1	40	60	30,451	8,027	26.4	5,946	27,737	21.4
Ghana	31.4	26	75	5,228	932	17.8	865	4,905	17.6
Togo	32.3	48	52	1,126	366	32.5	345	1,542	22.4
Indonesia	15.1	43	57	45,651	16,666	36.5	37,204	86,294	43.1
Zimbabwe	25.5	85	15	2,412	1,527	63.3	1,941	5,107	38.0
Lower-Middle Income									
Sri Lanka	35.5	87	13	3,322	1,864	56.3	2,402	4,185	57.4
Philippines	37.5	72	28	15,537	6,992	45	8,756	19,483	44.9
Jordan	15	28	72	1,395	332	23.8	537	933	57.5
Morocco	13.1	63	37	4,985	2,729	54.7	4,562	7,103	64.2
Peru	49	70	30	5,102	1,821	35.7	2,328	6,000	38.8
Colombia	17.7	27	73	7,738	1,719	22.2	2,210	5,145	43.0
Upper-Middle Income									
Mexico	10.1	62	38	19,790	11,031	55.8	13,980	18,530	75.4
Savings/Costs							112,805	222,463	50.7

*Data from The World Bank. *World Development Report 1999/2000* (New York: Oxford University Press, 2000).

**Based on data from Ross et al. *Profiles for Family Planning and Reproductive Health Programs* (Glastonbury,CT: The Futures Group International, 1999).

4.2 ADDITIONAL ISSUES THAT NEED TO BE ADDRESSED

The Enduring Problem of Dysfunctional Public Subsidies

In spite of efforts by governments and donors to increase the financial sustainability of contraceptive services, large numbers of clients who can afford to pay for contraceptives continue to receive them free from the public sector. Many governments remain reluctant to charge for contraceptives because 1) it may be politically unpopular and family planning is often considered a public good that should be provided free; and 2) the fear that contraceptive use may decline if fees are charged. Unfortunately, continuing to provide subsidies to those who can afford to pay constrains the growth of the commercial sector in providing contraceptives, increases the financial burden on the public sector, and further undermines prospects for achieving contraceptive self-reliance.

The serious financial impact of these subsidies is clearly shown in Table 2 where, for illustrative purposes, we have calculated possible savings in public sector contraceptive commodity costs if governments restrict the provision of free contraceptives to clients who are unable to pay for them. The illustrative calculations for 14 low- and middle-income developing countries assume that subsidies for contraceptive commodities are provided only to clients who are below the poverty line. Table 2 shows that all countries would benefit financially from restricting family planning subsidies to clients below the poverty line. Significant savings in commodity costs would accrue to countries such as Mexico, Morocco, Sri Lanka, Bangladesh, Zimbabwe, and the Philippines, where a large majority of the population still receives subsidized contraceptives in the public sector. Although the range is from about 17 percent (for Ghana) to 100 percent (for Bangladesh), as a whole the 14 countries could save over half of their projected commodity costs by the year 2015 if governments supply free contraceptive services to only those who are unable to pay for them.

The Problem of Poor Documentation of Contraceptive Financing Experience to Date

The literature contains relatively few well-documented examples of the experience or results of pilot or national scale programs that charge for contraceptives in public health facilities, in social security systems, or as part of community financing initiatives. This is especially true with regard to revenue and/or savings generated. Most examples cited in the literature focus on comprehensive health programs. Those that focused on family planning programs usually examined fees for services in the public sector, price structures, the effects of fees on family planning demand and use, or on income groups that benefit from subsidies—but not on actual revenues or cost savings.

Action-oriented research is urgently required to document actual revenues and cost savings before policy and implementation decisions can be taken regarding changing contraceptive commodity financing. Since documented family planning experience with Options 1 and 2 is limited, evaluative research is needed to ascertain 1) how effective these options are in generating revenue; 2) whether they encourage clients to switch from public to private sources of supply; and 3) what effect these options have on overall demand for contraceptives. Ongoing evaluative research will also be needed for Option 3 to understand how expanding private sector market share in contraceptive services affects government resources and resource use, particularly with respect to services for the poor. For Option 4, research is needed on the effectiveness of national health insurance or social security systems in covering contraceptives/RH services. Research on Option 5 is needed to determine the interest, viability, cost and institutional requirements for a Contraceptive Independence Initiative.

4.3 PROPOSED ACTION AGENDA

Identifying the Best Financial Options for Each Country

Depending on the level of socioeconomic development, the degree to which the demand for family planning is firmly established in the marketplace, and a tradition of paying for social services, some countries will be better able than others to mobilize new sources of finance for contraceptives. However, the fact is, donor funds as a share of total resources for contraceptive purchases are in decline, and most developing country governments currently do not have the revenue to make up the difference. **These governments must act now if they are to avoid potentially serious contraceptive shortages in the coming years.** Governments that have hesitated to move wealthier clients to the private sector for fear of hurting prevalence rates have a larger concern on the horizon: the prospect of national contraceptive stock-outs.

Countries that have begun to deal with the issue of contraceptive self-reliance have discovered that a combination of financing options is more likely to succeed than choosing only one option. Based on documented experience, the following guidelines should help determine which financing options, policies and tools will be most effective in a particular country context.

