POLICY LESSONS LEARNED IN FINANCE AND PRIVATE SECTOR PARTICIPATION

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PREFACE

In the effort to develop dynamic national family planning service systems, the U.S. Agency for International Development (USAID) has supported a sustained set of initiatives to strengthen private sector service delivery. Many of these, like the SOMARC, Enterprise, PROFIT, and Initiatives projects, have focused primarily on the operational side of program expansion (e.g., training private providers, helping clinic managers develop business and financial plans, improving management efficiency, and marketing products and services). This paper looks at how activities in the policy domain often determine the success or failure of efforts to develop private sector services. Ironically, one of the lessons learned in this paper is that private sector expansion often begins with public sector initiatives, a principle that is clearly reflected in recent policy-related technical assistance activities. This paper presents lessons learned during implementation of these activities and emphasizes ways to strengthen the policy climate and to plan for service expansion.

The activities described in this paper were primarily conducted under the USAID-funded OPTIONS II Project, implemented between 1990 and 1995. Many of these activities have been sustained and are being expanded under the POLICY Project over the period 1995 to 2000, creating a natural evolution across projects. This report synthesizes a large number of reports and technical assistance initiatives (see bibliography), which were carried out under the auspices of these two projects. The authors are indebted to those colleagues who prepared the original source material and shared their insights on lessons learned. Readers who would like more in-depth information about any of the country examples are invited to request copies of the documents in the bibliography or to contact the authors of this paper or the director of the POLICY Project.

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Introduction

Although estimates vary, the number of women using contraception worldwide will grow by as much as 160 million between 1990 and 2005. Growth in demand, coupled with increasing pressure on host-government and donor budgets, makes it imperative to mobilize additional resources and use existing resources more effectively for family planning and reproductive health service delivery. This goal can best be achieved by involving both the public and private sectors in service delivery, recognizing that both sectors have distinct, yet complementary roles.[1]

In the public sector, governments need to allocate more funds to reproductive health services. Many public programs are succeeding and are serving increasing numbers of clients. As donors phase out support, however, governments cannot afford the costs of large-scale programs and the costs of extending services to all users, whether rich or poor. Thus, the public sector would benefit from developing a partnership with the private sector. The latter can add precious resources to the family planning and reproductive health sector, thereby relieving the public sector of some of its heavy burden.

The commercial private sector also has its niche in national family planning and reproductive health programs. It is best positioned to serve consumers who can afford to pay for services that are accessibly and competitively priced. While already a major resource in many countries, the private commercial sector still has great untapped potential. Millions of couples in the developing world would turn to these services if they were readily available and affordable. Millions more would use the private commercial sector if market conditions and government policies were changed.

In many settings, policy or operational constraints limit the role of the private sector. For example, the availability of free government services may curb effective or potential demand for private services; without perceived demand, providers will not offer services. In addition, demand for private sector services may be constrained by low income, which deters consumers who want to use private services. On the supply side, legal and regulatory barriers such as high tariffs, stringent licensing procedures, and restrictions that impede the entry of providers into the market constitute significant disincentives.

Government has the responsibility to lay the foundation for the total family planning and reproductive health service delivery system and to make the private sector an essential actor in the system. Government can assume the role of an active partner with the private sector and ensure the accessibility and safety of commercial services through appropriate licensing and regulation, provision of population-based information to the private sector, dissemination of information to consumers, and strategic planning. Government also has the fundamental responsibility to fund services for users who cannot afford to pay for services in the private market or who, for other reasons, would be constrained from using the private sector.

Through policy analysis, strategic planning, and consensus building, the U.S. Agency for International Development (USAID) has assisted developing country governments in forging

[1] This paper focuses primarily on partnerships with the private commercial sector and does not address the potential for or outcomes of expanded public sector collaboration with not-for-profit private entities, such as nongovernmental organizations (NGOs), except in specific examples.

strong, fruitful partnerships with the private sector. But the road to effective health care financing and public/private cooperation has not been without obstacles. In many settings, public and private sector officials do not readily recognize areas in which they can help each other; in other settings, the will exists but an understanding of the steps to successful collaboration is lacking.

Over the years, USAID project staff have learned many lessons that can guide efforts to enhance the efficiency and sustainability of family planning and reproductive health programs. This paper examines lessons learned in USAID's Options for Population Policy (OPTIONS) Project and the POLICY Project, both of which have worked extensively in developing countries to foster private sector involvement in family planning and reproductive health care. Following a general discussion of lessons learned, the paper presents examples from 11 countries that describe efforts to remove impediments to private sector participation and effective health care financing. Issues range from taxation of imported commodities in the Philippines to divestiture of contraceptive brands in Jamaica to market segmentation in Egypt. In sum, the country examples illustrate the steps governments can take to ensure adequate financing of their programs, use their resources efficiently, and tap the extensive resources of the private sector.

Summary of Lessons Learned

1. **Government role in ensuring sufficient resources — *Governments should ensure that sufficient resources are available for services from both public and private sector sources.***
2. **Targeting government subsidies — *Government subsidies should be targeted to appropriate clientele.***
3. **Facilitating private sector provision of family planning services — *Efforts to increase private sector participation in family planning service delivery should begin with the public sector.***
4. **Clients' ability to pay — *Many public sector clients can afford to pay for needed services either in part or in full.***
5. **Legal and regulatory barriers — *Legal and regulatory barriers can impede the involvement/performance of the private sector.***
6. **Government role in regulating quality of care — *Governments have a fundamental role in regulating the quality of private sector health services; however, many governments lack experience in regulating the private sector.***
7. **Private sector interest in collaboration — *The private sector is often able and willing to work with the public sector as a partner.***
8. **Donor coordination — *Donors and cooperating agencies need to communicate and collaborate to ensure synergy of efforts in the field.***

Lessons Learned

1. Government role in ensuring sufficient resources — *Governments should ensure that sufficient resources are available for services from both public and private sector sources.*

In many countries—especially those with weak private sector family planning and reproductive health infrastructures—governments need to act to ensure that sufficient human, material, and financial resources are provided for service delivery. In sum, these resources come from both public and private sector sources. The difficulty for public policy is striking a balance between meeting social goals and staying within constrained public budgets. Sometimes governments set the balance point extraordinarily high and promulgate policies that call for providing health care and family planning at no cost to every member of society. Given the lack of public funds, such policies may be unrealistic. Further, the impact of policy is then felt in the private market such that the unintended effect is to curb interest of the private sector in providing services to better-off consumers. A more prudent public policy may be to direct resources to those who most need them, an approach that reinforces social goals without impeding the development of the private market.

Governments have a special responsibility to serve the residents of poor and rural areas, where the private sector often does not reach. At the same time, international donor organizations have a significant role to play in encouraging and enabling public sector officials to mobilize resources and ensure equitable access to services. Donor organizations' economic and financial analyses can help government officials understand the economic return on public investments in family planning and encourage them to fund programs selectively, targeting public resources where they are most needed and would have the greatest impact. Analyses can also determine the feasibility of implementing cost-recovery schemes and can examine the costs and benefits of alternative service delivery mechanisms. Given that an increase in the budget of one department or division usually means cuts in others, government decisions to increase funding for service delivery often meet with resistance among certain policymakers.

Technical assistance in resource allocation has been invaluable in many developing countries. In Turkey, for example, an analysis of project commodity costs assisted the government in estimating its needed financial allocations as USAID gradually phases out contraceptive commodity contributions (Cakir and Sine, 1995). The analysis projected demand for commodities based on various assumptions about market share by method and estimated procurement costs for each of the assumptions, producing a number of alternative budget estimates. The estimates provided a blueprint for likely contraceptive commodity costs and needs over the next several years as well as a guide for budgetary allocations. In addition to estimating costs and needs, the study report recommended that Turkish officials establish a line item for contraceptive commodities in the budget so that policymakers would continue to allocate resources for contraceptives. The government has since allocated funds for a test procurement.

In Indonesia, a study helped the government estimate the number of public and private sector contraceptive users and acceptors as well as public sector procurement costs generated under different scenarios of private sector participation (Winfrey and Heaton, 1996b). Among its key findings, the study revealed that an increase in private sector participation will likely yield large savings to the Indonesia Family Planning Board (BKKBN) in terms of reduced commodity procurement costs and reduced sterilization reimbursements.

2. Targeting government subsidies — *Government subsidies should be targeted to appropriate clientele.*

In many countries, public family planning services are available to all consumers, often at little or no charge. Two rationales provide the basis for offering deeply subsidized public sector family planning services. First, where rapid population growth is hampering economic growth, reduction in fertility is thought to provide tangible benefits to society at large as well as to individuals. From this perspective, family planning is considered a public good. Therefore, government is willing (and sometimes eager) to expend public resources to extend family planning services to all consumers regardless of willingness and ability to pay. Second, health care may be viewed as a social entitlement. In this scenario, government takes responsibility for providing universal subsidized health services on the assumption that universal coverage enhances equity, particularly in areas where people are considered too poor to pay for private care. Of course, in some settings the public sector is the only viable provider of family planning services, as when private sector services are either nascent or nonexistent.

