

Toward Contraceptive Self-Reliance in Turkey: Results from a Pilot Test of a Cost-Sharing Mechanism

Summary Report

Prepared by

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May 2001

Acknowledgments

Access to family planning services is one important factor contributing to quality of life in Turkey. Public sector reliance on foreign donor support for family planning is nearly ended and new ways of generating resources are required. The pilot study on testing a donation policy for achieving contraceptive self-reliance in Turkey (also referred to as targeting strategy) was conducted jointly by the Turkish Ministry of Health, General Directorate of Mother and Child Health and Family Planning, and the POLICY Project with funding by U.S. Agency for International Development (USAID). POLICY is a five-year project funded by USAID under Contract No. HRN-C-00-00-00006-00, beginning July 7, 2000.

Appointed staff from the organizations mentioned below have successfully undertaken all the activities necessary for the completion of the pilot study:

- The Ministry of Health (GD MCH/FP)
- Adana Provincial Health Department (MCH/FP Division)
- Icel Provincial Health Department (MCH/FP Division)
- Izmir Provincial Health Department (MCH/FP Division)
- Health and Social Aid Foundation

The authors of this report wish to express their gratitude to all the health personnel who not only recognized the value of the study, but who also contributed so generously of their time and performance in implementing the study. Provincial-level health personnel function at the very heart of the family planning service system as was demonstrated by the successful completion of this study.

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Introduction

Turkey's public family planning program historically relied on external donors for contraceptive supplies. However, in the early 1990s, donors signaled their intention to stop providing contraceptive supplies. In response, the Government of Turkey (GOT), at the urging of donors, articulated a self-reliance strategy by 2000.¹ A central feature of this strategy is a donation policy, whereby clients are asked to contribute a share of the commodity costs at public sector health facilities. The donation policy is envisioned to generate revenue to lessen the shortfall between Ministry of Health (MOH) resources and the total needed for contraceptive purchases.² Because those who are unable or unwilling to pay will be exempted from paying, the policy ensures that the poor have a source for family planning services.

The donation policy was adopted after a preliminary feasibility study in 1998 concluded that clients were willing to pay for contraceptive supplies.³ This report summarizes the findings of a pilot study of the donation policy that:

- Determined how the donation policy would affect family planning services at the primary health care (PHC) level, which includes maternal and child health and family planning centers (MCH/FP centers) and health centers;
- Tested the mechanism for collecting donations;
- Collected data to estimate the national revenue potential; and
- Determined optimal donation levels.

The Donation Policy

The pilot study tested three donation levels—high, medium, and low—with different prices for the contraceptives (Table 1). The donation policy instituted charges for oral contraceptives and condoms for the first time. For IUDs, the cost of the device was added to the service fee that was already being charged. Health faculty personnel, generally the midwives, explained the policy to clients and revised each client's self-reported status as “full payer,” “partial payer,” or “exempt.”

¹ For a detailed account of the self-reliance policy in Turkey, see “Case Study of Contraceptive Self- Reliance Effort in Turkey: Prospects and Lessons Learned,” POLICY Project, November 1999.

² Annual requirements for contraceptive procurement were estimated at approximately \$4 million.

³ “Turkey’s Health and Social Assistance Foundation: Feasibility Study of its Role in Raising Resources for Contraceptive Commodity Procurement,” POLICY Project, February 1999.

The Health and Social Aid Foundation (HSAF) managed the donation collection. According to the revenue-sharing policy, MCH/FP centers and health centers retained 20 percent of the revenue from contraceptive donations, the foundation branch retained 8 percent, and 72 percent was sent to headquarters for procurement of contraceptives. These, in turn, augmented supplies purchased with MOH funds.

Study Design and Data Collection

Study team investigators implemented one of the three donation levels in Mersin District in Icel Province (high); Tarsus District in Icel Province (medium); and Seyhan and Yuregir districts in Adana Province (low). Izmir Province served as a control area where no donations were collected. The pilot study covered a total of 155 facilities of which 121 were in the three pilot intervention areas and the remaining 34 in the control area. Pilot intervention facilities also included four MCH/FP centers among the health facilities surveyed—two in the low donation area, and one each in the medium and high donation areas. Data were collected using client tracking forms on the number of clients served and amount of contraceptive supplies dispensed, and analyses were conducted on 79,262 visits for contraceptive supplies between June and November 2000.