Financing Guidelines Based on the Five Options

FOR ALL COUNTRIES:

- **Use market segmentation and establish a "safety net"** and then systematically strive to reduce the contraceptive commodity burden on the public sector. As part of segmentation, governments must also take seriously the need to target scarce public sector resources, and shift wealthier clients away from publicly subsidized services.
- **Quantify the amount of contraceptives required,** now and in the future, and then determine the shortfall in funding required to meet the full demand for contraceptives. Set realistic targets for funding an increasing proportion of contraceptive purchases from government sources and thus reducing dependence on donors.
- **Create a foundation of enabling legislation, policies and regulations for the option(s) eventually chosen.**
- **Explore the option of charging fees for contraceptives/RH services.** Charging fees (Option 1) often encourages the better-off clients to shift to non-subsidized sources of supply and—at the same time—stimulates the commercial sector to increase RH service delivery.
- **Explore ways to expand the role of the commercial health sector.** Enacting enabling legislation, providing incentives and reducing barriers are basic steps each country can take to help expand the commercial health sector (while still regulating to protect public health goals).
- **Work at the community level.** Countries should "empower" local communities to initiate their own funding schemes (Option 2), especially for commodity re-supply.
- **Lay the groundwork for social insurance.** The permanent solution is to design and implement social insurance systems that create enduring, long-term financing for contraceptives/RH services on a national scale.

FOR LOW-INCOME COUNTRIES:

Because of high rates of poverty, the poorest countries will have difficulty in moving many clients from the public to the private sector. For these countries, there is a high probability that they will remain dependent upon international donors for their contraceptive commodities, even though donors' commitment to full supply is not assured. Nevertheless, there are actions that low-

income countries can take to move toward contraceptive self- reliance:

For countries with higher prevalence rates, market segmentation and charging for services (Option 1) and community financing (Option 2) are likely to be effective in generating more revenue for purchasing contraceptives. Higher prevalence rates may be taken as an indicator that clients and/or communities are more willing to pay for contraceptives/RH services. At the same time, expanding the role of the commercial private sector in RH service delivery (Option 3), with incentives and policies that reduce barriers to the private sector, is important even in countries with small commercial sectors. Every expansion of service, no matter how small, is a net gain for the country.

For countries with lower prevalence rates, Option 1 is still recommended, because it helps to target subsidies on the poor who need them; however, Option 1 is unlikely to generate much immediate revenue, especially if the country is poor. This will also be true with Option 2, because community financing for contraceptives/RH services is less likely to recover costs where demand for contraceptives is low. Incentives to mobilize the private sector (Option 3) are strongly recommended in lower prevalence countries.

FOR MIDDLE-INCOME COUNTRIES (HIGH OR LOW PREVALENCE):

Middle-income countries that are committed to achieving contraceptive self-reliance have the potential to do so by market segmentation, targeting to protect poor clients, policies that encourage the better off to seek services outside the public sector (Option 1), and policies that energize the commercial sector (Option 3). Community financing initiatives (Option 2) in these countries may focus on prepayment plans that include family planning as a way to move toward developing a national health insurance program. National social health insurance or social security programs (Option 4) are more prevalent in middle-income countries and these can be made to include contraceptives/RH services.

FOR DONORS AND TECHNICAL AGENCIES:

All the five options will require donor support if they are to be implemented. Putting Option 5 into action (the Contraceptive Independence Initiative) has the potential to benefit smaller and poorer countries by making hard currency and technical assistance available for contraceptive procurement.

4.4 BEYOND THIS PAPER—ADDRESSING CONTRACEPTIVE SELF-RELIANCE IN A HOLISTIC WAY

Dealing with the problem of contraceptive self-reliance in a holistic way means addressing issues that this paper does not cover, for example, actions that improve *effectiveness* and *efficiency of contraceptive supply chains,* including dispensing practices. Decisions regarding efficient commodity procurement and distribution systems, reducing wastage, increasing low staff productivity, the hiring of unnecessary staff, and developing standards to reduce incorrect or unnecessary treatments and services still need to be addressed by government managers and policymakers. Implementing such actions to increase effectiveness and efficiencies will help to contain costs, and in some cases even reduce costs, and thus contribute to contraceptive self-reliance.

In addition, none of the financing options will automatically increase government allocations for contraceptives/RH services—hard choices still need to be made by policymakers regarding budget allocations. For example, can a health ministry afford indefinitely for as much as 85 percent of its recurrent budget to be spent solely on salaries (as is currently the case in some developing countries)? Are the political and economic consequences of shrinking the government payroll greater than the negative impact of national contraceptive stock-outs? To achieve contraceptive self-reliance, these five financing options must be coupled with initiatives and policies that increase effectiveness, efficiency and the overall allocation of government budgets to contraceptive procurement. All of these actions, taken together, offer countries an opportunity to make important progress in the long-term goal of achieving contraceptive self-sufficiency.

None of the financing options will automatically increase government allocations for contraceptives/RH services—hard choices still need to be made by policymakers regarding budget allocations.

◄ ANNEX A ►

■ ADDITIONAL DISCUSSION OF FINANCING OPTION 1 Charging Fees for Contraceptives (RH Services) in the Public Sector

POTENTIAL IMPACT OF REVENUE GENERATED

Interpreting the data. Data needed to critically examine the effect and potential of user fees in RH programs in developing countries are not easily available. Although the financial management and accounting systems of many higher-middle and middle-income developing countries may be advanced enough to track revenue generated from user fees for contraceptives, with one exception (a study on Colombia), this information is not found in the literature. However, there are some data in the literature on revenue generated from pilot studies of user fees in health programs in sub-Saharan Africa. Most low-income countries' financial management and accounting systems are weak, and revenue data—if available—tend to be unreliable. Compounding the problem of poor record keeping, revenue collected at different levels of the health system may remain at the facility level or it may be forwarded to central treasuries where it is mingled with other government revenue. Moreover, fee revenue from family planning programs is rarely reported separately from overall health fees.