Increasingly, however, universal access to subsidized health and family planning services is not feasible. Few countries possess adequate public resources to finance the entire health care system, especially in a public system suffering from deteriorating infrastructure, low morale among poorly paid staff, and shortages of key resources such as drugs and supplies. In addition, universal subsidized health care may actually reinforce—not eliminate—the inequitable distribution of resources. While some governments may believe that the provision of free services promotes equity, the services are generally more accessible in urban areas, leaving rural residents underserved. Furthermore, resources are often diverted to high-cost, hospital-based services, which tend to benefit fewer individuals, and away from lower-cost services, which tend to benefit larger populations (Birdsall, 1989; Jiminez, 1987). In addition, free services can lead to long lines at service outlets and create incentives for providers to charge clients unofficially. From the perspectives of efficiency and equity, then, a desirable alternative to free family planning services is a targeted approach in which public funds are used to support providers serving vulnerable populations such as the poor.

Market segmentation is useful in assisting policymakers and program managers to effectively target their resources. In many countries, market segmentation studies have guided program managers in identifying well-off consumers and shifting them to more appropriate outlets (e.g., commercial providers), thereby conserving public resources. Consumer data can be used to segment the market into subgroups based on socioeconomic and other characteristics. Each subgroup, or market segment, can be analyzed to determine answers to questions on ability and willingness to pay, supply source, and other factors. USAID policy programs have successfully used market segmentation to alleviate governments' service delivery burden and to discourage the public sector from "crowding out" or undercutting private services.

In Egypt, for example, the market for contraceptives is generally well segmented. A recent study showed that a set of consumer characteristics clearly differentiates market segments for condoms, pills, and IUDs (Berg, Winfrey, and Sine, 1995), with the IUD market especially well segmented. The public sector has performed successfully in targeting users with low ability to pay, particularly in rural areas. Likewise, with widely available subsidized IUDs and oral contraceptives, private voluntary organizations and the private commercial sector have found appropriate niches and offer services and supplies at a variety of prices to meet the needs of the

existing pool of users. Based on these findings, the study suggests the enactment of policy reforms to sustain the segmented market. Clearly, understanding consumers' choices in this market will provide policymakers with important planning information to ensure that the evolution of the family planning system keeps pace with other social and economic changes.

3. Facilitating private sector provision of family planning services — *Efforts to increase private sector participation in family planning service delivery should begin with the public sector.*

The public sector provides the large share of family planning services in most developing countries. In many countries, however, the private sector (mainly the commercial private sector) is a major source for many contraceptive users.[2] Promoting policies that expand the provision of services through private sector channels will ensure increased financial resources for and better access to quality family planning services.

For three main reasons, it is beneficial for government and donor efforts to increase the role of the private sector in family planning. First, governments alone may not be able to meet the growing financial demands for family planning. Indeed, governments are beginning to face this harsh reality despite firmly held beliefs about health care as entitlement. Several governments of middle-income developing countries are grappling with changes in policies toward universal health care as donors have announced plans to phase out their support to the programs and to turn over responsibility to the host government. In these countries, programs have made great strides, but widespread infrastructure is costly to support. The tab for assuming all program costs without donor assistance—while still expanding coverage to reach hard-to-reach populations—is beyond the fiscal capability of governments. Governments can, however, stimulate additional investments in the private sector to obtain the necessary coverage.

Second, many poor people already obtain their family planning services from the private sector, sometimes because they do not have adequate access to public services but also because they often prefer private sector services if they can afford them. Given that practitioners must support themselves on consumer payments, consumer satisfaction is a key ingredient of private services. Attention to consumer satisfaction is reflected in amenities such as more convenient locations, shorter waiting times, competitive cost, and the availability of medicines and commodities.

The third reason to increase the private sector's role in the provision of family planning services is that many well-off consumers use public sector services, which may limit the access of poorer groups. From an economic standpoint, resources are not conserved if the public sector provides services to those who could pay for them in the private sector. Government programs should be geared to attracting new users who cannot afford to pay for family planning.

When governments do begin to open up to private sector participation, it is important that donor programs and polices support that direction. In Egypt, for example, the Ministry of Health has been concerned that promoting private services for more well-off consumers will leave it with the difficult task of serving large populations of the poor, often in difficult-to-reach areas. In such cases, donors can make it easier for the public sector to do the "heavy lifting" by offering

[2] A recent study shows that the for-profit private sector accounts for 10 to 50 percent of all family planning use in most countries that have conducted a demographic and health survey (Winfrey et al., 1998).

incentives. Incentives offered by donors are, however, sometimes contradictory. Motivated to develop widespread family planning programs, donors and host governments may adopt benchmarks for the public sector that call for increased volume. Despite the good intentions behind this performance measure, it may heighten unintended competition between the public and private sectors as better-off families are easy targets for the government program in its efforts to increase volume. In this case, it may be more useful to set up incentives that reward the public sector for serving consumers from a poor or disadvantaged background rather than for serving someone who might be a potential user of the private sector. In short, well-conceived government policies are needed to help stimulate the expansion of privately provided family planning.

Technical assistance has helped developing country governments pave the way for expanded private sector service delivery. Policy analyses, assistance in strategic planning, market segmentation studies, pricing studies, and other supports can demonstrate the need for private sector participation. In Egypt, for example, the government has identified private sector involvement as a priority as the country prepares to phase out USAID assistance and commodities. Technical assistance helped the government identify and remove legal and regulatory barriers to private sector service delivery and strengthened its ability to plan strategically and make informed decisions.

4. Clients' ability to pay — *Many public sector clients can afford to pay for needed services either in part or in full.*

In some settings, many poor families pay for their medical care and family planning services either in part or in full. Governments can establish cost-recovery mechanisms (e.g., user fees) or increase the price charged for public sector services when cost-recovery mechanisms already exist. User fees, commonly considered a means of generating revenue to cover operational costs, have many positive effects. They can increase the efficiency and equity of health and family planning services, even if the fees do not generate sufficient revenues to cover a large share of recurrent costs (Foreit and Levine, 1993). In addition, they can instill among clientele an appreciation of the value of services. Thus, policymakers are increasingly willing to consider implementing (or increasing) user fees for at least some health-related goods and services as long as the fees do not reduce overall demand for family planning or result in hardships to the poor.

However, the introduction and enforcement of user fees often meets considerable political and operational barriers. Fearing political backlash, governments that have historically provided free services typically are reluctant to start charging fees. Policymakers may be concerned that potential family planning users are sensitive to prices. They may expect user fees to result in a reduction of service use and a decline in contraceptive prevalence. Pricing studies that assess possible effects of establishing or raising user fees can allay these concerns. Such studies can also help policymakers and program managers formulate cost-recovery policies and successfully advocate for them, thus leading to implementation.

In Ghana, a pricing study had significant impact on the fee structure for public sector services (Kress et al., 1995). In a climate of inflation, government prices for family planning services had failed to keep pace with nongovernmental and commercial sector prices. The result was limited potential for cost recovery because consumers who would have otherwise used private or nongovernmental services took advantage of lower-priced government services. The study also found that in response to low official prices, individual public sector clinics were

charging higher prices unofficially. Thus, many public sector clients, even those in the lowest income groups, were asked to pay significantly more for their services and were willing and able to do so. In response, the study recommended that the Ministry of Health increase the official price and permit more revenue to be retained at the clinic level. Such steps would aid health facilities by increasing the revenue that could be used to support service delivery and quality improvements. The increase in public sector prices, the study asserted, would also foster sustainability by preparing the government for reductions in donor commodity assistance and by signaling well-off consumers to use the private sector.

The Ghana study suggested two options for increasing public sector prices: specific cost-recovery targets as a guide to setting new and future prices, and lower cost-recovery targets for rural consumers to attenuate the impact of the price increases. Finally, the study recommended administrative reforms concerning the use of retained earnings so that service delivery points would still benefit after the price increase. The Ministry of Health subsequently supported an increase in prices and the revision of guidelines for the use of revenues generated by sales of donated commodities.

5. Legal and regulatory barriers — ***Legal and regulatory barriers can impede the involvement and performance of the private sector.***

Legal and regulatory barriers make it difficult to establish or expand private sector family planning services. Government policies can restrict private sector service delivery either directly (e.g., by forbidding certain types of providers from supplying certain methods) or indirectly (e.g., by imposing taxation policies that render private services too expensive for target consumers). Common legal and regulatory barriers in the developing world include restrictions on methods and procedures, prescription requirements, constraints on private practice, value-added taxes and other sales/income taxes, import tariffs, advertising restrictions, patent/trademark barriers, and regulatory price controls.

Studies, analyses, and dissemination of results to key policymakers have helped alleviate legal and regulatory barriers to private sector service expansion. In Egypt, for example, a comprehensive study of the Egyptian reproductive health care system played a major role in liberalizing laws restricting provision of injectable contraceptives to licensed obstetrician-gynecologist (ob-gyn) specialists (Ravenholt and Butler, 1993). Although many public sector polyclinics employed an attending ob-gyn, general practitioners in private sector practice did not have a similar advantage. Hence, the laws put the private sector at a disadvantage. The study concluded that restricting the delivery of Depo Provera to ob-gyns was a significant constraint to expanded reliance on this method because private sector consumers could not obtain it from their preferred provider. Based on this finding, the report recommended that the Ministry of Health ease restrictions on Depo Provera and allow it to be distributed by general practitioners. The law was subsequently changed, dramatically expanding the availability of Depo Provera to consumers.

