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**THE ENTERPRISE PROGRAM FOLLOW-UP STUDY:  
WERE PRIVATE SECTOR  
FAMILY PLANNING SERVICES  
SUSTAINED?**

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**The Service Expansion and Technical Support Project (SEATS) of John Snow, Inc.  
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*Catherine Fort*

## GLOSSARY OF SUBPROJECTS AND RELATED ORGANIZATIONS

ADOPLAFAM	Asociación Dominicana de Planificación Familiar, Inc. (Dominican Republic)
AIOE	All India Organization of Employers (India)
AMPPF	L'Association Malienne pour la Planification et Promotion de la Famille (Mali)
BCS	Bangladeshiyo Cha Sangsad (Bangladesh Tea Association)
*	Benguet Gold Operations (the Philippines)
CFU	Commercial Farmers' Union (Zimbabwe)
*	COMATEX (Mali)
FEMAP	Federación Mexicana de Asociaciones Privada de Salud y Desarrollo Comunitario (Mexico)
FPAB	Family Planning Association of Bangladesh
FPAU	Family Planning Association of Uganda
FPOP	Family Planning Organization of the Philippines
HIO	Health Insurance Organization (Egypt)
*	Hippo Valley Estates (Zimbabwe)
ICC	Indian Chamber of Commerce
IMA	Indian Medical Association
JEDB	Janatha Estates Development Board (Sri Lanka)
*	Lonrho (Zimbabwe)
MEXFAM	Fundación Mexicana para la Planeación Familiar A.C. (Mexico)
PDA	Population and Community Development Association (Thailand)
*	Pharmacist and Drugstore Owner Program (Thailand)
PMAP	Personnel Management Association of the Philippines
P.S. Lanka	Population Services Lanka (Sri Lanka)
*	Sankalp Kiran (India)
*	SONATAM (Mali)
*	Triangle Ltd. (Zimbabwe)
*	Turkish Family Health and Planning Foundation
UBL	United Breweries Ltd. (Zimbabwe)
YKB	Yayasan Kusuma Buana (Indonesia)
YKM	Yayasan Kesejahteraan Muslimat (Indonesia)
ZNFPC	Zimbabwe National Family Planning Council

\* = No acronym used

## CONTENTS

Executive Summary . . . . .	1
I. Background . . . . .	4
Origins of the Enterprise Program . . . . .	4
Program Objectives . . . . .	4
Enterprise Subproject Partners . . . . .	5
Employment-based Partners . . . . .	5
Market-based Partners . . . . .	6
Achievements and Lessons Learned . . . . .	7
II. The Follow-up Study . . . . .	8
Purpose . . . . .	8
Methodology . . . . .	8
III. Analysis and Results . . . . .	10
Employment-based Programs . . . . .	10
Description of Subprojects Studied . . . . .	10
Sustainability Status . . . . .	10
Analysis . . . . .	11
Market-based Programs . . . . .	20
Description of Subprojects Studied . . . . .	20
Sustainability Status . . . . .	20
Analysis . . . . .	21
IV. Conclusions and Discussion . . . . .	35
Conclusions . . . . .	35
Sustainability . . . . .	35
Acceptor Rates . . . . .	36
Impediments to Sustainability and Expansion . . . . .	37
Remaining Issues . . . . .	38

## EXECUTIVE SUMMARY

Although more than two years have passed since the end of the Family Planning Enterprise Program, efforts to support the participation of the private sector in family planning continue. In the belief that much useful information could be learned from former Enterprise Program subprojects, the prime contractor for the Enterprise Program, John Snow, Inc. (JSI) sponsored a study to discover what had happened to a representative sample of subprojects which were operating when the program closed in mid-1991. This paper presents the findings of that study.

**Part 1** examines the context of the creation of the Enterprise Program in 1985 by the U.S. Agency for International Development. It next describes Enterprise's objectives and mandate to experiment with innovative approaches to test how, under what conditions, and at what cost the private sector could provide family planning services. These objectives were to:

- create sustainable private sector services,
- increase the volume of family planning services provided by the private sector,
- provide cost-effective services, and
- leverage private sector funds for family planning.

The two types of partners Enterprise worked with -- employment-based and market-based -- are then described, along with a brief summary of the experience of both types of projects. In total Enterprise supported 89 subprojects in 30 countries.

**Part 2** outlines the three-fold purpose of the follow-up study:

- to learn if subprojects that were operating in 1991 were sustained;
- to analyze the conditions or circumstances that most influenced these sustainability outcomes; and
- to ascertain whether or not Enterprise's findings on the key factors that influenced subproject success -- particularly sustainability -- were still valid. Enterprise defined a "successful" subproject as one that achieved at least one of the above-listed objectives.

The study methodology, including criteria used for subproject selection, is next described. Twenty-five cases were selected from the Enterprise portfolio of 89 subprojects: 16 employment-based programs and nine market-based programs. The subprojects selected, from all regions where Enterprise worked (Africa, Asia, the Near East, and Latin America), comprised the largest subprojects for which follow-up information was accessible. Subprojects represented both successes and failures.

**Part 3** analyzes which family planning services were sustained or not sustained and the conditions or circumstances that determined these outcomes. Although the study focussed primarily on sustainability outcomes, where data were available, a comparison was also made between study findings and Enterprise's original conclusions on what influenced subproject success. Insufficient financial data were available to form conclusions on the subprojects' relative cost-effectiveness or amount of private sector resources leveraged. However, there were sufficient data to examine how well services were sustained and how well most subprojects did in attracting acceptors.

The study found that the majority of the employment-based and market-based partners in the sample - 16 out of 25 -- coped reasonably well after the withdrawal of Enterprise support and maintained family planning services. Nearly all employment-based programs that were sustained covered program costs out of company earnings, although one subproject relied on in-plant commodity sales to generate income to cover program costs. *The employment-based programs in the sample that were most likely to be sustained:*

- *had committed company managers;*
- *had family planning programs that were seen by managers as benefiting companies in a tangible way;*
- *had strong linkages with competent sources of technical and logistical support; and*
- *were in reasonably good financial health.*

Almost all market-based programs were sustained. However, they had yet to cover family planning costs through service revenues. *Those subprojects that seemed to have the best prospects for achieving financial independence:*

- *integrated low profit-making family planning with more lucrative health services;*
- *had large operating budgets that allowed losses from one program area to be absorbed by savings (or income earned) from another;*
- *were efficient and controlled costs;*
- *set competitive prices for services;*
- *met, or had the potential to meet, the partner's financial objectives; and*
- *took advantage of any subsidized goods or services offered in the family planning marketplace.*

These findings were consistent with those made by Enterprise at the conclusion of its work in the market-based sector.