Cost recovery at the country level. National user fee systems in sub-Saharan Africa have generated an average of about 5 percent of total recurrent health system expenditure, including administrative costs.[98] Cost recovery ranges from a high of 15 to 20 percent (Ethiopia, 1984-1986) to a low of 0.5 percent (Burundi, 1982).[99] In Colombia, income from user fees covered 18.2 percent of MOH expenditures on health in 1991 and 16.3 percent in 1990. Cost recovery levels from user fees can fluctuate over time and be greatly influenced by factors such as fee increases, improvements in collection and administrative practices, inflation, economic recession or war.

With regard to family planning, charges for contraceptives and services recovered 49.8 percent of total expenditures in Colombia; of this amount 40.1 percent came from the sale of contraceptive commodities while 9.7 percent came from fees for services.[100] Other sources of revenue for family planning included international donations (17 percent), government allocations (16 percent), other revenue generation activities of PROFAMILIA (7.9 percent), and employer-employee contributions (6.9 percent).[101] Although it is exciting to see that contraceptive sales and services can cover almost half of family planning program and commodity costs, unfortunately this number is by no means representative, nor is it current. During 1992, PROFAMILIA still received free commodities from USAID, which were sold to generate revenue. USAID commodity donations were phased out by the mid-1990s. As contraceptives are now purchased on the commercial market, margins from sales are probably much smaller. More recent data need to be obtained from this and other programs to get a realistic picture of the potential for generating revenue from contraceptive sales.

Cost recovery at the district and facility level. Although data are limited for contraceptives and services, fees and/or fee increases for pills and condoms introduced in two districts in Bangladesh resulted in cost recovery ratios ranging from 6.2 to 7.5 percent in the government and NGO facilities studied.[102] No explanation is given as to which costs were included in these ratios. What is more striking is the fact that the improved accounting and administrative systems introduced with the fees reduced pill wastage by 40 to 50 percent. The authors suggest that if the improvements from this intervention were introduced nationwide, savings from the elimination of pill wastage alone could save the country as much as $4 million a year. In Thailand, large fee increases were introduced in government health centers and district hospitals for pills and injectables in four districts, and for pills distributed by volunteer health workers in two districts; the impact on revenue generated was studied. After the fee increases, the amount of revenue collected rose by a low of 51 percent in one district to over 2000 percent in another.[103] The results were so encouraging that the author suggests that further price increases could be made that—depending on the district—could double, triple, or even quadruple available revenue for financing contraceptives and services in the public sector.

At the level of primary care facilities, where costs are lower, charges for health services (data were not available for family planning per se) can cover a large share of non-salary recurrent expenditures such as drugs, medical supplies, equipment, maintenance costs, and even staff salary supplements. For example, 97 percent of non-salary operating costs in lower level health facilities were covered by fees in some health zones in the Democratic Republic of Congo, and over 100 percent of operating costs were covered in Guinea.[104] In Ghana's Volta Region, fees collected at government health facilities cover between 66 and 80 percent of non-salary operating expenses.[105]

In many countries, some or all of the fees collected at the facility level are forwarded directly to national treasuries, and it is usually not clear how this revenue is used. In countries where governments do not reinvest fee revenue in the health sector (a difficult determination to make given the limitations of the data), introducing fees may not increase resource levels for health services.[106]

MANAGEMENT AND ADMINISTRATION

Existing capacity. To effectively manage revenue generated by fees, adequate accounting and resource management systems and skills are required at all levels of the health system. These systems and skills often do not exist. Many developing country governments are decentralizing responsibility for managing services, including fee revenue, to local authorities without first giving them adequate preparation or resources to carry out their new functions.[107]

Actions needed. To survive the transition from being a donor-dependent organization to one that is more self-sufficient, PROFAMILIA in Colombia initiated major organizational changes. For example, PROFAMILIA now has one of the world's most highly developed cost recovery programs, based on a system of user fees, that could serve as a model for programs and countries.[108] The PROFAMILIA system:

- established clear financial objectives and goals;
- updates the estimation of total and unit costs quarterly;
- uses a highly structured accounting and budgeting system with decentralized components to account for fee income collected and its use;
- reviews (at least annually) user fee charges and policies;
- monitors the production of services rigorously;
- routinely verifies the quality of services delivered through on-site inspections and client interviews;
- operates a sophisticated administrative system that tracks fee collection, utilization and factors influencing yields; and
- conducts routine demand and demographic surveys and adjusts fees and services accordingly.

Most public sector user fee and cost recovery systems do not come close to PROFAMILIA's high standard. Governments may need to take the following actions to strengthen financial management capability at different levels of their health systems:

- Define the critical functions in the financial management system such as responsibility for fee management, authority to make decisions, and accountability for financial and program performance, and link them together as closely as possible.
- Modify the legal and regulatory framework to accommodate decentralized fee management systems. This will reduce confusion and potential disputes over the use of fee generated revenue.
- Revise or design new financial management systems and processes to account for user fees when they are introduced.
- Estimate the human and resource costs of establishing and maintaining new fee systems and determine whether these costs are sustainable.
- Phase in decentralized financial management systems, and the concomitant transfer of authority, in a way that allows for "learning by doing" and on-site adjustments to overcome problems.
- Conduct a job analysis for all categories of staff to define precisely what skills are needed to operate the new fee system effectively; then train staff accordingly (in planning, budgeting, accounting, financial management, supervision, etc.).

- Nurture commitment to decentralized resource use and control by keeping people informed and resolving conflicts between the "old way" and the new system.
- Revise and refine the decentralized system continuously through routine monitoring and evaluation.