In the Philippines, a study examined the impact of customs duties and a value-added tax (VAT) on the sale and use of imported contraceptives (Alano and Cross, 1994). It showed that eliminating the tax could increase oral contraceptive users by up to 25,000 couples per year. It also suggested ways in which the streamlining and removal of annual ceilings on imports could be achieved. The Department of Health (DOH) management committee adopted the recommendations unanimously and agreed to take the lead in managing the policy reform

process. Policy reform of this nature may, however, falter on the way to implementation. In fact, the Philippines did not adopt this reform for two reasons: first, the controversy surrounding the 1994 International Conference on Population and Development diverted attention from the VAT issue and, second, the VAT on imported contraceptives is part of a larger VAT system that the International Monetary Fund did not allow the Philippines to change at the time.

In Guatemala, the social security organization (IGSS), which provides health services to beneficiaries, operated under laws that did not allow it to provide family planning services. Nonetheless, a survey measuring the attitudes toward and use of contraceptives among female workers and the wives of IGSS employees showed that an overwhelming majority of IGSS beneficiaries wanted to plan their families but had to go to another health institution to obtain contraceptives (Kirmeyer and Mostajo, 1992). Widespread dissemination of the survey results at the regional and national levels ultimately led the president of the IGSS to draft a memorandum authorizing all IGSS facilities to provide a full range of family planning services to beneficiaries.

6. Government role in regulating quality of care — *Governments have a fundamental role in regulating the quality of private sector health services; however, many governments lack experience in regulating the private sector.*

Because of concerns over "turf," government officials are often hesitant to relinquish responsibility for service delivery to the private sector. Officials need to understand that the government will continue to play a vital role, not only as financier of services but also as a regulator of service quality, safety, and ethics. Unfortunately, many developing country governments are inexperienced in regulating the private sector. Public officials in developing countries often do not understand the private sector and subsequently impose regulations that are either too lax or too restrictive.

Donors can stimulate dialogue between the public and private sectors, engender trust and build communication links, and foster a regulatory framework that encourages rather than constrains private sector involvement in family planning service delivery. Through strategic planning sessions and other forums, donors can assist in forging public/private partnerships to ensure that appropriate regulatory mechanisms are structured and implemented (e.g., licensing, accreditation, inspection, provisions for malpractice claims) and that the private sector in a competitive market can do what it does best—provide quality services at competitive prices to informed consumers. In addition, donors can help the public sector establish a regulatory system that offers incentives for private providers to behave ethically and responsibly. Such systems have proven more effective than systems that rely solely on punitive measures.

Establishing effective regulatory systems is a first step in many developing countries. In the Central Asian Republics, for example, an examination of the regulatory systems in Kazakstan and Kyrgyzstan showed that regulations pertaining to the nascent private sector were few and vague (Ravenholt, 1994a,b). The project staff worked with the public sector in these countries to establish quality standards and incentives in order to encourage ethical and responsible behavior. With USAID assistance, governments of Central Asia are beginning to work effectively with private reproductive health providers without micromanaging their efforts.

7. Private sector interest in collaboration — *The private sector is often able and willing to work with the public sector as a partner.*

As mentioned earlier, many governments do not understand the private sector in terms of its diverse strengths, weaknesses, attitudes, and aspirations. As a result, governments often under-estimate the willingness of private providers to become involved in family planning service delivery. In many countries, large numbers of physicians, midwives, and other types of providers would gladly provide family planning services if they had the proper training and a receptive regulatory environment—which only the public sector can establish. Conducting surveys of private providers to identify their number, geographic location, qualifications, and interest in providing services can help public sector officials become more aware of the untapped potential of the private sector. Such activities have proven beneficial throughout the developing world. In Jamaica, for example, mapping all private service delivery points in the country and surveying private physicians to determine their clinical skills and interest in providing family planning services provided valuable baseline data for program planning that extended well beyond the immediate need to mobilize the private sector (Bailey et al., 1994).

Several studies carried out in India also provided new, concrete information about the potential of private practitioners and employers in the northern state of Uttar Pradesh. Among the major findings, the studies revealed that the vast majority of surveyed rural practitioners in the state are interested in providing family planning, even though they lack rudimentary training in delivering these services (Deolikar and Vashishtha, 1992). Involving these practitioners in family planning service delivery would be a significant achievement, given that a substantial portion of their current clientele consists of women of reproductive age. The studies also examined the potential for employers to add family planning benefits to employee health services, the potential for cooperatives to deliver family planning services, rural clients' perceptions of the quality of health/family planning care, and health care expenditures and utilization (Cross and Levine, 1993; Cross et al., 1993; Levine et al., 1993a,b). These studies helped build support among high-ranking Indian policymakers for rural, private family planning services.

8. Donor Collaboration — *Donors and cooperating agencies need to communicate and collaborate to ensure synergy of efforts in the field.*

In helping governments develop effective reproductive health programs, donors must communicate and collaborate to ensure that they do not work at cross-purposes. In numerous instances, a donor program has made significant strides only to see another donor undercut the effort through a lack of coordination. For example, over the years, certain donors have worked to build the private reproductive health care sector in developing countries, recognizing that private sector participation in family planning contributes to sustainability and minimizes future assistance needs. In some instances, other donor organizations have inadvertently undercut such efforts by flooding the market with free commodities, making it difficult—if not impossible—for private providers to compete. To avoid such a situation, donors should agree that a certain segment of the population requires highly subsidized products if it is to use contraception at all. Working with the host government, donors could ensure that subsidies are targeted only to those most in need while those willing and able to pay for a product or service patronize private providers.

In Turkey, donors recognized the need to coordinate their efforts and met to discuss strategies. Specifically, USAID/Ankara coordinated its plans to phase out contraceptive donations with other donors. As a result, various donors carried out their activities in a complementary fashion that contributed to each donor's specific objectives. The situation in Morocco, however, where USAID is helping the government prepare for the phase-out of contraceptive support, exemplifies the pitfalls of a lack of donor collaboration. As USAID works to foster contraceptive self-reliance, another donor has indicated that it may step in and provide free contraceptive supplies.

To ensure synergy and avoid duplication of effort, donors and their project staff should establish a mechanism for regular communication, meet regularly, and develop joint assistance strategies when possible. This same lesson applies to cooperating agencies (CAs) providing technical assistance. CA inputs need to be coordinated to ensure optimal impact of all activities. When CAs work with different host-country counterparts (for example, with the public sector to build service programs or with the commercial sector to build social marketing programs), it is especially easy to work in isolation and to forget that actions in one sector have an impact on another. Coordination can be helpful in getting the most out of technical assistance visits, expanding participation at seminars and training workshops, and exploiting data that may have implications for a variety of service providers in the health care system. In conjunction with host-country leaders, CAs can facilitate national strategic planning that is designed to look at the future expansion goals of public, private commercial, and NGO service providers. Strategic planning can be helpful in stimulating the relevant actors to be more dynamic, focused on their own niches within a segmented system, aware of each other's plans and actions, and willing to collaborate.

Country Examples

The following country examples are based on the technical assistance provided under two USAID-funded projects: Options for Population Policy II Project (Contract No. DPE-3035-C-00-6062-00) and the POLICY Project (Contract No. CCP-C-00-95-00023-04). Each country example indicates the applicability of one or more of the lessons described in the first part of this paper. The particular policy lessons that apply to the country example are highlighted in a box similar to the one below.

LESSONS LEARNED

- ✓ Government role in ensuring sufficient resources
- ✓ Targeting government subsidies
- ✓ Private sector provision of family planning services
- ✓ Clients' ability to pay
- ✓ Legal and regulatory barriers
- ✓ Government role in regulating quality of care
- ✓ Private sector interest in collaboration
- ✓ Donor coordination

BRAZIL

LESSONS LEARNED IN BRAZIL

- ✓ Government role in ensuring sufficient resources
- ✓ Targeting government subsidies
- ✓ Private sector provision of family planning services
- Clients' ability to pay
- Legal and regulatory barriers
- Government role in regulating quality of care
- Private sector interest in collaboration
- ✓ Donor coordination

FINANCE AND PRIVATE SECTOR ISSUES. Private sector family planning coverage in Brazil, among the highest observed in South America, focuses primarily on two methods: oral contraceptives and female sterilization. The latter is often carried out in conjunction with cesarean section deliveries. A large segment of the population is covered by prepaid medical plans such as health maintenance organizations (HMOs) and private health insurance that provide few temporary contraceptive methods. Given that fertility levels among their female beneficiaries are already low, managers of prepaid medical plans need to be convinced of the merits of offering family planning services as part of plans that already require an emphasis on cost containment, particularly since the expected benefits from births averted will be low.

Brazil's public sector is not involved in the provision of family planning services because the issue is too socially and culturally sensitive among government officials and Catholic leaders. Consequently, for individuals working outside the formal sector, access to family planning in the poorer states may be limited. Therefore, it is important for the government to assume an active role, provide direction, and target efforts at increasing access among the poor.