The study's findings on subprojects that successfully attracted large number of acceptors were also

consistent with Enterprise's earlier conclusions. *The most successful subprojects in the sample had:*

- *large company work forces or employee/beneficiary populations;*
- *a large number of service points;*
- *umbrella organizations acting as service vendors to a large number of companies under contract; or*
- *a large pool of insured beneficiaries.*

Least successful in attracting acceptors were the full-service clinics or hospitals catering primarily to middle-income clients.

In the group of sustained subprojects whose acceptor rates either declined or did not grow as quickly as anticipated, rates did not seem as much affected by the phase-out of Enterprise funds as by such other factors as:

- company layoffs or transfers,
- a movement away from family planning by private providers, and
- smaller-than-anticipated markets and/or intense competition for target markets.

One family planning program had not grown because it had already reached its saturation point with nearly complete coverage.

*The study also found emerging impediments to private sector family planning sustainability and expansion, many linked to the low profitability of family planning ventures. They included:*

- *a longer-than-anticipated time to reach a financial break-even point;*
- *stiff competition for a smaller-than-expected market; and*
- *public sector subsidies on family planning services that kept prices down artificially.*

Financial instability from a number of exogenous factors, including poorly managed country economies and the sheer difficulties of doing business in a world market, also hurt the balance sheets of many private sector partners.

**Part 4** discusses the study findings and makes recommendations for further study. More research in the private sector is needed on critical issues relating to donor concerns on subsidies, target markets, demographic impact, and the cost-effectiveness of private sector-based family planning programs.

## I. BACKGROUND

### Origins of the Enterprise Program

By the early 1980s, the U.S. Agency for International Development (USAID) and other members of the international family planning community recognized that government-sponsored family planning services alone would not meet burgeoning Third World demand for contraceptives. Demand for contraceptives was accelerating so rapidly that projected government revenues and available donor support would not keep pace. Thus, attention turned to the private sector.

Could additional revenue be raised through expanding service provision by the private sector and increasing contributions by users? Mobilizing the resources of the private sector for family planning was a rational strategy that had not yet been systematically tested. Knowledge was limited concerning the potential amount of private sector support and services, what role private organizations could play in expanding family planning programs, and how to tap into these resources -- how to market family planning in a way that would appeal to the interests of the private sector.

USAID's experience in working with the private sector had been largely confined to funding private, non-profit family planning agencies, commonly referred to as non-governmental organizations (NGOs). Available donor funds for core program support to family planning NGOs, however, were beginning to dry up. Concerns were mounting that these family planning NGOs would go out of business unless they diversified their funding base.

The stage was set for highly experimental family planning programs that would attempt to tap a heretofore untried resource: the entire variety of private sector organizations, including for-profit ones. One of the largest and most comprehensive programs that did this was the Family Planning Enterprise Program which USAID initiated in 1985 through a contract with John Snow, Inc. (JSI). The Enterprise Program was designed to experiment with service delivery in the private sector and to instill or improve private sector skills in family planning NGOs.

By the close of its contract in 1991, the Enterprise Program had financed 89 subprojects in 30 countries. These subprojects, representing a wide variety of commercial settings and implementation strategies, provided an important experience to guide the next generation of private sector program development in family planning.

### Program Objectives

The Enterprise Program, hereafter called Enterprise, had four program objectives:<sup>1</sup> to create sustainable private sector services; to increase the volume of family planning services provided by the private sector; to provide cost-effective services; and to leverage (attract) private sector funds for

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<sup>1</sup> For more detailed information on Enterprise Program objectives and lessons learned, see Moore, Richard, Issues in Private Sector Family Planning: The Experience of the Enterprise Program, John Snow, Inc. publication, September 1991.

family planning. In order to track progress during implementation and determine whether or not subprojects were successful, Enterprise developed a verifiable impact indicator for each objective:

- For **sustainability**: the percentage of donor interventions or investments that continue with their own funds;
- For **increasing family planning services by the private sector**: the numbers of new or transfer acceptors recruited;
- For **cost-effective services**: the donor cost per acceptor or couple year of protection (CYP); and
- For **leveraging private sector funds**: the amount of cost-sharing or co-investment by the private sector partner and the amount of the multiplier effect.

Enterprise differed from other private sector family planning programs in two important respects. First, it attempted to use the dynamics of the private sector to "sell" prospective subproject partners on providing sustainable family planning services at their own cost. Second, unlike other private sector family planning programs where "success" depended on their ability to produce outputs for one or more impact objectives, the "success" of the Enterprise Program was based on its ability to demonstrate how to maximize family planning impact through the private sector and to learn under what conditions, where, and at what cost.

### Enterprise Subproject Partners

The 89 subprojects that comprised Enterprise's portfolio reflected a variety of cultural milieus, levels of development and family planning philosophies. To simplify evaluation analysis the portfolio was broken down into two kinds of private sector partners, employment-based and market-based.

#### Employment-based Partners

These were manufacturing companies, plantations, mines, and commercial farms of all sizes that employed potential family planning acceptors and/or provided medical benefits to employee dependents. Employment-based partners were interested in family planning for a variety of reasons: to reduce the cost of medical (including maternity) care and other benefits paid out to employees and dependents, to reduce absenteeism, and to reduce employee turnover. Other motives of employment-based partners included engendering the good will of government by supporting family planning in the workplace and a purely humanitarian interest in improving the welfare of company employees and their dependents.

Workplaces ranged in size from a few hundred workers to over 5000; were in countries with and without population policies and programs; were in both rural and urban settings; had predominately male, female, or mixed labor forces; were parastatal or privately owned; and had either existing family planning services and/or in-plant health facilities or no on-site health care services.

Enterprise operated in the employment-based sector through a combination of strategies.

- Some involved working through an **intermediary or umbrella organization** that channeled financial, technical and other support directly to companies. Umbrella organizations that Enterprise typically worked with included employer's groups, chambers of commerce, family planning NGOs, and business and professional associations.
- Another strategy was to arrange or facilitate service delivery through **contracts with service vendors**. Service vendors that could provide training or other assistance were matched with employers wishing to begin or expand family planning services. In some cases, vendors provided the entire service. Typically, these vendors were family planning NGOs.
- Still another strategy involved **the company itself delivering services**; this made sense where the company was already providing services but wished to expand or upgrade them, or where the setting was remote or otherwise not accessible to a vendor.
- The final strategy involved **using community-based distributors in the workplace**.

### Market-based Partners

Functioning outside the public sector, Enterprise's market-based partners produced, distributed, financed, and/or delivered health services and products, financing them largely with earnings or investment capital. The goal of Enterprise's market-based partners was to realize a reasonable return on their investment. Thus, enhancing business prospects was a major motivation for market-based providers to support family planning.

Enterprise worked with three types of market-based partners: some provided health care services directly to individuals; some retailed contraceptive commodities on the open market; and others insured health and family planning services. Originally, only for-profit providers were included in the market-based category, but later non-profit entities that operated on the same market-oriented principles were added.

A number of strategies were tested by Enterprise in this sector.