Table 1: Donation and Private Market Prices in Pilot Intervention Provinces (in U.S. dollars)

	Client Donations in the Pilot Study			Private Market Prices	
	High donation area	Medium donation area	Low donation area	Average	Range
IUD	4.51	3.38	2.26	14.50	4.60 – 29.00
Oral Contraceptives (2 cycles)	2.26	1.50	1.13	6.00	3.29 – 8.60
Oral Contraceptives (1 cycle)	1.13	0.75	0.38	3.00	1.65 – 4.30
Condoms (12 pieces)	1.13	0.75	0.38	6.67	2.69 – 10.77

To assess changes in demand, consumption figures for the six-month pilot period were compared with figures for the corresponding period in 1999. To isolate the effect of the donation policy (net changes in demand), changes in demand in the control province were subtracted from changes in demand in the intervention provinces.⁴ Demand analysis not only measured changes in demand by method in each donation level, but compared intervention sites with the six main

⁴ When using net changes in demand, changes that occur in the same direction in both control and intervention provinces make the change attributed to the donation policy to appear smaller than the observed change, and appear larger when changes occur in opposite directions.

public hospitals and rural health houses in the pilot areas to determine if the donation policy caused demand to shift within the public sector, and to establish if there was a shift among methods. It is noteworthy to clarify that some of the main public hospitals provide postpartum and postabortion care, including distribution of contraceptive commodities. Few provide routine family planning services to a very small number of clients free-of-charge.

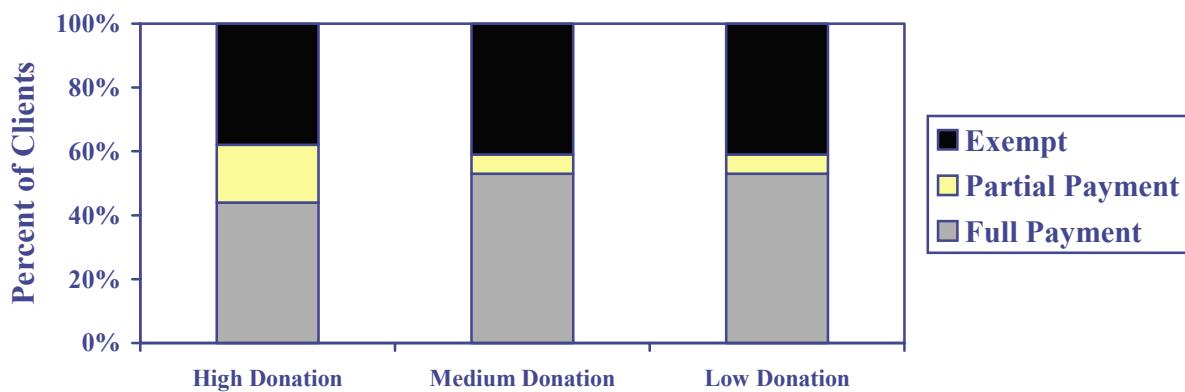
Investigators considered other factors (e.g., programs, activities, policies) that could have affected demand for methods at public sector outlets in order to isolate the effects of the donation policy. None of the factors investigated were judged to have had significant impact; therefore, any change in demand was attributed to the donation policy.

Revenue projections used two national expansion scenarios for each of the three donation levels. The first set of projections assumed the following: of the 81 total provinces, the donation policy would include the 56 non-eastern provinces and would exclude the 25 eastern provinces. The second set assumed that the donation policy would be implemented in only the 16 most populous provinces (excluding the eastern provinces).

Payments by Donation Level

Overall, 60 percent of clients made donations (51 percent were full payers and 9 percent were partial payers) and 40 percent of clients were exempted (Figure 1). This pattern was extraordinarily similar across all three donation levels. At the high donation level, the proportion exempted was nearly the same as in the other two donation levels, as was the proportion making some payment (either full or partial). However, the proportion making a partial payment was three times greater at the high donation level compared to the low and medium donation levels. While donation level did not change the amount of payments, the high donation level provided the greatest flexibility to accommodate differences in willingness to pay among clients.