In summary, it is important to 1) set realistic financial goals, 2) develop a sound methodology for estimating potential revenue, and 3) estimate the costs of establishing the administrative systems required to account for fee generated revenue. The phased implementation of activities according to absorptive capacity, with sufficient attention given to capacity building, is vital. Implementing an effective fee system on a national scale can take as long as a decade.[109] And, in some countries where administrative capacity is very low, the costs of upgrading administrative systems to implement a decentralized fee system can be high—sometimes too high to make fees a viable financial option.[110]

EFFECT OF FEES ON DEMAND FOR SERVICES

What effect does charging for services in the public sector have on the demand for contraceptives/RH services, particularly among the poor? Unfortunately, the evidence is often conflicting and methodological flaws in the research may have affected the accuracy of findings that seek to answer this question.[111] A short summary of the evidence cannot do justice to the complexity of the issue, or to the variation in findings by country and sub-population. That said, the literature indicates that very low and even moderate fees for contraceptives/RH services seem to have little impact on demand, even among the poor. Steep increases in prices, however, often have a devastating effect on the ability of clients—particularly poor clients—to access services. Recent family planning demand studies conducted in sub-Saharan Africa—Cameroon, Ghana, Tanzania, Zimbabwe, and Nigeria—tend to support these assertions.[112]

The negative effects of user fees are likely to be most keenly felt in low-income countries where the ability to pay for services is more limited, where demand for contraceptives and services is less firmly established, and where contraceptive prevalence rates are lower. On the other hand, more positive results are found in Thailand, where income and contraceptive prevalence levels are much higher. There was no change in contraceptive prevalence levels—even among the poorest—when large increases in prices were introduced in Thai public facilities for injectables and oral contraceptives.[113] There was, however, method switching (from orals to injectables) among the poorest—attributed to "sticker shock" over pill prices (the price increase for orals was much higher) and the need to reduce travel costs (fewer trips to the facility for the same coverage if using injectables). Similar results are found in two studies in Bangladesh, another country with relatively high contraceptive prevalence. In one, price increases in government and NGO clinics led to method switching but did not lead to a decline in contraceptive prevalence.[114] In the other, price increases introduced by the Social Marketing Company did lead to a drop in sales from users switching to other sources of pills and condoms but did not affect overall prevalence.[115]

MITIGATING THE NEGATIVE EFFECTS OF USER FEES BY IMPROVING QUALITY

With regard to health care services, research in Africa indicates that introducing quality improvements in facilities helps offset the negative effects of charging for services.[116] The studies also indicate that the probability that quality improvements will be made is much higher if health facilities are allowed to keep and use some portion of fees collected. Other studies actually show an increase in utilization—even among the poorest—if user fees are accompanied by quality improvements, particularly the increased availability of drugs.[117] However, quality improvements can be costly.[118] Important quality improvements such as increasing staff courtesy to patients cannot simply be addressed by generating fee income.[119] And, finally, demand for quality improvements (and the willingness to pay for them) in family planning programs may be less than for other types of health care services.[120]

◄ ANNEX B ►

■ ADDITIONAL DISCUSSION OF FINANCING OPTION 2
Community Financing for Contraceptives

COMMUNITY PARTICIPATION INCREASES THE LIKELIHOOD OF SUCCESS.

Separate the provision and financing of services. Ideally, communities should become the managers of their prepaid plans, negotiating service arrangements with providers that spell out the types of services to be provided, expected levels of quality, cost and the method(s) of payment. Thus, an important desired outcome of community participation is that the provision and financing of health/RH services are clearly separated; service providers can then be held accountable for the level and quality of services they provide. In reality, this degree of community control is rare because most communities do not yet have the capacity to exert this level of control.

Nonetheless, more successful (sustainable) community financing programs have higher levels of community participation in the organization and financial management of services. One example where the lack of community participation resulted in program failure is in Ghana, where community members subscribed to a prepayment plan under the Nkoranza Community Finance Scheme, a low participation community-finance model set up like an HMO. Under this scheme, the NGO service provider (a Catholic hospital) exerted complete financial and managerial control over the plan. Year after year, community members dropped out of the scheme, causing its eventual collapse. Community members felt the program belonged to the NGO, not to the community, and that earnings were not being used to improve service quality but to maximize the NGO's revenue. It has since been reorganized.[121]

Balance the need for an outside catalyst with community ownership goals. Most community financing programs require an outside catalyst (public or NGO) to help organize the community and provide it with technical assistance to develop its organizational and managerial capacity. Introducing prepaid mechanisms poses a particular challenge. Although the concept of "solidarity" or risk sharing is not new to most cultures, health insurance and its financial and managerial requirements often are. As a result, social insurance (as well as the simpler fee-for-service arrangements) is usually initiated not by the community, but by health providers, who tend to control the program. Community ownership of the program often does not develop, or is weak. The literature shows that the more successful community financing programs find a healthy balance between the community as 'consumer of services' and the community as 'empowered owner' on the one hand, and the outside catalyst as 'controller' and the outside catalyst as 'facilitator' on the other.[122]

IMPROVING QUALITY

Without a minimum level of quality improvements—which for many communities is ensuring the availability of essential drugs—community support for user fee and prepayment plans often collapses.[123] The same is true for ensuring contraceptive supplies, since without them there can be no contraceptive services. There is substantial evidence that clients are willing to pay for quality improvements, especially ensured availability of essential drugs.[124] Both user fee and social insurance mechanisms have been shown to be effective in improving quality, particularly with regard to ensuring drug supplies, when at least a portion of fee revenue remains at the collecting facility.[125] Moreover, quality improvements have the capacity to override many of the negative effects that increased fees may have on demand and utilization.[126] Quality improvements are also linked to successful cost containment, such as using personnel efficiently and adopting standards so that services are provided 'right the first time.'[127] The combination of increased revenues from community financing and cost controls has the potential to make more funds available for further quality improvements.