- **Fee-for-service arrangements** increased the accessibility of family planning services through existing service networks or by creating new services. These included hospitals, clinics, individual service providers, and market-oriented family planning NGOs creating new health service businesses.
- Another strategy involved working with **umbrella organizations** that provided easy access to a large number of service providers or retailers which, in turn, reached a large number of acceptors. Umbrella organizations included professional and trade associations, family planning NGOs or cooperatives.

- A third strategy tested the feasibility of **managed-care arrangements** as a vehicle for increasing access to family planning.
- The final strategy involved **advancing innovative public policy initiatives** to pave the way to enlightened privatization. This included seeking ways to reduce government subsidies for contraceptives and encouraging governments to contract with private sector organizations to provide family planning services.

### **Achievements and Lessons Learned**

As part of Enterprise's evaluation program, several studies were conducted on employment- and market-based program experiences.<sup>2</sup> The major findings, achievements and lessons learned from these studies will be discussed in more detail later; they are very briefly summarized below:

During the course of its work, Enterprise found that subproject partners needed at least some start-up assistance. Typically, Enterprise served the role of donor as "venture capitalist," sharing the risk, (both financially and politically) and providing otherwise unavailable resources. However, the private sector could co-invest enough funds or provide in-kind support for start-up to make leveraging a meaningful objective. Private sector partners often invested as much as Enterprise, and where these services were a priority, even more. Regarding subproject sustainability, once Enterprise funds had been phased out, the majority (88 percent) of its subproject partners continued to provide services with only minor public or donor subsidies. By the end of the program, Enterprise subprojects had served an estimated 436,000 new and transfer (mostly from the public sector) family planning acceptors; median cost per acceptor was \$15.25.

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<sup>2</sup> Skibiak, John P., Employer-Provided Family Planning in the Private Sector: The Lessons of Enterprise, March 1991; Fort, Catherine and Carolyn Hart, Market-Based Family Planning: The Enterprise Program Experience, September 1991; and, Fort, Catherine and Eve Epstein, Promoting NGO Sustainability: The Lessons of Enterprise, April 1991; John Snow, Inc. publications.

## II. THE FOLLOW-UP STUDY

### Purpose

More than two years have elapsed since the end of the Enterprise Program. Because important work in promoting private sector support to family planning continues, however, it was felt that useful information could be learned from a follow-up study of former Enterprise partners. Thus, a study was carried out to investigate:

- **Continued sustainability of subprojects:** At the end of the program, the majority of Enterprise's subprojects were still being sustained. Is this still the case -- have former subproject partners been able to continue or even expand family planning service delivery?
- **Related factors:** What were external conditions or circumstances most affected the partners' ability to sustain or not sustain service delivery?
- **Validity of earlier findings:** Are Enterprise's findings about influences on program sustainability (and the three other impact objectives -- attracting acceptors, cost-effectiveness and leveraging) still valid?

### Methodology

Twenty-five case studies were prepared on former subprojects. The subprojects selected for this convenience sample are representative of the Enterprise portfolio. They represented all regions where Enterprise had worked, both employment-based and market-based subprojects, and both successes and failures. However, the sample is biased toward projects where information was more readily available. Since the study was largely financed by JSI, it was important to keep costs down: former subprojects were selected for study if local consultants known to JSI could visit them, or if JSI staff already in the region or travelling to the country on other business were available. Interviews were also conducted by telephone.

A standardized questionnaire was used to collect information. Addressing activities that occurred during calendar years 1991 and 1992, it was comprised of seven sections: (1) organizational description, (2) user population description, (3) service description, (4) utilization patterns, (5) costs (total organizational budget, expenditure on health and family planning), (6) revenues (external support and sales of services), and (7) general observations.

Many individuals collected information from former subproject partners. Although the standard questionnaire was used, it was long and complicated, and no formal training was provided on how to administer it. As a result, data obtained varied considerably in quality and quantity. Finally, because of inadequate record keeping systems and other problems, many former subproject partners were unable to provide data on all questions asked.

For analysis, subprojects were divided into employment-based programs and market-based programs.

An analysis was conducted on each program to determine which family planning service systems were sustained and the conditions or circumstances enhancing prospects for sustainability. A comparison was made between these findings and Enterprise's original conclusions on what determined subproject sustainability and the achievement of the three other impact objectives.

### III. ANALYSIS AND RESULTS

#### Employment-based Programs

##### Description of Subprojects Studied

Sixteen former Enterprise subprojects that were employment-based were included in the study. Table I contains data on these subprojects, including the name of the partner, its country of origin, subproject funding, subproject start-up and end dates, type of industry and/or umbrella organization that served as an intermediary, and contraceptive acceptor rates. Eight are based in Africa, seven in Asia, and one in Latin America.

Within the group as a whole, nine subprojects were funded directly by companies and eight through umbrella organizations. Of the latter, five were with professional associations (one representing tea estates, one employers association, one chamber of commerce, one farmers association, and one personnel managers association), and three were with non-governmental family planning organizations. Companies receiving program assistance were in all major sectors -- manufacturing, mining and agribusiness. The size of the companies' work forces ranged from more than 5,000 to fewer than 500 employees. All subprojects, except one, employed community-based distributors. Few subprojects charged fees for services provided, and most of those were only token. Where data were available, utilization rates among the sustained subprojects varied considerably; some increased, some remained stable, and others declined.

##### Sustainability Status

Of the 16 subprojects examined, the family planning services of nine have been unequivocally supported and sustained since the end of Enterprise. These are, SONATAM in Mali, United Breweries Ltd. (UBL) in Uganda, Triangle Ltd. in Zimbabwe, Lonrho in Zimbabwe, Hippo Valley Estates in Zimbabwe, Population and Community Development Association (PDA) in Thailand, Janatha Estates Development Board (JEDB) in Sri Lanka, the Personnel Management Association of the Philippines (PMAP) in the Philippines, and Federación Mexicana de Asociaciones Privada de Salud y Desarrollo Comunitario (FEMAP) in Mexico.

Sustainability outcomes for the remaining seven have been mixed: some have continued most services and some have developed new services, while others' services have declined significantly or ended.

- The subproject with the Commercial Farmers' Union (CFU) in Zimbabwe was originally at two sites. One site closed down its family planning program, while the second site not only continued service delivery but expanded its program to new farms.
- A similar situation existed in another subproject with the Indian Chamber of Commerce (ICC) in Calcutta, India. One of the two industries recruited by ICC still provided family planning after the end of Enterprise involvement. Although the one

company did halt service delivery at its Calcutta plant, it initiated services at two other plant sites and was prepared to resume services in Calcutta at a future date.