INTERVENTIONS. Activities undertaken in Brazil encouraged expansion of the method mix offered by Brazilian medical plans and strategic planning for the provision of public sector family planning services at the subnational level.

HMO Method Mix. Cost considerations have constrained private provision of a full range of contraceptive options. From 1991 to 1994, several USAID-funded projects collaborated with a major Brazilian HMO, Promedica, in an operations research effort that examined the acceptability and cost-effectiveness of postpartum IUD insertion (Foreit, 1994b). At a hospital in the state of Bahia, Promedica found that postpartum patients who wanted more children readily accepted IUDs before leaving the hospital, thereby saving both client and provider costs of postdischarge insertion. Postdischarge insertion was also found to incur higher rates of outpatient consultations than the in-hospital, postpartum, or postabortion service. Women who did not desire more children continued to elect sterilization.

Because Promedica found postpartum IUD insertion to be cost-effective, the HMO disseminated the research results among other HMOs to encourage replication of the program. Although the worsening economic climate made it difficult for other providers to offer new services, the research fostered greater involvement of the public, nonprofit, and private commercial sectors in reproductive health service planning.

At the close of the study with Promedica, two issues remained. First, the Brazilian government and donors needed to address the issue of narrow method choice (e.g., both oral contraceptives and female sterilization are regularly available while IUDs are not) and the solutions needed to expand the range of available methods (e.g., IEC, advocacy, legal and regulatory reform). Second, other HMOs did not replicate Promedica's program of postpartum insertion in part because of the government's reluctance to provide the requisite support for the initiative. The public sector could perhaps facilitate training in IUD insertion to overcome provider bias and provide the policy support needed to make IUDs an option affordable to HMOs.

Strategic Planning for Public Sector Service Provision at the Subnational Level. Historically, the private commercial sector has delivered most formal family planning/reproductive health services in Brazil. Major policy issues have included the need to expand public sector service provision to reach certain target groups and the need for the national government to encourage strategic planning at the state level. In two underdeveloped states, Bahia and Ceara, one of the objectives for program expansion was development of a stronger program of public sector services specifically aimed at needy groups. To strengthen subnational planning, the state governments of Bahia and Ceara participated in strategic planning exercises within their health secretariats. As a result, Bahia's health secretariat completed a five-year plan for reproductive health, prepared a booklet summarizing the plan, developed the first-year implementation strategy, and hosted a collaborative meeting for state officials and international donors to launch activities. In Ceara, BEMFAM, Brazil's largest family planning NGO, contributed to the development of an operational plan for Viva Mulher, the state women's health program. Furthermore, the introduction of BEMFAM's analyses of Demographic and Health Survey (DHS) data at the appropriate stages of the planning process encouraged collaboration between the state and the private sector. The need for collaboration clearly exists within decentralized systems, and central governments must provide this direction.

CENTRAL ASIAN REPUBLICS

FINANCE AND PRIVATE SECTOR ISSUES. The governments of the member countries of the Central Asian Republics (CAR), due to their heritage of socialized medicine, have been reluctant to provide health care services for a fee or through the private sector. However, the poverty of the republics as they emerged from the Soviet system meant that the governments lacked the hard currency required to fund family planning services and free contraceptives.

LESSONS LEARNED IN THE CAR

- ✓ Government role in ensuring sufficient resources
- ✓ Targeting government subsidies
- ✓ Private sector provision of family planning services
- Clients' ability to pay
- ✓ Legal and regulatory barriers
- ✓ Government role in regulating quality of care
- Private sector interest in collaboration
- ✓ Donor coordination

INTERVENTIONS. The USAID-funded Reproductive Health Services Expansion Program (RHSEP)[3] realized at the outset that it was necessary to become familiar with European socialized health systems vis-à-vis private sector service delivery. Attempts to formulate a policy encouraging private sector participation in the family planning market began with efforts to encourage public sector recognition of private sector potential.

RHSEP's first steps were to generate awareness of the problem, facilitate advocacy for reproductive health, and create interministerial forums for planning purposes. Subsequent activities were designed to encourage increased allocation of public and private sector resources to reproductive health needs and to advocate for greater inclusion of the private sector with government counterparts. The latter was especially urgent given the embryonic state of the private sector in the former Soviet Union. In addition to raising the awareness of the public sector about private sector potential, collaborative efforts in Uzbekistan led to the establishment of a physicians' association.

Another important policy issue was the legal and regulatory barriers that prevented effective family planning programming. The RHSEP invested in social marketing to accomplish the transition to private sector service provision and conducted a legal and regulatory analysis in Kazakstan and Kyrgyzstan. The analyses disclosed a number of barriers: restrictions on sterilization except for medical reasons; limitations on the administration of Depo Provera; medical biases against hormonal contraceptives; licensing restrictions for private providers; limitations on the range of permissable private providers versus public provider family planning activities; registration restrictions on imported pharmaceuticals; and a regulatory framework that precluded private sector development (see Ravenholt, 1994 a,b).

With technical assistance, counterparts took preliminary steps to ameliorate conditions in the regulatory environment to encourage private service provision in the CAR. In Kyrgyzstan, counterparts prepared, printed, and disseminated new medical guidelines, although at present, the Kyrgyzstan government needs to ensure implementation of the new guidelines

[3] RHSEP was a program of technical assistance carried out from 1993-1996 to facilitate a supportive policy environment and efficient delivery of diverse reproductive health services. Six cooperating agencies participated in the program: OPTIONS, AVSC, JHU/PCS, JHPIEGO, DHS, and SOMARC. See OPTIONS Project (1995).

because legal and regulatory barriers continue to restrain the development of family planning systems. Heavy licensing fees for establishing a private voluntary organization or a private practice and a long and cumbersome licensing process are major impediments to change. Taxes on private sector medical providers are extremely high, making it difficult for private practices to survive. Specific problems require identification and analysis. Subsequent advocacy activities to remove these and other policy barriers will be necessary.

Counterparts in the CAR needed a great deal of training in quantitative and qualitative data analysis. The last centrally collected demographic data came from the Soviet census of 1989; since then, the republics have maintained separate data collection systems. RHSEP conducted provider surveys in a number of the republics to fill data gaps. During this process, local counterparts received extensive hands-on technical assistance to improve the scientific integrity of data collection and the quality of the data analysis. Ultimately, the training will mean a better profile of consumers.

As the republics decentralize their government systems, the use of data to identify geographic areas in which the private sector can flourish will become more important. Understanding the consumer market helps stakeholders advocate for the difficult policy decisions that will facilitate development of the private sector. Leaders need data to identify the target markets for subsidized public sector services and sustainable private sector services. The policy environment would also benefit from efforts to build population-based data relevant to market segmentation, policy analysis of supply and demand, impact of subsidies, and modeling of the impact of various policy changes. A supportive policy environment for the private sector would also ensure that private sector providers have access to family planning and reproductive health communication materials and affordable equipment.

Overall, the CAR governments do not fully understand the high human capital and service costs associated with high fertility levels and reliance on abortion rather than modern contraceptives. As a result, CAR governments have placed a low priority on contraceptive procurement. They do not include contraceptive products on their essential drug lists and therefore cannot purchase them with European Community loans or import them free. Stakeholders must continue to support the development of a diversified contraceptive market and ensure distribution of contraceptives throughout the system.

With respect to donor coordination, the RHSEP encountered some difficulty in building long-term strategies in the face of the short-term humanitarian aid funneled into the CAR through counterpart donor programs. Not all donors are committed to a segmented market, and some donated commodities compete with private sector initiatives. Improved communication and collaboration among donors is necessary.

EGYPT

LESSONS LEARNED IN EGYPT

- ✓ Government role in ensuring sufficient resources
- ✓ Targeting government subsidies
- ✓ Private sector provision of family planning services
- ✓ Clients' ability to pay
- ✓ Legal and regulatory barriers
- Government role in regulating quality of care
- ✓ Private sector interest in collaboration
- Donor coordination

FINANCE AND PRIVATE SECTOR ISSUES. In Egypt, leaders have made strong statements about the need to reduce the population growth rate, but operational policy issues (such as institutional capabilities, the policy environment for reform, and contraceptive pricing and cost-recovery issues for sustainability) limit development of an optimal mix of family planning sources and methods. Maintaining a strong private commercial sector has the potential of increasing the efficiency and effectiveness of the family planning program through reliance on market forces, yet policies such as price controls may reduce access. Efforts are underway to increase the use of available data for effective programmatic decision making, especially in terms of strengthened decentralized program planning.

INTERVENTIONS. Assistance in support of sustainability and private sector participation in Egypt's reproductive health sector focused on allocating more government resources to population activities; shifting the family planning program toward greater independence from donor support; developing recognition among government leaders of the private sector's great potential for generating and meeting demand for family planning services; and creating a favorable legal and regulatory environment for improved access to a sufficiently wide range of methods. To address these issues, three types of studies were carried out: a set of expenditure studies, a legal and regulatory analysis, and a set of policy studies.