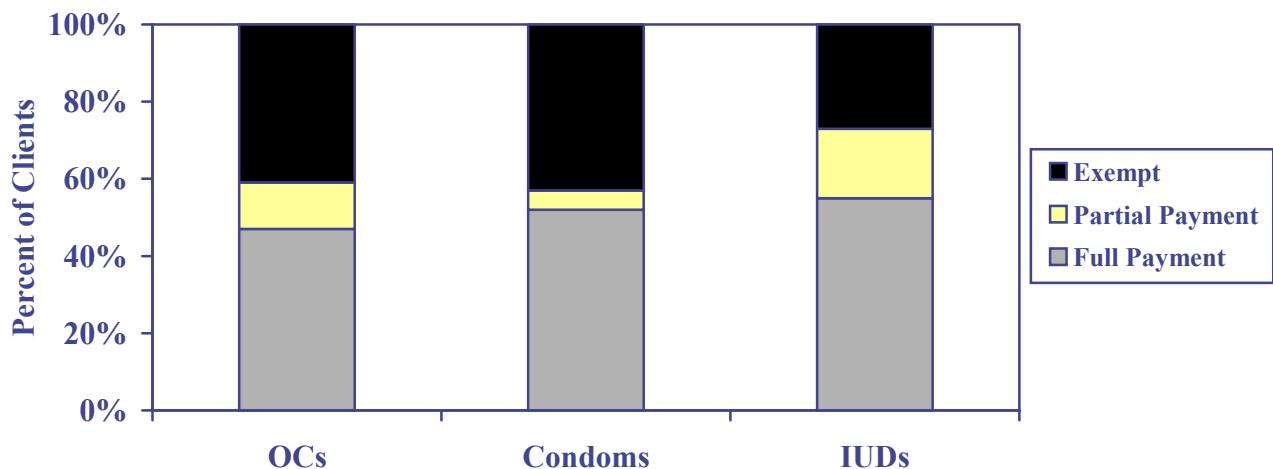
Figure 1: Payment Pattern by Donation Level



Payments by Method

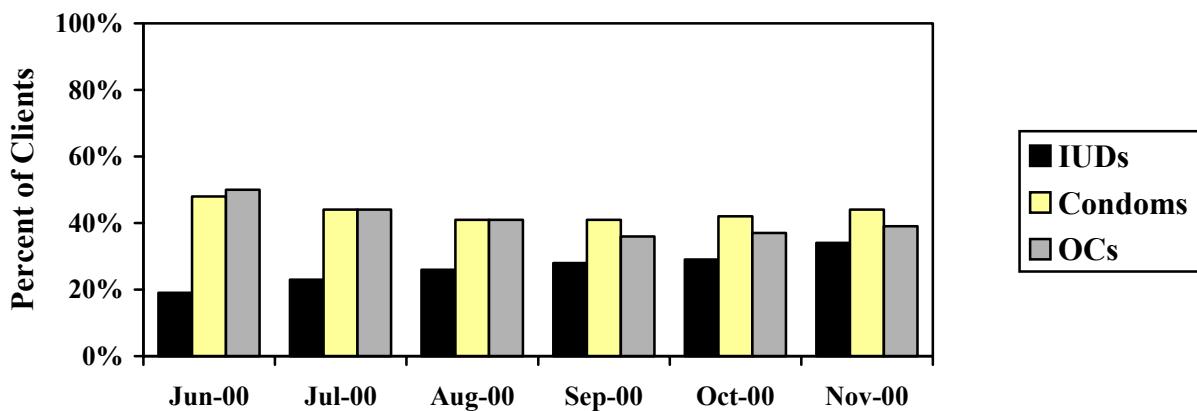
The proportion of clients making either partial or full payment was nearly the same among oral contraceptive and condom clients (59 and 57 percent, respectively), and higher among IUD clients (73 percent) (Figure 2). A higher proportion of IUD clients also made partial payments (18 percent) compared with oral contraceptive (12 percent) and condom clients (5 percent). It appears that more IUD clients are willing to pay higher prices than oral contraceptive or condom clients. This is a curious finding, since IUD prices increased more than other prices.