- The subproject with the Bangladeshiyo Cha Sangsad (BCS) (Bangladesh Tea Association) never got past the planning stage.
- Benguet Gold Operations in the Philippines halted its long-running family planning program when the company went out of business.
- Without substantial donor assistance, the sustainability prospects of the company service vendor program at L'Association Malienne pour la Planification et Promotion de la Famille (AMPPF) look bleak. AMPPF, a Malian NGO, provided family planning services under contract to two local companies, SONATAM and COMATEX, both of which also received support from Enterprise. SONATAM's family planning program has been sustained, but COMATEX stopped providing most services about one year after Enterprise's funding ended.
- Nearly all of the industries supported by the All Indian Organization of Employers (AIOE) in India discontinued service provision at the workplace soon after Enterprise funding ended.

### Analysis

By mid-1991, Enterprise had concluded that successful employment-based subprojects (defined as subprojects most likely to be sustained, attract large numbers of acceptors, be cost-effective and leverage funds) were companies that:

- provided relatively generous non-wage benefits to employees and dependents;
- had large employee populations of 5000 or more;
- were financially sound;
- had top and middle management that provided serious support to the project;
- had "captive" populations such as those found at isolated mining, plantation, or agribusiness communities; and
- worked through or utilized an umbrella organization or a community-based distribution (CBD) strategy.

In addition, Enterprise found that several characteristics which seemed important at the outset of a program did not prove to be important to subproject success. These included: interest of the labor union in family planning as a benefit, clinical facilities already available, and whether the services were provided by company management or by a contracted service vendor. Finally, a high cost per acceptor (to the employment-based partner) did not have a negative influence on project success as

long as the company's return on investment -- savings -- was positive.

Where the follow-up study found enough data to support or refute Enterprise's findings (for example, family planning expenditure data were too sketchy to allow comparisons of subproject cost-effectiveness or leveraging), all of these findings are still valid. A few factors may be less important than originally envisioned. For example, among the many subprojects studied that had a CBD component, some were sustained and some failed.

In analyzing the conditions or circumstances that most influenced long-term program success, particularly sustainability outcomes, three factors stand out as being the most critical: (i) an active partnership between companies and private and/or public sector institutions providing competent technical and logistical support; (ii) strong commitment from management, particularly at the top, which worked to overcome resistance throughout the ranks, and (iii) the financial health of employment-based partners.

- i. *An active partnership between companies and private and/or public sector institutions providing competent technical and logistical support.*

*Strong Institutional Linkages.* In every employment-based subproject reviewed, the sustainability prospects of family planning programs were greatly enhanced by the presence of strong institutional linkages with competent sources of in-country technical assistance and other program support. In fact, many obstacles that could stymie family planning service delivery in companies, such as small factory size and only passive management involvement, were overcome if there were strong, pro-active, outside institutions (usually family planning agencies) willing to intervene.

As already mentioned, Enterprise found that the most fertile ground for successful subprojects was with companies that (1) provided relatively generous non-wage benefits to employees and dependents, (2) had large work forces, and (3) had captive populations needing services. Four of the sustained subprojects, Triangle, Lonrho, Hippo Valley and JEDB fit this description, and all have been able to attract large numbers of acceptors (see Table I). Two other sustained subprojects, UBL and PMAP, also provided non-wage benefits and had large captive populations using company health services -- particularly dependent populations -- but these companies had work forces of only 700 to 1,000 individuals and acceptor numbers were correspondingly lower.

In all six of these cases, however, there were very strong bonds with outside institutions that helped to train staff, develop IEC programs, provide commodity support, keep company management informed and active, and even serve as a liaison with government. This support continued after the end of Enterprise. Most of the institutions providing support were family planning NGOs such as the Family Planning Association of Uganda (FPAU), the Zimbabwe National Family Planning Council (ZNFPC), Population Services Lanka (P.S. Lanka) in Sri Lanka, and the Family Planning Organization of the Philippines (FPOP).

A good example of this kind of cooperation existed in the Philippines: when it became evident that some **Personnel Management Association of the Philippines (PMAP)** -affiliated companies were not giving time off for in-plant employee motivators to sell contraceptives during work hours, FPOP marketing officers stepped in and served as in-plant motivators and distributors (this initiative was

crucial for FPOP, which depended upon sales of contraceptives for income). The professional association, PMAP, also played an active role in identifying participating companies, helping to organize the programs within the workplace, and keeping company managers involved. In addition, all the Philippine subprojects benefitted from backup support and monitoring from the government agency, the Department of Labor and Employment (DOLE). Ultimately, PMAP and FPOP were able to expand the program from the original 20 companies sponsored by Enterprise to 30. (Although still affiliated with PMAP, FPOP eventually lost seven of these companies to government contraceptive distributors who now provide them with free commodities.)

**Population and Community Development Association (PDA) in Thailand and Federación Mexicana de Asociaciones Privada de Salud y Desarrollo (FEMAP) in Mexico**, which focussed on smaller companies that did not provide many benefits to employees, were also sustained. Because of their many company service points, acceptor numbers or couple years of protection (CYP) were relatively high. In the case of PDA, sustained activity even included companies where management's attitude towards family planning was passive; that is, support went only as far as giving permission for a family planning program to operate in the workplace. In both cases (PDA and FEMAP), two very strong and very active family planning organizations took the lead in establishing the company contacts, in organizing and providing the services, and in providing extremely good backup and monitoring support.

When Enterprise funding ended in December 1989, PDA was selling temporary family planning methods to 446 factories, hotels, and other workplaces in three major cities of Thailand. Employees wishing other methods were referred to convenient PDA clinics. Since Enterprise's involvement, the number of PDA workplace sites has increased to 604, with in-plant sales limited to oral contraceptives (condoms were distributed free as part of its AIDS campaign). During 1991 and 1992, almost 1.2 million cycles of oral contraceptives were sold, representing about 89,000 CYP. Work forces at companies PDA has supported have ranged in size from 50 to several thousand employees.

PDA has financed the entire program (including overhead) from its sales of oral contraceptives in the workplace. Sales have been robust as PDA's prices have been lower than those charged by private drugstores, its chief competitor. This program has been financially lucrative for PDA because it has received contraceptives free from the Thai Government and donors such as Enterprise. Eventually, however, PDA may be forced to purchase oral contraceptives commercially because the Thai Government (its chief supplier) may cut back on commodity donations. Of course, this would radically change the financial picture of PDA's company sales program, and the NGO would have to alter its fee structure to keep the program sustainable.

FEMAP sold packages of comprehensive in-plant health and family planning services to both small and large companies. In fact, two of the most lucrative services FEMAP offered to companies were ultrasound and X-ray (PDA also sold in-plant health services such as X-ray but had to drop them because of competition from other private providers). The amount charged to the company for services depended on the size of its work force. FEMAP made enough from these services to subsidize other parts of its operation. For example, income from FEMAP's Sales of Services Program -- comprised of industrial contracts with 57 industries serving 5,000 acceptors -- came to more than \$44,000 in 1992, while costs totalled only about \$19,000. These surplus funds subsidized

FEMAP's CBD programs for low-income users, supporting an additional 12,900 acceptors.