Intended to examine public sector resource allocation and support of the private sector, public sector expenditure studies—designed and carried out from 1991 to 1992—showed a relative increase in donor support for the family planning program and a decline in the percentage of public sector costs borne by the Egyptian government (Heilman et al., 1992). The summary report entitled "Trends in the Public Sector Costs of Family Planning Programs in Egypt and Their Policy Implications" (Heilman, 1993) was presented to ministry officials under the auspices of the National Population Council (NPC). The expenditure studies demonstrated to both the Egyptian government and USAID the importance of measuring the cost of providing family planning services. Results of these studies have found extensive application in planning for the long-term sustainability of the Egyptian program. Furthermore, the expenditure studies have institutionalized the capability of some service delivery organizations to collect relevant data.

Expansion of the private sector's participation demands a supportive legal and regulatory environment (i.e., enhanced public sector coordination). A 1993 legal and regulatory analysis identified those laws and regulations that significantly constrained private contraceptive manufacturing (Ravenholt and Russel, 1993) and the expansion of family planning services provided by private practitioners and pharmacists in Egypt. The analysis and conclusions were subsequently presented at a high-level seminar attended by Egypt's Minister of Population. According to USAID, the analysis played a major role in changing the law that prevented general practitioners from administering Depo Provera.

Three policy studies conducted in 1995 that looked at increased private sector participation yielded important policy implications. The findings from a study of consumer profiles suggested that the market was well segmented across the types of providers supplying services (Berg, Winfrey, and Sine, 1995). In rural areas where the private sector was not able to expand because of an impoverished and/or dispersed population, the public sector provided contraceptives. Findings from the second study (Winfrey and Sine, 1995), which focused on the issue of IUD source and pricing, demonstrated the importance of marketing a moderately priced IUD to preserve private commercial sector participation. The third study of private physicians and pharmacists (Foreit and Sine, 1995) suggested that private physicians could be encouraged to become more active in family planning service delivery as well as possible private sector responses to the end of donor-subsidized contraceptives.

These reports, widely disseminated by USAID/Cairo and the NPC, were presented in May 1995 at a national conference, "Further Strengthening the Policy Environment for Family Planning in Egypt." Attended by a cross-section of public and private sector family planning decision makers and program managers, the conference launched four policy advisory working groups intended to advise the Ministry of Population on issues of pricing, contraceptive method expansion, legal and regulatory issues, and curriculum development (for a number of reasons, however, the working groups never convened). In addition, the three papers stimulated dialogue within the government on topics such as method mix and market segmentation for public and private sector service delivery—all the more important as USAID takes a new look at financing and sustainability issues in the Egyptian program.

With nearly 50 percent of family planning services provided by the private commercial sector, Egypt holds a strong advantage over countries struggling with initial market segmentation efforts. Nonetheless, operational policy issues still remain. The roles and responsibilities of key institutions must be specified, the strategic vision clarified, and leaders' ability to achieve these visions enhanced.

GHANA

LESSONS LEARNED IN GHANA

- ✓ Government role in ensuring sufficient resources
- ✓ Targeting government subsidies
- Private sector provision of family planning services
- ✓ Clients' ability to pay
- Legal and regulatory barriers
- Government role in regulating quality of care
- Private sector interest in collaboration
- Donor coordination

FINANCE AND PRIVATE SECTOR ISSUES. Since 1989, no family planning services in Ghana have been completely free. While the commercial sector has been raising prices to keep pace with inflation, the public sector has maintained the same token price levels. As a result, people who desire family planning services generally do not patronize the private sector. To promote the use of private sector resources in Ghana, then, the main issue was that of public sector finance.

INTERVENTIONS. A pricing study was conducted in 1995 to assist the Ministry of Health (MOH) in setting prices for services delivered through the public sector (Kress et al., 1995). The study revealed that government prices had not kept pace with inflation or with NGO and private sector prices, thereby inhibiting cost-recovery potential and over-subsidizing consumers who had the ability to pay for private or NGO services. Many public sector clients, even those in the lowest income group, were willing and able to pay more for needed services.

The study made two recommendations regarding an increase in public sector prices. The first called for specific cost-recovery targets as a guide to setting new and future prices. The second outlined a strategy for using lower cost-recovery targets for rural consumers to attenuate the impact of price increases on them. Together, these steps would aid health care facilities by generating revenue that could be used to support service delivery and quality improvements without reducing demand. The increase in public sector prices would also foster sustainability by preparing the government for reductions in donor commodity assistance and by signaling well-off consumers to use the private sector. Finally, the study recommended administrative reforms concerning the use of retained earnings so that service delivery points would benefit from the price increase. The pricing study and accompanying presentation spurred support from the MOH to raise prices in 1995 and reallocate the use of revenues generated by sales of donated commodities.

The emerging USAID assistance program has provided an opportunity to support Ghana's efforts to reform pricing mechanisms and evaluate policy actions. When the public sector failed to meet its targets for short-term methods in 1996 (as measured by couple-years of protection or CYPs), the 1995 price increase was suspected as a cause. A follow-up study (Kress and Dayaratna, 1997), however, found that the price increase was linked to the 1996 shortfall in public sector short-term commodity distributions, but not because of a reduction in demand. Prior to the 1995 price increase, there was considerable leakage of public sector commodities into the commercial market. Government CYP targets reflect the total distribution of public sector commodities, regardless of their final disposition. The public sector price increase reduced the leakage of contraceptives into the commercial market, so the targeted CYP was not achieved. Thus, the shortfall in short-term method CYPs actually represented a "return to reality," whereby products distributed by the public sector were now being consumed by public sector clients. Although the situation in Ghana is not fully resolved, the 1995 price increase and subsequent recommendations have been useful in exposing a more accurate picture of the market in addition to recognizing the market niche of clients with a demonstrated ability to pay more for contraceptives.

GUATEMALA

LESSONS LEARNED IN GUATEMALA

- ✓ Government role in ensuring sufficient resources
- Targeting government subsidies
- Private sector provision of family planning services
- Clients' ability to pay
- ✓ Legal and regulatory barriers
- ✓ Government role in regulating quality of care
- Private sector interest in collaboration
- Donor coordination

FINANCE AND PRIVATE SECTOR ISSUES. Although some support for family planning and reproductive health programming exists within the Guatemalan government, it is difficult for the public sector to create or maintain a strong position that would favor reproductive health given the climate of vocal opposition to family planning among conservative government and Catholic church leaders. Because the policy environment is unlikely to promote an expansion of public sector service provision, family planning and reproductive health activities in Guatemala would benefit from collaboration with the private sector. The Guatemalan Social Security Institute (IGSS), a quasi-private sector entity financed by employee and employer contributions, provided an important inroad to the development of private sector support for and participation in family planning.

INTERVENTIONS. Over a two-year period ending in 1993, IGSS physicians participated in a process to change the laws to permit the IGSS to provide family planning services. With technical assistance, an IGSS team conducted a survey to measure attitudes toward and use of contraceptives among female IGSS beneficiaries and the wives of male beneficiaries (Kirmeyer and Mostajo, 1992). The survey showed that the majority of beneficiaries wanted to plan their families and to use IGSS facilities to obtain contraception. The results provided the basis for a memorandum authorizing IGSS to begin providing family planning services. IGSS has made great strides in expanding its new family planning program. It offers on-site programs located at IGSS facilities in the capital and in Escuntia. IGSS plans to expand its programs further, although it is struggling to find the resources to do so.

With technical assistance, a committee of experts from both the public and private sectors revised provider guidelines to update the family planning and reproductive health standards of practice. While supportive of the recommendations, the MOH was uncomfortable in pursuing further reform in view of the government's current reluctance to address reproductive health. Indeed, the MOH is not comfortable with treating reproductive health as an isolated issue. The current stalemate within the public sector underscores the need to mobilize different entities within the private sector. Although IGSS is a willing partner, its efforts are stymied by a lack of funds. Guatemala would benefit from the greater participation of NGOs that are willing to support reproductive health issues and of commercial sector representatives that have a demonstrated interest in providing family planning services.

High-level attention to the issue of medical barriers, in the form of a request by the vice minister of health, launched a legal and regulatory reform effort in 1992. The MOH collaborated with technical advisors to conduct a survey of 102 providers in eight regions to measure their attitudes and practices regarding family planning and contraceptive methods. The report, "An Assessment of Medical Barriers to Family Planning Programs in Guatemala" (MOH, 1992), revealed significant barriers to the provision of family planning services and offered clear policy recommendations to overcome these obstacles.

INDIA

LESSONS LEARNED IN INDIA

- ✓ Government role in ensuring sufficient resources
- Targeting government subsidies
- Private sector provision of family planning services
- Clients' ability to pay
- ✓ Legal and regulatory barriers
- ✓ Government role in regulating quality of care
- ✓ Private sector interest in collaboration
- Donor coordination

FINANCE AND PRIVATE SECTOR ISSUES. With a 1997 population size of over 150 million persons, the state of Uttar Pradesh (U.P.) is India's largest state. Modern contraceptive prevalence is slightly more than 20 percent, reproductive health indicators are poor, and public health services reach only a small portion of the population. In this environment, technical assistance has focused mainly on the development and implementation of the $325 million Innovations in Family Planning Services (IFPS) Project, a bilateral project that seeks to increase family planning access and quality and raise demand for services. One of its main approaches is to expand the use of the private sector as a conduit for services and information.