Figure 2: Payment Patterns by Method



Initially, fewer condom and oral contraceptive clients made full donations, but this increased over the pilot period (Figure 3). Concurrently, the proportion of oral contraceptive and condom clients being exempted fell steadily over the first four months of pilot study before leveling off. This trend occurred for all three donation levels, indicating a maturation effect. That is, clients initially were unprepared to pay the new donation price but were increasingly willing to make donations as they became familiar with the policy.

Figure 3: Trends in Proportion of Clients Exempted



The opposite trend occurred among IUD users, who were already accustomed to paying for IUD insertion. The proportion making full payments actually declined more than 10 percentage points over time for the medium and low donation levels, but remained relatively constant at the high donation level. It is unclear why this pattern occurred only for the medium and low donation levels. The steady level of payments at the high donation level suggests, however, that the price was not set high enough to discourage payments for IUDs.

If these trends have indeed leveled off, as appears to be the case for oral contraceptives and condoms, then the revenue raising potential is greater than that forecasted later in this report.⁵

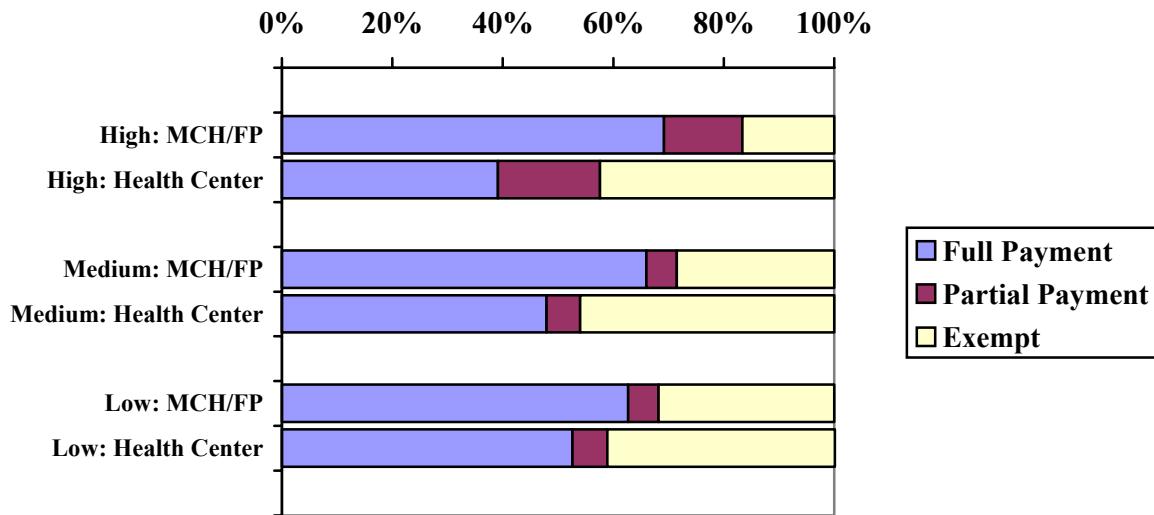
Payments by MCH/FP and Health Centers

In each of the three intervention provinces, a higher proportion of clients at MCH/FP centers, compared with clients at health centers,⁶ made full donations for their contraceptive supplies, whereas a lower proportion were exempted (Figure 4). Comparing only health centers across the three intervention provinces, the proportion of full paying clients decreased as the donation price increased. Predictably, payments were opposite across prices: as prices rose, more clients offered partial donations or chose to be exempted. In contrast, a different payment pattern occurs at MCH/FP centers where there were fewer partial and full payers at the low donation level than at the medium or the high levels, which had the highest proportion of full and partial payers.

⁵ The distribution of payment categories used for that analysis was the average distribution across the six-month pilot study period, meaning that a greater proportion of clients was assumed to be exempt than was indeed the case at the end of the period.

⁶ MCH/FP centers are compared only to urban health centers since MCH/FP centers are located only in urban areas.