IMPROVING EQUITY AND ACCESS

The difficulty of direct targeting. Direct targeting in community financing programs (using means tests or other exemption mechanisms) tends to work no better than described under Option 1. The same problems are found: the truly poor may not be exempt from paying while the better off may receive free services. Standing (1997) notes the "fruitless search for appropriate income-based criteria to determine who gets exempted, and the great difficulty that even communities have in implementing exemptions in a fair way." Distinguishing the poor from not-so-poor is fraught with pitfalls since income is an "ever-changing patchwork of the tangible (e.g., seasonal cash, land) and the intangible (e.g., gifts, informal credit)."[128] Another reason why the poor may not be well protected by direct targeting approaches is that there are strong incentives for communities not to grant exemptions, since doing so leads to revenue loss.[129]

The effectiveness of characteristic targeting. Many communities have been more successful in using characteristic targeting, rather than direct targeting, to define the truly indigent. Readily understood social categories such as widows, victims of natural disasters and the blind have been exempted from paying. These categories of vulnerability, while narrow, may be easier and more effective for communities to implement than categories based on income.[130]

Encouraging competition and self-selection targeting. The literature provides virtually no examples of self-selection targeting being used in community financing as part of user fee or prepayment mechanisms (the Babouantou Mutual Aid Association in Cameroon, as described in Atim 1999, with membership based on ethnic group, is the one example found). Competition does not occur in many communities because of the lack of service providers. To encourage competition—even in rural areas—offering demand- instead of supply-side subsidies may work.[131]

Potential for using voucher systems. Vouchers are another community financing mechanism, with participants using vouchers for services (or choosing their provider and being reimbursed up to a certain amount). Perhaps such freedom of choice would encourage more NGOs, or even commercial providers, to enter rural markets. Other potential benefits of a voucher system include better quality services from providers who feel more accountable to their clients, and more competitive prices for services. However, voucher systems would require more sophisticated administrative systems than currently exist in many communities. Operations research is needed to document the potential costs and benefits of voucher systems for contraceptives/RH services.

Equity issues with risk-sharing arrangements. The annual premiums charged by prepaid plans can impose a hardship on poor households,[132] yet progressive prepayment systems (where contributions are levied according to ability to pay) face the same difficulty that plagues exemption mechanisms in user fee systems—determining who qualifies as "poor." In addition, while charging a flat premium to all members often causes hardship for poor households, rate concessions to the poor may alienate wealthier households or financially weaken prepayment arrangements.[133] Nonetheless, prepayment mechanisms seem somewhat better at improving equity and access than user fees.[134] The reasons for this success include 1) service costs are shared between contraceptive users and non-users, between the healthy and the sick, and between the rich and the poor; 2) certain target populations that frequently have difficulty accessing cash for services in times of need (such as poorer women) may have better access to care under a prepaid system;[135] and 3) in agrarian communities where cash may be readily available only after the annual harvest, the once-a-year premium (or tax) for prepaid plans may actually be easier to pay than fees for services paid at the time of need.[136]

ENHANCING EFFICIENCY

User fee and prepayment mechanisms used in community financing can cause inefficient service provider behavior, i.e., service providers may be tempted to over-prescribe drugs or provide unnecessary services to generate more revenue.[137] Some prepayment schemes may suffer from moral hazard if protective mechanisms such as co-payments are not introduced to discourage over-utilization, although high travel/time costs in seeking care probably helps dissuade unnecessary use.[138]

Community financing programs that are not part of the overall health system may encourage greater use of less cost-effective care when lower levels (the primary care facilities) charge higher fees than the higher levels (hospitals). This problem may be overcome by a graduated fee structure (higher fees in higher levels and vice versa). Use of the most cost effective service can also be encouraged by introducing "by-pass fees," and by making quality improvements that encourage use of appropriate lower level health facilities.[139]

MANAGEMENT AND ADMINISTRATION

Organization of community-financing management committees. There is great variation in the way communities organize themselves to manage and administer community financing programs. In Guinea, for example, management committee members are elected, while in Benin local leaders are appointed. In Niger, delegates from local committees are appointed to district-level management committees where funds from many communities are pooled. In Cameroon, the MOH has established a legal framework for creating a private non-profit solidarity fund at the provincial level. Communities elect members to sit on local health fund committees and delegates from these are chosen to serve in the general assembly of the provincial fund. In Thailand, funds are kept at the community level but managed by paid professionals who are, in turn, overseen by representatives appointed by the village. Thus, local traditions, skills and capabilities greatly influence the structure and organization of community financing programs. Whether or not these local management structures can operate successfully depends on the availability of supportive systems such as:

- secure banking facilities;
- outside private or governmental technical agencies to provide assistance and training;
- adequate pharmaceutical supply and distribution systems;
- national guidelines and regulatory mechanisms;
- robust management information systems (MIS) to track services and resource use.

Key inputs needed. Most communities will require outside skilled assistance to help with setting up and managing the daily operations of community financing programs. Administrative assistance from a credible outside source, for example, was crucial in providing legitimacy and financial accountability to community financed family planning services in Indonesia (in many cases, the national voluntary welfare organization (PKK) played this role).[140] In Thailand, the community pays professional drug fund administrators according to how profitable the fund is for its investors (village members). In Niger, trained administrators are hired to assist local and district management committees. The costs of trained management and administrative assistance can be fairly high and reduces available funds for community health services. However, if skilled administrators make funds more sustainable, and benefits outweigh costs, then this should be accepted as a necessary cost of community financing. In the final analysis, the success of community management depends on strengthening the financial management and oversight capacities of local members of management committees.[141] In many countries, the lack of sound financial management and audit systems is a pervasive problem throughout the health care system, but is often especially acute at the district or community levels. Because local capacity is weak, communities are not given authority to make decisions, participation remains low, and chances for long-term sustainability are undermined. Gilson (1997) refers to the 'chicken and egg relationship' between raising and managing finance at the community level through user fees (and other mechanisms) and decentralization. Although limited financial resources undermine the success of decentralized administration, raising local revenue to overcome this constraint calls for an effective decentralized management structure.