*Weak Support and Subproject Failure.* Unquestionably, the weakness of the family planning NGO, **L'Association Malienne pour la Planification et Promotion de la Famille (AMPPF)** in Mali was a factor in the failure of **COMATEX's** family planning program. The concept of selling services to companies was new to AMPPF and, until recently, of little interest to its management. In fact, until the end of 1989 when AMPPF's former managing director resigned, there was no interest in or commitment to the idea of financial self-reliance. As a result, the family planning service contracts with the two companies **COMATEX** and **SONATAM** were low priorities. The overall organizational weakness of AMPPF and the overly ambitious design of its service program to companies (the responsibility of Enterprise) also contributed to subproject failure. Throughout Enterprise's involvement, AMPPF failed to cultivate supportive relationships with the two companies, motivate company management, or provide the kind of on-site supervision and support so vitally needed for program success. Although family planning at **SONATAM** somehow managed to survive, at **COMATEX** it did not.

In Bangladesh, serious disputes between **Bangladeshiyo Cha Sangsad (BCS)**, the Bangladesh Tea Association, and the Family Planning Association of Bangladesh (FPAB) resulted in an Enterprise subproject which never passed the planning stage. In addition to personality clashes, issues arose concerning the appointment of a project coordinator and which organization was to pay salary expenses. It is possible that these disputes could have been resolved by an outside arbitrator, but by this time Enterprise had ended, no other party in Bangladesh had played that role.

The lessons of the subproject with the **Indian Chamber of Commerce (ICC)** in Calcutta are also instructive. This subproject, which relied on the family planning NGO Sankalp Kiran for technical assistance, failed to develop support mechanisms for companies within ICC which would have helped to ensure long-term program sustainability (this was also the case in another unsuccessful subproject in India, AIOE). ICC identified the companies that received assistance. However, beyond this, the association had only limited involvement. Training was not provided to ICC to develop its capability to support employment-based family planning programs.

Four companies were initially identified by ICC as being interested in supporting employment-based family planning. Two of the four companies dropped out early. For the remaining two, Sankalp Kiran was enlisted to provide family planning services. Many problems and design flaws plagued the subproject: there were no in-plant motivators trained, and all services (even distribution of temporary methods) were provided off site at nearby clinics; the availability of IEC materials was limited; company management was hardly involved in the subproject; and, the subproject implementation period (9 months) was too short.<sup>3</sup> Subsequent to the end of Enterprise involvement, one of the two remaining companies halted family planning provision as it was renegotiating its labor contracts. (Recently, however, this company has hired Sankalp Kiran to provide services at two other of its plants outside of Calcutta.) For the sole remaining company, the NGO continued to provide services. Although company management refused to contribute, donations from Sankalp Kiran's other projects paid for services.

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<sup>3</sup> Given the high company dropout rate, the company selection must also have been flawed.

*To Subsidize or Not to Subsidize....* If an external partner is willing to provide everything, including payment, it is possible to establish a family planning program with any company; only permission to operate is required. Moreover, as long as an individual company's employee/dependent populations are large or there are a number of company service points under one umbrella program, a large number of acceptors can be reached. Even so, what level of long-term subsidy (if any) can be justified? Particularly in the case where public donations are supporting private sector activity, do long-term subsidies undermine the goal of mobilizing private sector resources to meet the resource gap in the provision of family planning services?

In the Enterprise experience, in order to start up private sector provision of family planning, some outside subsidy was required at the outset, particularly in countries where there was no previous experience with employment-based programs. However, Enterprise tried to limit its financial support to the early years of the subproject and required that the subproject partner share part of the start-up cost. By the time Enterprise support ended, subprojects were expected to cover their own costs entirely. In the sustained subprojects examined in this study, this was largely the case, with companies usually financing family planning out of company earnings. None of these companies tried cost-recovery schemes such as fee for service; fees charged, if any, were token. This strategy makes sense if management is assured that its family planning program will eventually be paid for out of anticipated cost savings.

The one program cost that even sustained subprojects did not fully cover was contraceptive purchases. Nearly all the sustained subprojects did purchase their contraceptives but from sources that sold them at subsidized rates, usually family planning NGOs. Some companies such as UBL purchased part of their commodity needs from family planning NGOs (or from SOMARC distributors who charge closer to real market prices), and at the same time received free commodities from the government. JEDB and the subprojects in India received all contraceptive requirements free from their governments. CFU members in Zimbabwe refused to support family planning without free contraceptives, and these were provided to farmers by the local NGO, ZNFPC. PDA did not charge companies for commodities sold in their workplaces since it sold commodities directly to employees. But like many family planning NGOs, PDA received these commodities free and passed the savings along to the consumer in the form of subsidized prices.

The availability of free contraceptives can also hurt an NGO trying to earn income from contraceptive sales in companies. For example, like PDA, FPOP earned income by selling commodities to employees in PMAP-affiliated company family planning programs. However, the free contraceptives provided by the Philippines Government to some companies seriously cut into FPOP's commodity sales.

- ii. *Strong commitment from management, particularly at the top, which worked to overcome resistance throughout the ranks.*

*Involving Management to Overcome Resistance.* The sustainability outcomes of two subprojects -- AIOE in India and PMAP in the Philippines -- can be contrasted to show how involving management can help to overcome resistance to family planning. Both subprojects worked through professional organizations.

**The All India Organization of Employers (AIOE)** subproject, which was not sustained, was an ambitious effort to establish family planning programs in up to 60 industries and in the informal sector (with Beedi cigarette makers) in three underserved areas of India (Bihar, Karnataka and Rajasthan). Within six months of the termination of the Enterprise Program, however, nearly all of these programs ground to a halt. Among the many problems responsible for this was the lack of support shown towards employment-based family planning by company managers. In large measure, this was due to the inadequate effort made to involve management and keep it informed and motivated. At best, top management displayed only passive interest by letting the subproject operate within the company. In Rajasthan, where personnel managers were given the responsibility to oversee the new workplace programs, turnover was high, causing a loss of continuity. Middle management, too, lacked commitment or interest. There were cases reported where management would not give time off for workers to get counselling or contraceptives. Additional problems were the subproject's short duration (given its overly ambitious goals), a poor project design that did not ensure follow-up and institutionalization of support for the post-project period, and political upheavals.

In contrast was the Philippine subproject with **PMAP**, which established family planning programs on the island of Cebu in 20 geographically dispersed companies employing 16,000 workers. (Later, 10 more companies were recruited.) Because companies were selected according to how top management viewed family planning, the personnel managers who were responsible for overseeing company family planning programs were very committed to the new effort. However, this strong commitment at the top to provide family planning at the workplace was not always shared down the management chain. Many efforts were made to overcome this problem, including regular meetings. Under PMAP auspices, key family planning and other program managers from all the participating companies met regularly to share experiences and problems. In addition, company managers were informed regularly about the new company programs. Ultimately, top management helped to motivate others by officially endorsing family planning through memorandums to middle management.