Figure 4: Payment Patterns by MCH/FP and Health Centers



The reason MCH/FP centers collected donations from more clients is unclear. MCH/FP centers are generally believed to serve better-off clientele and offer higher quality than health centers.⁷ Clients may be willing to pay more for a perceived higher quality of services. With only four MCH/FP centers participating in the pilot study, the difference could be related more to characteristics of those facilities (e.g., staff attitudes and experience) rather than of their clients. MCH/FP centers do have more years experience charging for IUDs than do most health centers.

Payments by Rural/Urban Location

No clear pattern of payment emerged from clients' rural and urban status in the intervention provinces. A higher proportion of rural clients made full donations in the area with the low donation level, whereas the opposite was true for the medium donation level. Payments at the high donation level resembled the low donation level, with only a slight difference between rural and urban clients.

Overall, slightly more rural health center clients made a full donation for their contraceptive supplies. The explanation may be that staff at rural health centers are more familiar with their clients' ability to pay, making it more difficult for nonpoor rural clients to claim exemption. Or poor and nonpoor clients may visit rural health centers equally, since fewer private sector outlets are available. Urban sites have more private sources, providing alternatives to those who can pay their fees.

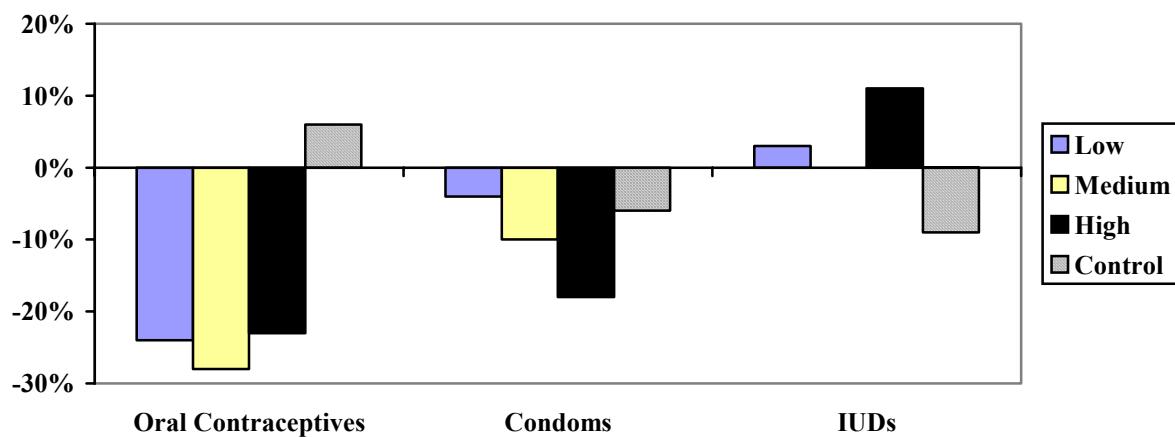
In the end, there is no evidence that clients in rural areas are unable or unwilling to make donations to a greater degree than urban clients, meaning that rural clients are not unequally disadvantaged by a donation policy at any of the donation levels tested.

⁷ Personnel communication: MOH General Directorate for MCH/FP senior staff.

Demand Analysis

For most methods, there was a small decline in demand at the MCH/FP centers and health centers in the control province and relatively larger declines in the intervention provinces (Figure 5). The donation policy had the greatest negative impact on the demand for oral contraceptives. Demand fell uniformly in the intervention provinces, while it increased slightly in the control province. The donation policy did significantly affect the demand for oral contraceptives, although the relative donation level did not. Therefore, selecting the high donation price for oral contraceptives during a national rollout is clearly justified. Because oral contraceptives had the smallest public–private price differential, clients may switch to private outlets equally at each donation level.

Figure 5: Change in Demand from 1999 to 2000



Similarly, demand for condoms declined for all three donation levels. In contrast to oral contraceptives, however, demand for condoms was price-sensitive: the higher the donation levels, the greater the drop in demand. Condoms may be price sensitive whereas oral contraceptives are not because the public–private price difference is larger for condoms than oral contraceptives. Condom clients may switch to private outlets only at the highest donation levels, as the public–private price difference decreases.

In contrast to oral contraceptives and condoms, no impact was observed for IUD demand at any donation level. Again, the explanation may be found by comparing donation prices with the lowest private price. This difference is the largest gap of all the methods and was apparently sufficient to discourage clients from switching to a private source.