INTERVENTIONS. More than 80,000 traditional practitioners deliver the large share of outpatient health care in U.P. They practice medicine in most villages and constitute an enormous untapped resource. A survey of these rural practitioners collected data about their backgrounds, the type and amount of services offered, and their interest in improving their knowledge of family planning and reproductive health (Deolalikar and Vashishtha, 1992). The study determined that rural practitioners could potentially form an extensive network of service and information providers for spacing methods. It also set forth the foundation for pilot projects under the IFPS Project. The pilot projects proved so successful that working with rural practitioners has become a major focus of the project.

A study of employers surveyed current family planning provision, employee needs, and companies' interest in expanding employee benefits if provided with technical assistance (Cross et al., 1993). Such programs, if widely adopted, could potentially provide family planning to 10 percent of the reproductive-age population in U.P. Subsequently, the IFPS Project has funded several major efforts to expand family planning benefits through employers and their associations.

Another study examined Primary Agricultural Credit Societies (PACS), handloom cooperatives, sugar cooperatives (both growers and factories), and milk cooperatives (Cross and Levine, 1993). Although members of cooperatives generally desire access to expanded family planning and reproductive health services, cooperative officials expressed wariness that delivery of more wide-ranging services and the diffusion of resources would compromise the primary functions of the networks. The study further suggested that the U.P cooperatives might not be sufficiently developed structurally to handle expansion. However, given the broad inclusion of (most often rural) workers and the established economic and communication networks offered by cooperatives, the study detailed the most plausible avenues—milk cooperatives exhibited the highest potential—for initiating demonstration projects that might serve as successful models for others. The IFPS Project now sponsors seven milk cooperative projects that use community-based distribution workers to cover several hundred thousand cooperative members and their families.

An important component of investigating alternative mechanisms for service delivery is a thorough understanding of client needs. Accordingly, a fourth study examined client needs through a series of focus groups (Levine, Cross, Chhabra, and Viswanathan, 1993). The study revealed that government doctors are viewed as more highly qualified for family planning work than their private sector counterparts. However, in all other aspects of perceived quality of care, private sector physicians outranked public providers. The study suggested that effective IEC to dispel common misunderstandings about various family planning methods, specialized training of private physicians, and a responsive government referral system, especially for clinical methods, could greatly expand access and quality of services. Findings from this study were used to increase the emphasis on quality in the IFPS Project.

A fifth study on health care expenditures and utilization, based on 1990 survey data of 18,102 households across 21 states including U.P., reviewed the demographics of health care utilization and the implications for efficient public and private sector service provision (Levine, Cross, Gopal, and Viswanathan, 1993). The report revealed that Indians have a lower rate of health care contacts than has been deemed necessary for preventative care and that the rates vary across demographic groups, with female children receiving the least care. Further, the cost of service in rural areas exceeds urban care costs; and the poor generally do not use primary health centers (PHCs) as frequently as the more wealthy, even though PHCs were designed to serve the poorer population. An increase in public sector fees would signal wealthier clients to use private sector resources as well as potentially generate additional revenues for the public sector. Increased revenues could be applied to improving accessibility and reducing costs of health care services in rural areas.

These activities in India between 1992 and 1995 were instrumental in helping to formulate strategic approaches to implementing the IFPS Project. A recent and extensive USAID evaluation found that the project was using highly effective approaches to meet family planning needs in U.P. This initial success is partially a result of the sound strategic planning and policy analysis work based on these early studies. Building on the studies as a foundation, SIFPSA (the implementing organization for the IFPS Project) implemented a number of pilot projects. These projects have recently been appraised by using rapid assessment techniques, with the most promising initiatives identified for expansion.

Policymakers and program managers have continued to be interested in creating more effective public/private partnerships. With technical assistance, decision makers used population-based survey data (from the PERFORM survey) to look at consumer segments and patterns of usage of public and private sector family planning. Most recently, a market segmentation analysis addressed both social marketing and policy interests by identifying new marketing strategies for social marketing products. Shop audits and a study of the impact of subsidies, among other studies, contribute to strengthened private sector service programs and a more favorable policy climate for private sector expansion.

INDONESIA

> **LESSONS LEARNED IN INDONESIA**
>
> - ✓ Government role in ensuring sufficient resources
> - ✓ Targeting government subsidies
> - ✓ Private sector provision of family planning services
> - ✓ Clients' ability to pay
> - ✓ Legal and regulatory barriers
> - Government role in regulating quality of care
> - ✓ Private sector interest in collaboration
> - ✓ Donor coordination

FINANCE AND PRIVATE SECTOR ISSUES. USAID and the government of Indonesia have decided to phase out USAID support in the health, population, and nutrition sector over the next few years. Concurrently, the Indonesian government expects to achieve replacement level fertility by the year 2005. At present, in an effort to foster sustainability of the national family planning program, the Indonesian government supports a large percentage of family planning program costs and would like to improve resource allocation and expand private sector distribution of contraceptive products and services. In 1993 and 1994, as USAID was finalizing the decision to phase out aid, donor coordination was stepped up to create an understanding of the policy issues in Indonesia, particularly issues pertaining to private sector finance, method mix, and quality of reproductive health care services.

INTERVENTIONS. In 1993, as part of the expansion of the private sector, the Blue Circle Social Marketing Program began an association with the Gold Circle Community-Based Distribution Program. Essentially, market analysis determined that the market would support the sale of a wider choice of contraceptives concurrent with the continued marketing of Blue Circle products (Maher, 1992). Introduction of a new line of commercial products was planned to stimulate competition and attract that portion of the market that could afford to pay and that would select Gold Circle products in response to a new social marketing campaign. As with the Blue Circle campaign, the public sector provided marketing support for the private sector products while the private sector agreed to offer products at lower prices in expectation of increased market share. The public sector planned to launch Gold Circle products with as much of a promotional effort as with a competitive product but subsequently decided that advertising for Blue Circle could support, rather than compete with, Gold Circle products. As planned, the Gold Circle products are currently filling a growing market share of Indonesia's social marketing program.

To identify the appropriate clientele that would shift to reliance on private sector services, several studies conducted in 1996 identified the current users' methods and sources in Indonesia. The studies provided the Indonesian Family Planning Board (BKKBN) with information that helped the public and private sectors identify actual and potential markets. The relatively low level of private sector delivery of family planning services must be interpreted with care as many private sector providers rely on full-time public salaries but offer private services independently after hours. Consumer analysis revealed that groups of clients that had some experience in turning to the private sector for maternal and child health care (MCH) or that could afford private sector services chose public sector services for family planning (Foreit, 1996). Based on the assumption that MCH services are similar to family planning services, the consumer analysis points to an opportunity to signal clients who have the ability to pay to increase their use of private sector sources for family planning. Use of economic signals

could strengthen the extent of market segmentation. The distribution of program services already shows that the public sector is doing a good job of reaching the most rural areas, which is where the private sector may not be able to expand because of sparse populations and higher levels of poverty.

A market segmentation study in Indonesia revealed that the contraceptive market is generally well segmented by price, although it offers great potential for increased private sector participation (Winfrey and Heaton, 1996). The study found that the private sector serves better-off clients more often than the public sector, except in public hospitals, which serve clients who are very similar to those patronizing private sector providers. In addition, while private sector clients are generally well off, almost 50 percent of public sector clients are in the highest two expenditure quartiles. Therefore, there is considerable potential for private sector expansion. These findings have motivated a dialogue for developing rational and consistent policies for market segmentation in Indonesia.

The process of shifting clientele to a more efficiently segmented market requires the identification and elimination of barriers that otherwise impede private sector service provision. A legal and regulatory analysis (Ravenholt, 1996) underscored the need for improved targeting of public sector services to low-income populations, thereby increasing the potential for private sector growth among middle- and higher-income groups. As a foundation for this effort, the government needs to collaborate with the private sector in an information campaign to address three fundamental barriers: the general misconception that family planning services are a government entitlement for everyone; the misconception among private providers that most of the population cannot afford to pay private sector prices; and, as of yet, the lack of a market segmentation plan backed by the genuine commitment of the government.

Indonesia has recently moved to link family planning to a "quality of family life" classification system through which families are segmented according to economic, social, and religious factors. The system would enable the government to identify families at the low end of the scale and to target such families for public sector services. It follows that families classified as more wealthy would be targeted by the private sector. Fundamentally, the task for the Indonesian government, private sector counterparts, and international donors is to ensure provision of expanded services for a growing population of family planning clients. The public sector needs a more focused picture of what reproductive health programs cost and what increased levels of resource requirements might be expected under any expansion scheme. With this information, both the public and the private sectors will be in a better position to propose efficient and effective strategies for market segmentation.