*Commitment Linked to Perceived Benefits.* In many subprojects studied, the strength of management's commitment to family planning was directly linked to how much top management believed that family planning was benefiting the company. Enterprise often supported cost-savings analyses to demonstrate the savings to companies from their family planning investment. Although cost-savings analyses were not always necessary to get management to commit to family planning at the workplace, they did pay off when, for example, the financial situation of the company changed and there was pressure to cut program costs.

The Sri Lanka, Zimbabwe and Uganda subprojects clearly demonstrate this point. In Sri Lanka, Enterprise supported an effort of the **Janatha Estates Development Board (or JEDB** -- one of the largest agribusinesses in the world with a work force of 200,000) to provide family planning at 60 of its 269 tea, rubber and coconut estates. Under a contract with JEDB, P.S. Lanka provided technical assistance, training, and voluntary surgical contraception (VSC) services. The Sri Lankan Government provided contraceptives free through JEDB clinics. The company provided generous benefits to its workers, many of them female, and a cost-savings analysis conducted as part of the project showed Rs. 1.15 saved for every Rs. 1.00 invested in family planning. By the end of the subproject, over 7,000 acceptors had been enrolled, and company management was committed to

sustaining its program in spite of serious financial problems and the presence of political terrorism on company estates.

After the end of Enterprise's involvement, the company (formerly a parastatal) underwent a number of radical changes, foremost among them privatization. However, throughout these transitions, management has continued to strongly support family planning. Recently, the financial situation of JEDB has improved, and the company itself intends to finance expansion of its program to the remaining 209 estates. Utilization at the 60 original sites, after increasing during 1991 to over 10,000 new and continuing users, dropped to about 8,300 as the target area reached its saturation point with nearly all married women of reproductive age covered.<sup>4</sup> Permanent methods were preferred.

In Zimbabwe, **Lonrho**, **Triangle**, and the **Hippo Valley Estates** have faced serious financial difficulties over the past three years. The ravages of severe drought have particularly hurt the two sugar estates, Triangle and Hippo Valley. Triangle has had to lay off more than 5,000 of its 6,500 work force, and Hippo Valley, part of the Anglo-American group, has transferred most of its 4,300-person work force to its other operations in Zimbabwe. Likewise, the Lonrho gold mines have also suffered from falling gold prices and other financial difficulties. Nonetheless, all three companies have continued to strongly support their workplace family planning programs, without any outside financial assistance. Contraceptives have been purchased from the Zimbabwe National Family Planning Council (ZNFPC) and from Geddes, a SOMARC distributor.

The cost-savings analyses conducted for Lonrho and Triangle showed savings accruing to both companies over the long-run, particularly for Triangle. (Hippo Valley based its decision to invest in family planning on Triangle's experiences.) In addition to financial incentives, these companies also realized that family planning services benefitted the health of workers' families and reduced the chances that good workers would leave. Because these companies' work forces were mostly male, male motivation for family planning was provided in the workplace. To address sexually transmitted diseases such as AIDS, the companies distributed free condoms in the workplace and in company beer halls. As a result, contraceptive prevalence rates increased dramatically.<sup>5</sup> The number of acceptors has declined somewhat, however, as layoffs and transfers were put into effect in 1992.

**Uganda Breweries Ltd. (UBL)** has also continued its family planning program in spite of a less-than-healthy balance sheet, and the program has been expanded to include an AIDS awareness and prevention campaign. During Enterprise involvement, a formal cost-savings analysis was not conducted. Nonetheless, management understood that the family planning program resulted in lowered absenteeism, fewer accidents, and higher productivity from reduced maternity leave. At the end of Enterprise, management continued the program for these reasons and because (1) they had invested funds in capital improvements (clinic renovations) and other infrastructure and trained staff.

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<sup>4</sup> JEDB acceptor data were extrapolated from P.S. Lanka's records.

<sup>5</sup> KAP studies were conducted at Lonrho and Triangle. Baseline KAPs indicated prevalence rates of about 40 percent at Lonrho and 20 percent at Triangle. End-of-subproject KAPs indicated that prevalence had increased to around 60 percent for both companies. The Lonrho KAP was considered to be less reliable than Triangle's.

and (2) they did not want to risk losing the goodwill of employees and of the Government of Uganda for its work in family planning and AIDS prevention. Although overall contraceptive utilization rates remained stable during 1991 and 1992 (455 and 445 acceptors, respectively)<sup>6</sup>, condom use nearly tripled as a result of UBL's AIDS campaign.

The experience of the **Commercial Farmers Union (CFU)** in Zimbabwe differed. A family planning project using CBDs was initiated at two CFU sites: Doma with 92 participating farms and Nyanzura with 103. Farmers paid the salaries of the CBDs, who distributed contraceptives provided free by ZNFPC. Shortly after Enterprise support ended, Doma farmers closed down their family planning program. However, at Nyanzura farmers not only continued their support but also expanded the program to an additional 31 farms. The reasons for this are again linked to commitment and perceived benefits. Commercial farms in Zimbabwe do not provide employees (farm workers) any benefits except housing. CFU and the commercial farmers provided family planning in the workplace to improve their workers' living standard and to provide them with a service much in demand.

In addition to the humanitarian motive, the farmers strongly felt the need to engender the good will of the Zimbabwe Government, which favored family planning. In the changing political and economic climate of Zimbabwe, the commercial farmers, who were white, had an interest in maintaining good relations with the Government in the face of possible land reform policies that might reduce their holdings. This motive explains what happened in Doma. New reform policies recently instituted in the Doma region meant that some farmers were required to give up a portion of their land for resettlement of the landless. As a result of this policy, Doma farmers stopped paying CBDs, and the family planning program was terminated. Land reform has not yet hit farmers in Nyanzura.

In both Mali and Mexico, companies were required to pay into national social security schemes to help cover costs of health services for workers and dependents. As a result, many company managers approached by Enterprise did not readily see the payoff of investing in family planning since the company itself would not save on health care costs. Although in Mali, the former tobacco parastatal **SONATAM** agreed to sponsor a family planning program, management support for it was very weak during Enterprise's involvement. SONATAM did provide clinic space and staff, but Enterprise picked up almost the entire cost of the program. A planned cost-savings analysis was never conducted. If it had been conducted and were positive, it is possible that this might have helped overcome management resistance. Eventually this resistance led to contraceptives not being reordered on time, and the in-plant IEC program was halted.

Later, the **Malian** Government sold the parastatal, and the company was reorganized and management changed. The financial health of the company, now private, has improved, and the company's new management team has strongly supported the program. IEC activities have been resumed and adequate supplies of contraceptives have been purchased from AMPPF. The program has been sustained, and CYP actually increased from 372 in 1991 to 441 in 1992.