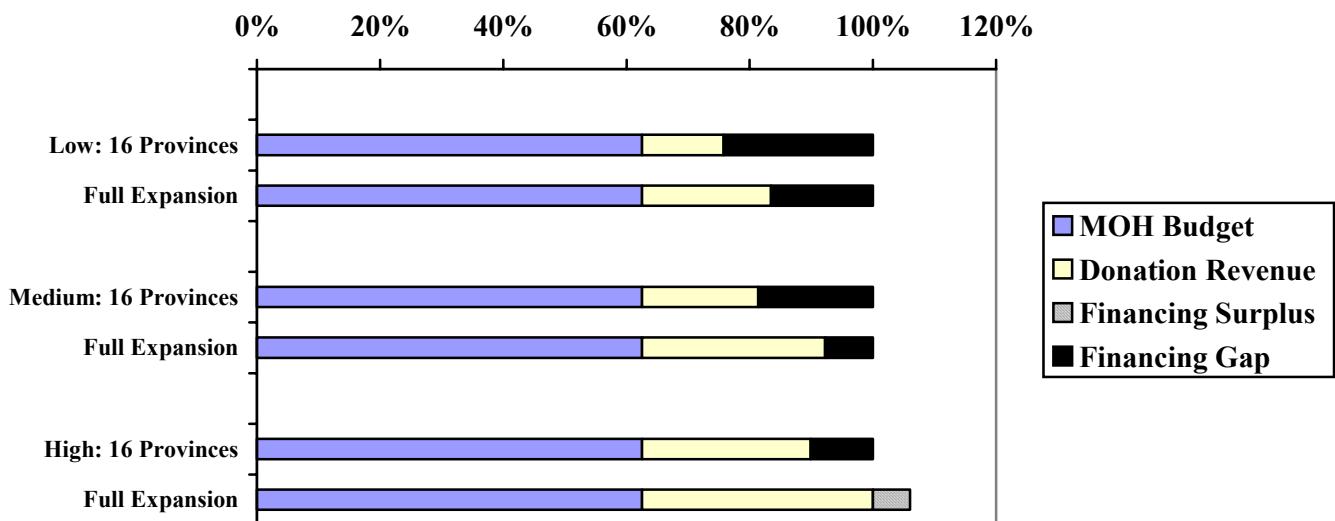
While demand for all methods dropped at the intervention sites, it increased at public hospitals in the intervention provinces. In the control province, meanwhile, overall demand for contraceptives dropped at public hospitals (the number of oral contraceptive and IUD clients increased slightly but a large nominal decrease of condom clients drove the overall trend). These patterns provide only weak support for the contention that clients switched sources within the public sector. Still, that possibility cannot be ruled out; therefore, it is advised that the donation policy be extended to include all public hospitals.

It is unlikely that clients in the intervention provinces would have switched methods from oral contraceptives to condoms or vice versa as a result of the donation policy, since a one-month supply for both methods was priced equally. The possibility that some clients switched methods to use IUDs cannot be ruled out, particularly in Icel Province (high donation) because a one-year supply of all methods was similarly priced. Even here, however, the increase in demand for IUDs accounted for only 28 percent of the decrease in demand for the other methods (if one assumes that all changes in demand resulted entirely from method switching and not from new or discontinuing users).⁸

Revenue Projections

A total of US\$33,055 was collected in the three intervention provinces, US\$23,800 of which is for supply procurement (according to the revenue-sharing policy). The high donation level contributed the greatest amount. If the donation policy were implemented in all 56 non-Eastern provinces, only the high donation level would raise sufficient revenue to close the gap between MOH resources (estimated at \$US2.5 million per year) for contraceptive commodities. In fact, the high donation level would generate a small surplus (6 percent), which could be used to improve the national stock cushion of contraceptives. If the donation policy were expanded only to 16 of the most populous and better-off provinces applying the high donation scenario, the MOH would have to mobilize US\$2.9 million instead of US\$2.5 million to meet the public sector program requirements.