JAMAICA

> **LESSONS LEARNED IN JAMAICA**
> - ✓ Government role in ensuring sufficient resources
> - ✓ Targeting government subsidies
> - ✓ Private sector provision of family planning services
> - ✓ Clients' ability to pay
> - ✓ Legal and regulatory barriers
> - Government role in regulating quality of care
> - ✓ Private sector interest in collaboration
> - ✓ Donor coordination

FINANCE AND PRIVATE SECTOR ISSUES. In Jamaica, family planning services are integrated into the entire primary and secondary health care delivery system. The widespread availability of free public sector services led to a corresponding decrease in the number of commercial sector service providers. Without privatization and balanced market segmentation, sustainability of what was primarily a public sector-driven family planning program could not be achieved. Strategic planning called for steps aimed at promoting private sector activity in family planning service provision**.**

INTERVENTIONS. Assistance in Jamaica focused on the National Family Planning Board (NFPB), which traditionally brokered donated commodities. In 1992, USAID initiated an incremental phase-out—slated for 1993 to 1998—of its support for commodity supplies. A study of the NFPB's sustainability (Clyde, Levy, and Bennett, 1992) led to an effort to shift wealthier clients from the public to the private sector. Although the NFPB had been distributing donated contraceptives for 20 years, its socially marketed products were losing their market identity in a program that was far from sustainable. In addition, with the phase-out of donated contraceptives, the government did not have the resources to continue supplying commodities at the same level indefinitely. One solution called for providing the private sector with the opportunity to take over and revitalize the products' image and to develop its own market share further. Toward this goal, the government of Jamaica worked to divest the contraceptive brands marketed under the Commercial Distribution of Contraception (CDC) Project.

The findings of the sustainability study encouraged and facilitated the NFPB's efforts to privatize the CDC Project through a competitive tender process. Although the MOH was concerned that a private buyer would unreasonably raise CDC product prices, it negotiated a contract that satisfied both government and private interests. The MOH achieved full divestment, thereby expanding the private sector role in family planning service delivery. Furthermore, the divestment laid the foundation for an expanded social marketing initiative that has multiplied the brands of pills and condoms accessible to lower-income market segments. Once the public sector stopped distributing free contraceptives, private interests were motivated to introduce a variety of products to compete in the market. Consumers now have access to a broader selection of pills and condoms and, with the recent introduction of Depo Provera, a broader method mix.

The history of Depo Provera provision in Jamaica clearly illustrates how public sector regulations can be a barrier to private sector expansion, even while the government tries to facilitate that expansion. The government of Jamaica had a law prohibiting use of any pharmaceutical for indications not approved in the country of manufacture. Because Depo Provera was not approved for contraceptive use in the United States, the Jamaican private sector was prohibited from entering the Depo Provera market. For its own activities, however, the government waived the restriction. Once the United States approved Depo Provera as a contraceptive, the Jamaican private sector could legally market the product. Uptake of the

method has been slow, however, in part as a result of slow growth in demand. In addition, the

private sector has not marketed the product aggressively enough to encourage a higher rate of prescriptions (e.g., the product is available in pharmacies but is not often prescribed), and expansion of the private sector market still suffers in competition with the less expensive public sector product. The government could assume a more positive facilitating role to encourage growth in the private sector's market share.

Because the NFPB had defined itself as the supplier of contraceptives, the prospect of divestiture left the organization without a clear vision of its role. The NFPB initially did not realize the broad responsibility it would assume as a coordinator and facilitator of the expanded private sector role. With technical assistance, however, the NFPB had the opportunity to plan its role in the sector within the constraints of limited public resources and ambitious national policy goals for fertility reduction. A strategic plan for the phase-out period 1993 to 1998 delineated NFPB's mandate and the organization's most efficient role for achieving national goals (NFPB, 1992). The plan called for increased contraceptive prevalence through improved access to high-quality family planning services (including voluntary surgical contraception for those who chose that method), strengthened IEC activities, attention to services for adolescents, and promotion of private sector participation in service delivery. Providing the tools needed by the NFPB to assume this new role was a protracted process that called for information dissemination, acquisition of new procurement skills, transfer of technology to the private sector, and communication of NFPB's new mandate to the various stakeholders.

To understand perceived benefits, barriers, and patterns of use resulting from regulatory barriers, a 1994 consumer study examined attitudes and behavior regarding contraception (Chambers and Branche, 1994). Focus groups across the country provided insight into consumers' perceptions of and motivations for each modern method of contraception. The study contributed to the NFPB's appreciation of the need for targeted educational activities to improve consumers' knowledge about contraceptive methods.

Finally, a study of private sector service providers mapped all private sector service delivery points in Jamaica and surveyed the providers' skills and interest in providing family planning (Bailey et al., 1994 a,b). The study findings provided valuable baseline data for program planning that will be useful beyond the immediate need to mobilize the private sector and that will find application in public sector strategic planning. The findings were applied to the design of a pilot project intended to draw clients able to pay for reproductive health services away from public health outlets. Through the pilot program, 15 private providers received training and information on the latest technology.

In Jamaica, the coordination of USAID CAs and family planning service providers in the public and private sectors contributed to the successful transformation of the family planning program. CAs worked together to get the most out of inputs while the collaboration between the MOH and the private sector on the privatization of the CDC Project led to more comprehensive leadership in family planning service policy and program administration.

MOROCCO

> **LESSONS LEARNED IN MOROCCO**
>
> ✓ Government role in ensuring sufficient resources
>
> Targeting government subsidies
>
> ✓ Private sector provision of family planning services
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> ✓ Clients' ability to pay
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> ✓ Legal and regulatory barriers
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> Government role in regulating quality of care
>
> Private sector interest in collaboration
>
> ✓ Donor coordination

FINANCE AND PRIVATE SECTOR ISSUES. The government of Morocco and King Hassan II are fully committed to strengthening and planning for the sustainability of the country's family planning program. Recently, the family planning unit within the Ministry of Health was upgraded in status and visibility. In addition, a separate Ministry of Population was created to help support an intersectoral focus on population issues. Maturation of the family planning program has led to an agreement between the Moroccan government and USAID on a five-year phase-out of U.S. technical assistance and commodities. While this step reflects the stability and growth of the Moroccan program, the rate of population growth and the increasing number of women of reproductive age dictate that resource allocation of hard currency must be undertaken at levels necessary to maintain and enhance prospects for operational sustainability of the family planning and maternal/child health programs underway or planned. Because Morocco has a free public health system that is widely used, continued efforts to expand the private sector's role in service provision have faced some difficulty. Approximately 35 percent of women currently using modern methods obtained their contraceptives from private commercial sources. Policy efforts must include a focus on translating high-level support for family planning into activities at the service level.

INTERVENTIONS. Preparations for the USAID phase-out have included, among other activities, identification of major policy issues, a legal and regulatory analysis, and a cost analysis of host-country contributions to the family planning program. Defining the policy agenda at the outset of the preparations permitted strategic planning for the phase-out.

One of the priority policy issues identified in the paper entitled "Morocco Agenda: Identification of Key Areas of Concentration" was the need to enhance the private sector's role in the provision of family planning and reproductive health services (Bennett et al., 1993). Subsequent legal and regulatory analysis (El Fathi, 1994) revealed that no debilitating barriers hamper the current family planning program or block the further development of private sector involvement in the program. This finding gave the Moroccan government a clear mandate to remove the numerous small barriers that often conspire to slow progress. For example, although private physicians were not prohibited from providing family planning services, they had little experience or few medical guidelines to follow. To address this gap, the MOH initiated the training of a small group of family planning service providers. In maintaining a dialogue with private providers and identifying ways to meet their perceived needs, the government can play a vital role in facilitating the private sector's growth.

A host-country contribution cost analysis conducted in 1994 and 1995 facilitated the government's assumption of an increasing proportion of family planning program costs (Emrich and Jeffers, 1995). Even though the Moroccan government was not initially prepared to

undertake the responsibility for contraceptive procurement, the cost analysis was a condition for disbursement of USAID funds under the bilateral project. The analysis of the government budget was meant not only to identify resources allocated for family planning but also to reveal the extent to which the government would free up resources by devolving some family planning responsibilities to the private sector. It could also be useful in revealing to the Moroccan government the costs of achieving various program targets and of program subsidization.

An analysis of DHS data examined women who reported that they did pay for some private sector health services (Foreit, 1994a). The analysis determined that, despite some private sector use, women were likely to take advantage of the free public sector pills, thereby contributing to underutilization of the private sector. By assuming responsibility for providing the necessary data and strategic planning to inform and guide the private sector, the government can help identify appropriate avenues for private sector expansion.

As a result of the above activities, the government of Morocco has strengthened its resolve to build a partnership with the private sector to ensure that Moroccans have expanded access to contraceptive services. A specific effort to diversify resources began in 1996 with a study of the proposed inclusion of family planning services in health insurance programs. At present, only about 15 percent of Morocco's population are covered by health insurance; and even this limited coverage does not include family planning services. Preliminary results of the health insurance study reveal that the marginal cost of adding family planning coverage would range from 0.1 percent of current reimbursement payments for IUD use to 6 percent for sterilization (Guedira, 1996). Because the study was only recently completed, it is too early to evaluate its impact, although the study recommendations call for the national health insurance program to grow in scope and coverage, with family planning progressively added.

For the Moroccan government to increase its contribution and improve market segmentation, it must not only plan for reform but also be capable of implementing it. Therefore, a focus for policy work is to transfer attention from policy formulation to implementation. Specifically, both an increase in levels of service provision and the expanded roles of new actors point to the need for strategic planning. Strong policy champions must be able to enunciate the needed changes and to lead public, private, and NGO implementing partners to make the difficult changes necessary to implement the new program.