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<sup>6</sup> Acceptor numbers for 1992 are an estimate, based on nine months data (January through September, 1992.)

With Enterprise support, **FEMAP**, the Mexican family planning organization based in Ciudad Juarez, attempted to sell family planning services to the in-bond industries along the border (called *maquiladoras*). A principal target of this initiative were nine local industrial plants of a major US company. Management resisted as the selected company was already contributing to the national social security program, and it did not believe that a health and family planning program would have a positive impact on worker productivity. It took 18 months to convince management to allow FEMAP to conduct an analysis of possible savings from family planning investment in two plants.

FEMAP found that the high rate of turnover (144 percent annually) and absenteeism (7 percent monthly) was due largely due to pregnancy and maternity leave; management had thought workers were leaving for other jobs. FEMAP showed management that it could save several million dollars in improved efficiency, reduced turnover, and absenteeism by investing in family planning services for its workers. In addition, FEMAP repackaged its services to make them more acceptable, offering a wide range of social services that included occupational health and safety, X-ray, ultrasound, family medicine and family planning. By the end of Enterprise, management had offered FEMAP a contract for family planning provision in two plants. These contracts are still in effect, and a new contract has been negotiated for a third plant in Mexico City. Acceptor rates in the two plants grew from a very small percentage of the female labor force (only 63 acceptors) by the end of Enterprise, to 85% of married women of reproductive age at the time of the follow-up study.

iii. *The financial health of employment-based partners.*

*When Survival Is at Stake.* Funding from somewhere (company earnings, cost-recovery, or donors) must be available to finance family planning services. Particularly during difficult times when a company's very survival is in question, the continuation of family planning services may be in jeopardy. A review of the experience of the 17 subprojects indicates that very strong management commitment to family planning, coupled with strong links to competent sources of technical and other assistance, can help shelter or at least delay the negative effects of a company's poor financial position. This was demonstrated by the Lonrho, Triangle, Hippo Valley, UBL, and JEDB subprojects. JEDB, and to some extent, SONATAM (where management commitment to family planning came later), carried on long enough to see their financial positions improve. In three other cases, however -- COMATEX, PMAP and Benguet Gold Operations -- the poor financial condition of companies led directly to the reduction or elimination of family planning at the workplace.

Serious financial difficulties at **COMATEX**, a textile company employing about 1,200 in the provincial town of Segou, Mali, have led company management to reduce its health budget, practically eliminating money for contraceptives. Like SONATAM, this former parastatal had been privatized and its management reorganized. But unlike SONATAM, COMATEX did not financially recover from privatization. Thus, where there were over 1,000 family planning users in 1991, in the first half of 1992, there were only about 200.

The **PMAP** subproject, which had managed to expand family planning activities to 30 affiliated companies, eventually lost nine to bankruptcy. Most of these were trading and mining operations. Bankruptcy also affected another subproject in the Philippines, **Benguet Gold Operations**, where Enterprise helped to revive the company's long running, but poorly organized, family planning

program. After Enterprise support was phased out, the company extended family planning services to six more mining sites. However, falling gold prices, along with the political costs and general unpopularity of strip mining, forced the company to go out of business in 1992.

### Market-based Programs

#### Description of Subprojects Studied

Nine former Enterprise subprojects that were market-based were included in the study (see Table II). Two were based in the Near East, five in Asia, and two in Latin America. Because subprojects in the market-based portfolio differed in terms of approach and objectives, they are best described in terms of the strategies they followed to add or expand family planning services.

The study sample can be broken down into three market-based strategies:

- **Umbrella organizations**, working through professional associations to reach large numbers of service providers or retailers. Two subprojects fall under this category - the Indian Medical Association (IMA), which focussed on physicians, and the associations representing pharmacists and non-pharmacist retail drugstore owners in Thailand.
- **Fee-for-service operations** to increase the availability of family planning services. The small clinic franchise operations of two NGOs (MEXFAM in Mexico and ADOPLAFAM in the Dominican Republic) and the full-service clinic/hospitals of three NGOs (Yayasan Kusuma Buana [YKB] in Indonesia, the Turkish Family Health and Planning Foundation in Turkey, and Yayasan Kesejahteraan Muslimat [YKM] in Indonesia) fall under this strategy.
- **Insured or managed-care plans** to increase access to family planning. The Egyptian parastatal, Health Insurance Organization (HIO), and the feasibility study for a health maintenance organization sponsored by the Indian NGO, Sankalp Kiran, represent this strategy.

#### Sustainability Status

Enterprise's mandate was to experiment. Thus, the program funded some high-risk market-based subprojects knowing that their sustainability prospects could be low but hoping to learn important lessons even from failures. Nonetheless, Enterprise funded these subprojects with the intention that they would be sustained once its support was phased out.

Of the nine subprojects under analysis, one -- the HMO feasibility study prepared for **Sankalp Kiran** -- did not develop into an operational program under Enterprise's tenure, nor was it intended to. Enterprise's role was only to sponsor a study to ascertain the financial viability and business prospects of a planned HMO. After the study was completed in early 1991, Sankalp Kiran actively searched for outside investors. Of the remaining eight subprojects, only the one with the Thai pharmacists and retail drugstore owners was not sustained; all other subprojects are still operating.

However, to date, none of these subprojects has achieved financial independence. The seven market-based subprojects currently operating still receive monetary and in-kind support. Without this continued support, it is likely that some would have failed once Enterprise funding ended. Clearly it takes longer to achieve financial independence than either Enterprise or any of its partners recognized.

On the positive side, Enterprise's seed capital did pay off in terms of readily available follow-on funding for subprojects, mostly from public sector sources: IMA expanded the Enterprise-sponsored pilot project with new donor support from two USAID cooperating agencies; Pathfinder continued Enterprise's work with HIO; USAID/Santo Domingo provided follow-on core support to expand ADOPLAFAM's operation; YKB and the Turkish Foundation continue to subsidize their clinics out of surplus corporate revenues; and YKM-affiliated hospitals and clinics have always had, and still continue to receive, donations from YKM's parent organization for budget shortfalls. In the case of MEXFAM, Enterprise was one of several donors funding the clinic franchise program and was one of the earliest to phase out its support. In the two cases in which Enterprise's initial investment did not stimulate follow-on funding -- the Pharmacist and Drugstore Owner Program in Thailand and the HMO feasibility study in India -- the activities were not considered good business opportunities by those who were expected to provide the support.

### Analysis

At the end of the program, Enterprise analyzed what conditions or circumstances most influenced project success. Are Enterprise's findings on the key factors that influence prospects for achieving subproject success -- particularly sustainability -- in the family planning marketplace still valid?