Figure 6: Revenue Projections



⁸ Using net changes in demand (observed change in demand in the high donation province, minus the change observed in the control province), there were 365 fewer oral contraceptives users and 610 fewer condom users, compared with a total increase of 275 IUD users (259 more at PHCs and 16 more at hospitals).

Physician and Midwives' Perceptions

Eight focus-group sessions were conducted in the intervention provinces to explore the perceptions and experiences of the physicians and midwives who directly participated in the pilot study. A total of 92 physicians and midwives from 63 facilities (52 percent of all intervention facilities) were included in the focus groups. These health personnel reported that clients' reactions to the donation policy were generally favorable, although clients frequently asked about the rationale for the policy. In their experience, no clients chose to leave without the supplies they sought during a visit or exhibited antagonism toward the policy.

The principle that family planning services should be provided free-of-charge persisted among facility staff. However, nearly all recognized that the sustainability of the national program depended on implementing a donation policy. They were supportive of Turkey's program becoming self-sufficient and, therefore, generally agreed that the policy should be expanded to other provinces.

Providers reported that the introduction of the new donation policy was uncomfortable in its early stages, and they had difficulty communicating it to clients. Most providers felt that if clients were to be asked for a donation, a midwife would be the best at handling it. Midwives became more comfortable with this role as the pilot study progressed. Staff expressed appreciation for the flexibility in deciding who should determine a client's payment status and collect donations. Providers thought that well-designed orientation and training sessions, especially for family planning nurses/midwives, would be important to the success of expansion.

Recommendations

Recommendations drawn from this pilot study are presented below in three broad categories: (A) the expansion process, (B) donation price and retention levels, and (C) administrative procedures (see Table 2). Each recommendation is described in more detail on pages 11–13.

Table 2: Study Recommendations

A. Expansion Process	B. Donation Price and Retention Levels	C. Administrative Procedures
A.1: Expand the donation policy to as many provinces as quickly as feasible	B.1: Implement a three-tiered donation level	C.1: Designate clinic midwives to discuss the donation policy with family planning clients
A.2: All PHC facilities should implement the same donation level, as well as public hospitals	B.2: Set donation prices at or above the levels in the pilot study's high donation level	C.2: Facility staff should decide who will collect donations and issue receipts
A.3: All PHC facilities in expansion provinces should implement the donation policy	B.3: Retain revenue according to the rates agreed on in the current revenue sharing policy	C.3: Monitor staff, especially during the first quarter of implementation in each province
A.4: Exclude rural health houses from the donation policy	B.4: Maintain one set of prices throughout the initial expansion (end of December 2002)	C.4: HSAF province branches should establish a clear, transparent accounting mechanism to track the transfer of donation revenue from facilities and to HSAF headquarters
A.5: Implement the donation policy uniformly in rural and urban facilities	B.5: Eliminate a separate price for a two-month supply of oral contraceptives	C.5: Log donation categories and the method dispensed in the facility's patient registry log
A.6: Conduct orientation in all provinces implementing the donation policy		
A.7: Recruit midwives from the pilot study areas to participate in the orientation		