◄ ANNEX C ►

■ ADDITIONAL DISCUSSION OF FINANCING OPTION 3
Expanding the Role of the Private Sector in Providing Contraceptives

ASSURING QUALITY OF CARE IN THE PRIVATE SECTOR

Limited government capacity to ensure quality of private services. In the latter half of the 20th century, excessive government regulation constrained the growth of the private health sector in many countries. Paradoxically, many countries enter the 21st century facing the challenge of providing sufficient oversight of a rapidly growing commercial health sector. A study of the private health sector in Bombay, for example, documented medical negligence and substandard services in many of the city's private medical practices and private hospitals. This was attributed to weak standards, lax enforcement of regulations and overwhelmed authorities unable to oversee the burgeoning number of practitioners.[142] Similar problems exist in Nigeria, where the number of private physicians and private hospitals is expanding very rapidly.[143] In Malawi, where the state-run Medical Council has strict licensing requirements and a well-developed set of minimum quality standards, it cannot keep up with facility and medical practice inspections.[144]

The private sector cannot always be relied upon to police its members where government oversight is weak. In many countries, local medical and professional associations do not yet have the capacity for self-regulation and enforcement of quality standards.

Regulating private insurance. In a health system with many private insurers, governments often need to intervene with regulations and incentives that promote fair competition and equitable coverage, such as reducing "cream skimming" (where insurers enroll only the healthiest population segments to reduce the number of claims and maximize profits.)[145] Government monitoring is needed of population segments covered by insurance, the quality of care provided by the various insurance plans, and the level of consumer satisfaction. Since the financial viability of some private health insurers may be questionable, government oversight is also needed to protect consumers from badly managed plans. For example, in 1996 Nigeria was rocked by the collapse of its largest private health insurer that covered 17,000 enrollees and beneficiaries.[146]

Recommended actions. Two actions are suggested to redress the ineffectiveness and poor enforcement efforts of governments trying to ensure quality of care provided by the private sector.[147]

1. Even if enforcement capacity is poor, establish a minimum set of quality standards and regulations, including criteria for licensing and registration. This applies to the private insurance industry as well. As the commercial sector expands and becomes more established, it will only get harder for government to impose legal controls affecting commercial interests. Therefore, minimum quality standards should be established early in the process of commercial sector expansion.
2. Use incentives, instead of regulations, to ensure quality of care. Incentives are especially effective in more developed countries with some oversight capacity. For example, governments can use incentives such as tax relief, soft loans, subsidies or government guarantees to influence the behavior of private providers and insurers. "Good behaviors" would include working in under-served areas, insuring the more hard-to-reach or disadvantaged populations, providing more preventive services, or seeking accreditation by meeting quality standards. Taiwan has successfully linked eligibility for payments under its National Insurance Program to practitioner accreditation, which is an entirely voluntary procedure.

GOVERNMENT CONTRACTING WITH THE PRIVATE SECTOR

Advantage of contracting to governments. Increasing attention is being paid to the advantages of governments contracting with private providers to improve the efficiency of health service delivery. Experience to date has been in contracting for clinical services (for example, district hospitals in Zimbabwe and South Africa) and for non-clinical auxiliary services (for example, medical equipment in Thailand; catering services in Bombay; security and cleaning services in Port Moresby).[148] For clinical services, the rationale for contracting is efficiency, for example, providing service in an under-served area that would be difficult and/or expensive for the government service. For non-clinical services, the rationale includes lower costs, less burden on public sector managers, and an increased ability to use labor more flexibly (important where public employees are prone to strikes).[149]

Drawbacks of contracting. Although often seen as an alternative to inefficient government provided health services, contracting requires a strong governmental role in contract procurement, management, monitoring and financial management—systems that in many developing countries are weak.[150] Moreover, contracting calls for decentralized capacity in resource allocation and management, since bids often involve multiple local suppliers that are too numerous for central levels to effectively manage at a distance.

In many developing countries, the management capacity of lower levels of the health system is still too weak to be able to manage contracts effectively.[151] Common problems include contracts having been entered into where public authorities had little knowledge of their own costs as a basis of comparison; where little attention was paid to service specifications, incentives, or pricing methods; and where contract design and monitoring responsibilities were unclear.[152] The failure to define performance expectations and link them to penalties for non-performance doomed the outcome of some contracts in Zimbabwe.[153] A final drawback is that in poorer countries the number of potential private suppliers is often too small for there to be genuine competition.

WHEN TO CONTRACT OUT HEALTH SERVICES:

- Public sector staffing levels are considerably higher than those in the private sector (i.e., the private sector has higher worker productivity);
- Civil service conditions of service make it difficult for the public sector to use labor flexibly;
- Reducing staff or altering employment conditions in the public sector is politically difficult;
- Legal and banking systems exist to support contracting;
- Government procurement procedures are resistant to patronage or corruption; and
- Substantial numbers of potential private suppliers already exist and are providing services similar to those needed by the government health system.[154]

◄ ANNEX D ►

■ ADDITIONAL DISCUSSION OF FINANCING OPTION 4
Covering Contraceptives under National Health Insurance or Social Security Programs

IMPACT OF EXTENDING RISK-COVERAGE USING GOVERNMENT FINANCE

Saving government resources. Publicly financed or mandated insurance coverage for the employed workforce can be entirely financed out of payroll deductions and/or employer contributions. Government is thus relieved of providing health and family planning services to the workforce and can redirect public revenue to provide services (including contraceptive services) to lower income groups. Adding family planning services to self-financed social insurance also makes economic sense for social insurance fund managers. For example, studies of two social security systems found very high benefit-to-cost ratios from averting the costs of births in Turkey and averting the costs of births and abortion complications in Mexico.[155]