Finally, the Moroccan experience has underscored the necessity of coordination among international donors if progress is to be achieved on any agenda. All donors should support the process of phasing out the provision of contraceptives, as well as specific efforts both to encourage growth of the private sector market share and to strengthen the MOH's positive regulatory role. Therefore, the planning process should include not only the stakeholders from the public and private sectors but also the relevant donors who intend to support the process.

PHILIPPINES

FINANCE AND PRIVATE SECTOR ISSUES. By 1986, the Philippine family planning budget had declined to a point where family planning expenditures in the Philippines ranked below all other Asian countries. The expenditure level reflected the struggle within the Philippine policy environment for implementing reform. The strong position of the Catholic church, particularly in the context of world discussions at the International Conference on Population and Development (ICPD), and the fiscal demands of the International Monetary Fund make the formulation of effective policies especially challenging. Although the Philippines has increased support for family planning activities since 1989, the family planning/reproductive health sector remains underfinanced in part as a response to cultural values. Nevertheless, opportunities exist to stimulate greater financing for family planning, especially through private sector investment.

LESSONS LEARNED IN THE PHILIPPINES

- ✓ Government role in ensuring sufficient resources
- Targeting government subsidies
- ✓ Private sector provision of family planning services
- ✓ Clients' ability to pay
- ✓ Legal and regulatory barriers
- Government role in regulating quality of care
- Private sector interest in collaboration
- Donor coordination

INTERVENTIONS. Two studies promoted private sector growth as a means of diversifying the stream of revenue. One examined the Medicare system that, before 1993, provided no outpatient benefits; the second assessed the laws and regulations governing the importation of contraceptive commodities.

In the first study, senior managers of the Philippine social security systems, high-level officials of the Department of Health (DOH), Mission staff, and representatives of private research and academic institutions collaborated, with the benefit of technical assistance, to scrutinize and promote the expansion of the employee social security system (Medicare) to include family planning and child survival services (Griffin et al., 1992). The study showed that 28 million beneficiaries would receive outpatient services, including family planning, at an additional cost of less than 10 percent of current expenditures if Medicare implemented utilization controls and simple cost-containment measures. The results were widely disseminated and presented to the Medicare Commission Board with a proposal to develop demonstration projects to prove the financial viability of outpatient reimbursement. Commission members voted unanimously to proceed with the Medicare reform demonstration projects, signaling an enormous breakthrough at the policy level. Commission members further charged the USAID-funded private sector bilateral project with testing output results in two areas of the country.

Since the results of the Medicare study were issued, however, the Philippine health system has undergone a redesign, such that the National Health Insurance Corporation has replaced Medicare. Under the new system, the authority to determine covered services has been devolved to local government units, which now have the option of including family planning and reproductive health services in their basic package of benefits, as recommended in the original Medicare study.

The second study examined the impact of customs duties and the value-added tax (VAT) on imported contraceptives through an analysis of laws, codes, and operational policies and procedures involved in the importation of contraceptives (Alano and Cross, 1994). In estimating

the effect of the VAT on sales and usage, the study showed that eliminating the tax could increase

the number of oral pill users by up to 25,000 couples per year. The paper also suggested ways in which streamlining and removing annual ceilings on imports could be achieved, thus addressing clients' ability to pay for contraceptives.

While the DOH management committee adopted the study's recommendations unanimously and agreed to take the lead in managing the policy reform process, it has not implemented the recommendations. However, consideration of de-taxing family planning commodities coincided with a broader debate on VAT in general and with the controversy that erupted in the Philippines before the country's participation in the 1994 ICPD. Consequently, reform of the VAT for contraceptives was delayed. More recently, the opportunity to advance this issue has been renewed with Philippine government support.

The two studies illustrate the difficulties in stimulating private sector involvement in the Philippines. Further advocacy efforts are important and will be incorporated into the National Population and Development Advocacy Plan. The plan aims to generate and solidify support for population and family planning programs in the Philippines, with target audiences in both the public and private sectors. Support for advocacy activities has been instrumental in the recent shift in the Catholic church's stance, which has resulted in conditional support for the Population Bill currently under review for passage.

Furthermore, current activities support the initiation of the National Family Planning Strategy, which provides a broad framework for addressing family planning. Its major objectives include program sustainability regarding the role of the private sector and segmentation of the family planning market. Private commercial distributors and NGOs account for less than one-third of the modern contraceptive market in the Philippines, although some indications suggest that this share may be declining. This is an optimum time to encourage government facilitation of private sector growth.

Clearly, national policy and goals must be supplemented by policy initiatives supporting private sector growth. Because the Catholic church's interests are sometimes in conflict with the goals of commercial enterprises, private interests are understandably hesitant to expand their role in service provision. (For example, the church organized a boycott of a company that tried to introduce injectable contraceptives.) At the same time, the provision of public sector or donor-subsidized commodities to the NGO sector has blurred the price differential between public and NGO-sponsored products. The public sector now has the opportunity to facilitate private distribution of commodities and develop a more highly segmented market.

USAID is supporting improved market segmentation with the goal of increasing private sector provision of family planning and maternal/child health services. The first phase of the USAID approach addresses the lack of data and information on the potential role of and constraints to private sector expansion. A 1996 study examined the potential for an increased private sector role and presented initial strategies to facilitate such a development (Ravenholt, 1996). A second study of family planning use identified the existing market segments (Alano et al., 1997). Another study underway addresses the market structure to determine how prices are set for contraceptives in the Philippines, and a consumer intercept study examines why consumers choose public and NGO services. A legal and regulatory study is also planned. A technical working group chaired by DOH staff is overseeing the conduct of these studies.

TURKEY

LESSONS LEARNED IN TURKEY

- ✓ Government role in ensuring sufficient resources
- Targeting government subsidies
- ✓ Private sector provision of family planning services
- Clients' ability to pay
- ✓ Legal and regulatory barriers
- Government role in regulating quality of care
- ✓ Private sector interest in collaboration
- ✓ Donor coordination

FINANCE AND PRIVATE SECTOR ISSUES. In 1994, USAID and the government of Turkey announced their intention to phase out USAID donation of contraceptive commodities over a five-year period (1995 to 2000). Thus, the main goal for family planning programming in Turkey is sustainability. The public sector provides family planning services through a series of specialized family planning clinics and through integrated services at other Ministry of Health delivery sites. Family planning services and supply methods (e.g., pills and condoms) are also widely available in the private sector. In addition, the Ministry of Labor's Social Security Institute (SSK) has the potential to play a significant role in the family planning program. The possibility also exists for program expansion through NGOs and insurance programs.

INTERVENTIONS. In preparation for phase-out, a cost and procurement study was conducted to update the projected costs of commodities, to identify legal and regulatory barriers, and to analyze the implications of source and method mix options (Cakir and Sine, 1995). The review of the contraceptive procurement process focused on forecasting, budgeting, physical procurement, and distribution, with an emphasis on budgeting. By providing recommendations intended to have an impact on a broad policy environment, the study's findings challenged stakeholders to address issues of sustainability and encouraged coordination among donors and within the Turkish government.

The government's assumption of responsibility for contraceptive procurement was delayed by the question of whether the MOH was willing to allocate the necessary resources. At the time, the prevailing interpretation of Turkey's national policy was that the MOH was mandated to provide services to everyone. Yet, analysis showed that the government could not afford to take over the entire contraceptive provision program from USAID; thus, it was necessary to consider the policy implications of encouraging the private sector to assume a larger role while still meeting the national policy of services for all. As part of the process of achieving self-sufficiency in contraceptive commodities, the government of Turkey initiated its first trial procurement of contraceptives in 1996. Procurement efforts are continuing.

In 1995, Turkey's MCH/FP General Directorate initiated a meeting of public and private sector organizations to canvass a broad range of issues related to the impending USAID phase-out. The meeting was a first step in the process to create links between the public and private sectors and to identify support for family planning service provision. One topic discussed during the meeting was government procurement of contraceptive products from the private sector. Some pharmaceutical companies were sufficiently encouraged by the government's offer of participation to host follow-on meetings as a means to further communication and collaboration between the public and private sectors.

Follow-up efforts in 1997 to expand the role of private sector participation have consisted of three activities. First, a key informant study identified major private sector actors with a potential interest in collaborating with other stakeholders on self-reliance issues (POLICY Project, 1996). Because efforts to include private sector counterparts have often attracted only a small group of individuals well known to each other, the study identified potential new stakeholders—thus expanding participation to a wider group. Second, a baseline market segmentation revealed how the market is structured (i.e., who is providing which services and products to whom) (Cakir and Sine, 1997). Third, the market segmentation study served as the centerpiece for discussion during a meeting of public and private sector stakeholders in the national family planning/women's health program. Participants representing a broad range of public, private, commercial, and NGO interests examined the results of the market segmentation study, evaluated the efficiency of the current market structure, and discussed visions of a preferred market structure, inclusive of more private sector involvement. These activities facilitated increased levels of private sector participation.

This country example highlights the types of opportunities donors might exploit to help governments take innovative steps in the face of policy dilemmas. The government of Turkey has learned that there is value in sharing data and analysis, seeking out collaboration with private sector organizations and individuals, and devising strategies to overcome difficult policy positions.

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