A. Expansion Process

- A.1: Expand the donation policy to as many provinces as quickly as feasible.*** During the first year, the policy should be extended to the 16 most populous provinces. According to revenue projections, this limited expansion will fall short of the amount needed for contraceptive procurement; therefore, the policy should extend to additional provinces the following year. The 25 eastern provinces should be excluded for the foreseeable future, since they constitute a special development zone.
- A.2: All PHC facilities should implement the same donation level, as well as public hospitals.*** Although there was no conclusive evidence from the pilot study, it is possible that clients may switch from PHCs to public hospitals for their contraceptive supplies to take advantage of price differentials. This trend would most likely benefit urban clients living closer to hospitals and decrease the current rural–urban equity of the donation policy.
- A.3: All PHC facilities in expansion provinces should implement the donation policy.*** PHC facilities that currently do not participate in the HSAF system, but who raise (and retain) their own revenue may be reluctant to implement the donation policy. Their participation is important because they consume a large proportion of MOH contraceptive supplies commensurate with their service load. Appeals to national program sustainability needs and equity concerns (MCH/FP clients are generally better off than other health center clients) were effective in soliciting their participation during the pilot study. Additionally, smaller health centers in remote locations should be required to participate in the policy as well as in all the orientation and training sessions.
- A.4: Exclude rural health houses from the donation policy.*** Rural health houses (which dispense less than 1 percent of public sector contraceptives to very poor clients) did not implement the policy during the pilot study. Yet, significant changes in the volume of services at these facilities were not readily apparent. Clients from other public facilities are unlikely to switch their source of contraceptive supplies to rural health houses, given their remote location.
- A.5: Implement the donation policy uniformly in rural and urban facilities.*** The pilot study presented no evidence that the policy affected rural clients more negatively than urban clients.
- A.6: Conduct orientation in all provinces implementing the donation policy.*** PHC facilities in intervention provinces (Icel and Adana) that did not implement the policy during the pilot study will need orientation, as will facilities in new provinces. Similarly, those provinces changing to the high donation level will also require reorientation. Orientation sessions should emphasize that it takes time for providers and administrators to become comfortable implementing the policy. It is a learning process that affects their own behavior, as well as changes in client attitudes and payment patterns.
- A.7: Recruit midwives from the pilot study areas to participate in the orientation.*** Midwives will likely play a role in collecting donations, and many gained valuable experience during the pilot study. These midwives should be selected based on their performance during the pilot study, their articulateness, and their potential as trainers.

B. Donation Price and Retention Levels

B.1: Implement a three-tiered donation fee level. Most providers recognize the value of providing the flexibility to collect full, partial, or no payment to accommodate differences in clients' willingness and ability to make donations. The high proportion of clients who made a partial donation attests to the importance of this option. Clients' payment patterns should be monitored regularly.

B.2: Set donation prices at or above the levels in the pilot study's high donation level. The donation price should be calculated to allow the MOH to recover the expected cost of commodities (keeping in mind that 28 percent is retained by PHC facilities and HSAF branches). Setting donation prices at less than this amount will likely generate insufficient revenue. Donation prices may need to be set above prices in the high donation level due to changes in the exchange rate (contraceptives are purchased using U.S. dollars).

B.3: Retain revenue according to the rates agreed on in the current revenue sharing policy. These retention rates were well accepted during the pilot study and provide HSAF headquarters with sufficient revenue (72 percent) for central procurement of contraceptive commodities.

B.4: Maintain one set of prices throughout the initial expansion (end of December 2002). Since some provinces will begin implementing the policy later than others, donation prices should remain constant to allow clients and providers in all provinces to adjust to them. The need to change donation prices should then be assessed annually to adjust for changes in the exchange rate and commodity prices.

B.5: Eliminate a separate price for a two-month supply of oral contraceptives. Two cycles are double the price of one cycle; thus, there is no need to list a two-month supply separately. Clients who request a two-month supply should be asked to pay twice the amount for a one-month supply. Clients who are unable to pay the full donation price should be encouraged to pay what they can for a one-month supply, unless extenuating circumstances justify a two-month supply.

C. Administrative Procedures

- C.1: Designate clinic midwives to discuss the donation policy with family planning clients.*** Midwives should determine, in consultation with clients, their payment category (full payment, partial payment, or exempt).
- C.2: Facility staff should decide who will collect donations and issue receipts.*** During orientation sessions, let clinic staff know that it worked best when midwives performed these functions in the pilot study. However, a procedure whereby the midwife issues the client a payment slip and the facility's administrative clerk collects donations and issue receipts is also acceptable. Midwives should expect that they may experience some initial discomfort in this new role, but it subsides.
- C.3: Monitor staff, especially during the first quarter of implementation in each province.*** Providers' comfort with the donation policy improved over time, but monitoring for trouble spots and support by the pilot study coordinating team may have helped. It will be useful to devise similar mechanisms to identify problems and intervene as expansion proceeds in each province.
- C.4: HSAF province branches should establish a clear, transparent accounting mechanism to track the transfer of donation revenue from facilities and to HSAF headquarters.*** The facility reporting forms and branch reporting forms used during the pilot study should form the backbone of this mechanism.
- C.5: Log donation categories and the method dispensed in the facility's patient registry log.*** This procedure will help monitor and evaluate the policy and should be described in the donation policy guidelines and explicitly endorsed by province health directors.