Expanding coverage to lower income populations. Has national social insurance led to poorer quality health services for the poor? Some believe that the emergence of social insurance as a financing mechanism in Latin America has led to a dual health care system—a 'second class' government-financed health system for the poor and a 'first class' social security system for the employed. Akin (1987) believes that the evidence supporting this is not clear-cut. For example, the dual nature of health systems in Latin America is actually declining as government social insurance expands. As economies develop, and more workers are employed in the formal sector, more are covered by social insurance. As incomes rise and public revenues increase, countries can afford to offer

broader subsidized coverage for lower income populations. This has certainly happened in many of the higher-middle income countries of Latin America, and middle-income countries (such as Colombia) that have invested in health financing reforms are also likely to benefit from growing social insurance coverage.

Impact of national social insurance on funding for contraceptives. At the country level, we know very little about the impact of extending national social insurance on funding for contraceptives/RH services, and there is urgent need for research on three key issues:

1. Does extending coverage to employed populations actually "save" government revenue and if so, how large are these savings? Are governments actually redirecting "saved" resources to expand service coverage for the lower income groups? (In Colombia, there is some evidence that this may be happening, but financial and service data needed to verify service expansion for lower income groups were unavailable.)
2. Although there are a few compelling examples of countries offering less comprehensive and less costly health benefit packages to make insurance more affordable for lower income populations[156], the literature does not speak to this experience with contraceptives and RH services. Is there sufficient demand among target populations to offer contraceptives, and perhaps other reproductive health services, as part of a less comprehensive benefits package? Are these packages self-sustaining (will premiums cover costs?) and how affordable are these packages to lower income groups? What impact do such packages have on contraceptive service access (physical and financial) and contraceptive prevalence?
3. Empirical data are lacking on the costs and benefits of including or excluding certain contraceptive methods from coverage under compulsory insurance programs. Should compulsory insurance only cover more expensive clinical methods, thus forcing the better off to purchase low-cost methods in the commercial sector? What effect would this kind of coverage have on fund sustainability and contraceptive use?

These issues need to be investigated and addressed before countries can make appropriate investments in expanding social insurance to cover contraceptives.

MANDATING EMPLOYER-PROVIDED SERVICES TO FREE UP GOVERNMENT RESOURCES

An alternative to national social insurance for lower-income countries. In countries without publicly financed health insurance or social security systems, governments can mandate that employers in the formal sector pay for certain key medical benefits.[157] This is a relatively common practice in sub-Saharan Africa, a region with limited national social insurance systems. However, government-mandated benefits usually focus on curative care and often do not extend to preventive services, including reproductive health (although sexually transmitted diseases and HIV/AIDS are increasingly being included).

USAID and other donors have been active since the 1980s in convincing employers to provide family planning services. Basing their arguments on increased economic productivity from pregnancies averted, reduced staff turnover and lower child care costs (plus intangible benefits such as earning the goodwill of governments and their employees), donors have persuaded many employers worldwide to provide family planning services for their employees.[158] In sub-Saharan Africa, where the workforce in the formal sector is largely male, these arguments are less persuasive unless employers extend health benefits to dependents. Nonetheless, companies are increasingly providing these services to employees, either directly or by contracting with private providers. Some employers simply agree to reimburse workers for health care expenses (directly or through private insurance).

Mandated medical benefits work best with relatively large companies with the resources to fund these services. Citing Tanzania as an example, Shaw and Griffin (1995) note that in many low-income countries employer-mandated schemes may not be economically efficient or viable because many private companies (and resulting risk pools) are too small. To overcome this, they suggest that governments create an employer-mandated insurance scheme that combines payments into a common pool. To increase the size of the risk pool still further (and its efficiency and viability), the authors suggest that governments combine these funds with medical aid schemes for civil servants. How feasible this would be in terms of administration and political support would vary from country to country. One incentive that governments might want to consider is allowing the employer-mandated insurance scheme to purchase contraceptives through government bulk purchasing arrangements, thus lowering commodity costs.

The benefits of mandating services. Employer-provided insurance or services benefit governments in their quest to extend more services to the poor and underserved. As Shaw and Griffin point out, this is due to the fact that a sensibly designed government-mandated benefits system, supported by employers and employees, improves equity by channeling the well-off into a system that they finance themselves (rather than the government). This then allows the government to redirect resources to the unemployed and other disadvantaged groups. In this light, governments should consider mandating coverage of some family planning services, particularly the more expensive contraceptive services that many of the affluent are now obtaining from subsidized public facilities.

◄ ANNEX E ►

MAJOR USAID PROJECTS FOR EXPANDING THE ROLE OF THE PRIVATE SECTOR IN CONTRACEPTIVE SELF-SUFFICIENCY AND REPRODUCTIVE HEALTH SERVICE DELIVERY

USAID has been the leader for nearly two decades in promoting the growth of the private sector—particularly the commercial private sector—in family planning service delivery. The larger USAID-funded programs are listed.

- *The Commercial Market Strategies Project (ongoing).* CMS Project initiatives include expanding markets and consumer demand to promote more sustainable social marketing programs and developing partnerships with pharmaceutical companies to increase the demand for, and the availability and sustainability of low-priced family planning products. Other CMS programs include expanding and strengthening private provider networks; strengthening NGO sustainability; promoting health financing alternatives (such as commercial health services and social insurance); advocating for policy change; and promoting corporate social responsibility.
- *The POLICY Project (ongoing).* The POLICY Project creates supportive policy environments for family planning and reproductive health programs by promoting participatory policy processes and population policies that respond to client needs. Among the activities of the Policy Project and/or its precursor project, OPTIONS, are market segmentation analyses, assessing legal and regulatory policies affecting the delivery of family planning services in both the public and private sectors and increasing private sector participation in RH service delivery.
- *Contraceptive social marketing projects supported by the Social Marketing for Change (SOMARC) Project (1984-1998) and Population Services International.* Contraceptive social marketing projects use commercial techniques and retail outlets to market low-cost contraceptives to low-income consumers. Donor subsidies are provided for product promotion, and in most cases, for contraceptive commodities. Many contraceptive social marketing projects have included skills training for pharmacists and retail staff. In later phases of the SOMARC Project, a sustainable model was implemented that "graduated" programs from reliance on donor subsidies and commodities.
- *Promoting Financial Investments and Transfers to Involve the Commercial Sector in Family Planning (PROFIT) Project (1991-1997).* PROFIT focused on increasing the commercial sector's involvement in family planning with activities such as providing credit and other support for private practitioners; integrating family planning services into managed care organizations; expanding the commercial distribution of contraceptives; enhancing family planning knowledge and skills of pharmacists; and improving access to health insurance. Debt conversion transactions and new endowments for NGO sustainability were also supported along with a few employer-provided family planning programs.
- *The Enterprise Program (1985-1991).* The precursor to the PROFIT Project, the Enterprise Program worked with commercial sector employers to add family planning benefits for their workers. Support

was also provided to develop NGO capacity as facilitators of employer programs, as managers of franchise-type programs with private doctors and midwives and as direct providers of services. Enterprise also worked directly with several commercial sector partners such as insurance organizations and professional medical associations.

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[26] Examples of these community-government partnerships include Zambia (van der Geest et al. 2000); Cameroon (Sauerborn et al. 1995); Niger (Diop et al. 1995); Benin and Guinea (Soucat et al. 1997); and Thailand (Supakankunti 2000).

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[75] CMS, 2000a.

[76] Janowitz, et al. 1999.

[77] Cited in Janowitz, et al. 1999.

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[93] Sine, 1999.

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[99] Gilson, 1997.

[100] On the expenditure side, 56 percent of total family planning expenditures were spent by PROFAMILIA, the largest supplier of contraceptive and other reproductive health services in the country. The Colombian Ministry of Health spent only 20 percent of the total.

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[109] Hardee and Smith, 2000.

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[140] Taylor, 1993.

[141] Diop, et al.1995.

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[149] A six-country study of contracting experience (in Mexico, Pakistan, South Africa, Tanzania, Uganda, and Zimbabwe) had similar findings, and adds government corruption, combined with bureaucratic obstacles to staffing changes, as additional reasons for contracting out both clinical and non-clinical health services. (McPake and Ngalande-Banda 1994)

[150] Mills, 1998.

[151] McPake and Ngalande-Banda, 1994.

[152] Mills, 1998.

[153] McPake and Ngalande-Banda, 1994.

[154] Mills, 1998.

[155] Cakir, et al. 1996; Martinez, Manautou J. *Cost-Benefit Analysis of the Family Planning Program of the Instituto Mexicano del Seguro Social (Economic Impact). [Analisis del costo beneficio del programa de planificacion familiar del Institio Mexicano del Seguro Social (Impacto Economico)]* (Mexico City: Academia Mexicana de Investigacion en Demografia Meidica, 1987).

[156] Mexico, Ecuador, Panama and Costa Rica. (McInnes 1993; Alarcon et al. 1991; IMSS 1986)

[157] Shaw and Griffin, 1995.

[158] Two reviews of employer-provided family planning initiatives that were sponsored by the USAID-funded Enterprise Program—a program that invested heavily in employer-provided family planning—are found in Fort 1994 and Skibiak 1991; a more general view of USAID-funded experience is found in Epstein 1996.

◄ ACRONYMS ►

AIDS	acquired immune deficiency syndrome
BI	Bamako Initiative
CBD	community-based distributor
CMS	Commercial Market Strategies Project
CSM	contraceptive social marketing
CII	Contraceptive Independence Initiative
CYP	couple years of protection
DHS	demographic and health survey
EU	European Union
FP	family planning
GAVI	Global Alliance for Vaccines and Immunizations
GDP	gross domestic product
HIV	human immuno-deficiency virus
HMO	health maintenance organization
HSR	health sector reform
IEC	information, education and communication
ICPD	International Conference on Population and Development
ILO	International Labor Organization
IPPF	International Planned Parenthood Foundation
IUD	intrauterine device
MIS	Management Information Systems
MOH	ministry of health
MOF	ministry of finance
MWRA	married women of reproductive age
NGO	non-governmental organization
OC	oral contraceptive
PAHO	Pan American Health Organization
PATH	Program for Appropriate Technology in Health
PPO	preferred provider organization
RH	reproductive health
SSK	Sosyal Sigortalar Kurumu
STD/STI	sexually transmitted disease/sexually transmitted infection
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAT	value added tax
VII	Vaccine Independence Initiative
WHO	World Health Organization

MEETING THE CHALLENGE

Securing Contraceptive Supplies

SECURING SUPPLIES FOR REPRODUCTIVE HEALTH

The Interim Working Group on Reproductive Health Commodity Security (IWG) is a collaborative effort of John Snow, Inc. (JSI), Population Action International (PAI), the Program for Appropriate Technology in Health (PATH) and Wallace Global Fund. Recognizing the important leadership role of the UN Population Fund (UNFPA) in meeting the goals of the 1994 Programme of Action, the IWG's objective is to further these goals by raising awareness about the importance of securing reproductive health supplies. The IWG seeks to identify the causes of failures and weaknesses in commodity systems and to spur actions that will contribute to securing essential supplies for the delivery of reproductive health care.

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