Enterprise concluded that an individual market-based strategy was less likely to achieve all four of the impact objectives than an employment-based one. Of the four objectives, ensuring that a subproject achieved sustainability was usually Enterprise's first priority. Enterprise found that the likelihood of a market-based operation being sustained was directly linked to its profit-making potential. In this vein, the most successful market-based operations were those that integrated low-profit family planning with other, more highly demanded health services, or services that filled a new market niche. In addition, as with the employment-based portfolio, Enterprise found that market-based operations that had a number of service points or large beneficiary pools were able to attract the largest number of acceptors.

Enterprise also made recommendations on how a donor could best use its funds in the market-based sector:

- Economies of scale were best achieved by working through an umbrella organization representing a large number of market-based operators or through pre-paid service institutions with large numbers of beneficiaries.
- Given the amortization of program costs over time -- that is, where the private sector assumes the ongoing cost of future services -- a market-based subproject could still use donor funds cost effectively, even where donor cost per acceptor was high.

- Leveraging private sector funds (cost-sharing) tended to be easier with non-profit market-based operators than with for-profits; non-profits had easier access to free or cheap capital, and they often paid lower or no taxes.

Enterprises' findings are still valid -- where data were available to either support or refute them (expenditure data were sparse). However, three factors have emerged as being the most critical for achieving program sustainability: (i) It is difficult to make money providing family planning services, particularly to low-income consumers; (ii) Integrating health with family planning services may help to increase the profitability of market-based ventures, especially when services are geared toward middle-income clientele. However, this type of venture may also fall short of earnings expectations; (iii) A smaller-than-expected market, along with public sector subsidies on family planning meant to promote use, may be contributing to low earnings and impeding prospects for long-term financial independence.

- It is difficult to make money providing family planning services, particularly to low-income consumers.*

*Professional Association Programs.* The failure of the **Thai Pharmacists and Retail Drugstore Owners Association** subproject illustrates this point. Collaborating with the Bangkok office of the Program for Appropriate Technology in Health (PATH), Enterprise worked with professional associations representing pharmacists and non-pharmacist drugstore owners to upgrade service delivery through retail outlets. The project did not involve contraceptive distribution but aimed at reducing the rising number of contraceptive failures from oral contraceptive *misuse*. A study indicated that users who purchased orals from drugstores were the most likely to forget to take them, probably because of insufficient instruction and supervision provided. This finding was significant in that Thailand's 8,000 drugstores played a key role in oral contraceptive provision (orals are sold without a prescription).

In two areas of Thailand, the subproject linked the professional associations representing pharmacists and non-pharmacist drugstore owners with sources of pharmaceutical and counselling expertise at two local university schools of pharmacy. The goal was to reduce the misuse of oral contraceptives by improving the quality of service delivery at retail drugstores and raising consumer awareness of correct use. This model tested the hypothesis that drugstores would be interested in participating in the project because it was good for business and that what was good for business would improve family planning service delivery in the country.

Although oral contraceptive sales were not a large part of a drugstore's business, improving the quality of the service provided to customers was seen by pharmacists and drugstore owners as giving them a competitive edge. If pill customers appreciated the service they were getting, they were expected to return for other products and to refer their friends. As a result, during Enterprise's involvement, both pharmacists and drugstore owners participated actively in the program, which tailored training to the academic competence of each. In addition to training, participants received reference materials, posters, and stickers promoting proper pill use, free advertising, and special recognition. Subproject costs were mostly covered by Enterprise; participants paid for transportation, and two drug companies (one local and one international) paid for reprints of pamphlets and counter stickers.

At the end of the project, it was expected that the professional associations would continue to support services through member contributions. Tentative plans had also been made between the associations and the universities for extending the program to cover antibiotic counseling. However, when funds ran out for oral contraceptive display and educational materials, the professional associations and their members declined to pay for reprints. Members also declined to pay for additional training. As a result, training has continued only sporadically, and has been paid for by the universities. The original program lost its momentum and has been unable to spawn new activities to combat other over-the-counter drug-related problems.

The reasons that association members failed to sustain their program financially are straightforward. First, oral contraceptive sales did not make up a large part of a pharmacist's or drugstore owner's business. At the end of Enterprise's involvement with the subproject, many drugstore owners did claim that the training and promotional campaigns had had a positive impact on sales of oral contraceptives and other drugs. However, none would produce records to corroborate this claim, so the extent of the subproject's impact on their businesses could not be verified. In fact, one common complaint heard during end-of-subproject interviews was that counselling oral contraceptive customers properly took away too much time from other customers, especially during hours when drugstore personnel were busy. Some also claimed that no additional promotion was necessary since certain brands of orals sell themselves.

Second, there was a long tradition of Thai universities providing free continuing education to business and professional members of the community. This "subsidy" was an accepted and widespread practice -- so much so that many subproject participants believed it was not their responsibility to financially support drug education programs.

It is not yet clear whether the family planning activities of another Enterprise-supported professional association, the 85,000-member **Indian Medical Association (IMA)**, will be sustained over the long-run. The goal of the IMA subproject was to give selected physicians advanced training in modern spacing methods, especially in prescribing and counselling for oral contraceptives. Studies indicated that physicians' lack of knowledge was preventing them from prescribing the pill more widely. This, along with inadequate counselling on oral contraceptives' side effects, were barriers to continued use among the younger couples that preferred a reversible family planning method.

Enterprise contributed funds for a small pilot project to develop the capacity within the IMA to train physician members in oral contraceptive technology, counselling, and IEC techniques, and to implement a service demonstration project in three states. Fifteen IMA members were trained as trainers. These, in turn, trained 270 other members. Along with training, physicians were given a small stock of oral contraceptives (supplied by IMA). However, establishing doctors as pill distributors was not a goal of the program. Instead, the program emphasized linking the physicians with sources of supply at local pharmacies, and pharmacists were encouraged to increase stocks to meet an expected increase in demand from prescriptions.

After training, participating physicians were interviewed periodically about their attitudes towards family planning and how the program had affected their practices. The results of one of these surveys (conducted six months after training) indicated that most found the training to be useful, most had positive attitudes toward providing family planning services, most were actively promoting oral

contraceptive use, most wanted training in other methods (particularly IUDs), and a little more than half perceived that promoting orals could be financially advantageous.

After Enterprise's involvement ended, two USAID cooperating agencies stepped in with new support to expand IMA's program (Development Associates and the Johns Hopkins University), and by early 1993, 1,600 additional doctors had been trained. Interviews conducted between training sessions indicated that the number of doctors reporting new family planning acceptors rose from 14 to 48 percent. Similarly, doctors who reported prescribing orals rose from 26 to 65 percent. The fact that pharmacies in four districts of Gujarat started stocking oral contraceptives is evidence of the increased demand for oral contraceptives.

These are strong indications that IMA's program has been working. Nonetheless, it is still not clear what will happen to the program once donor funding ends. On the positive side, unlike the pharmacist and drugstore associations in Thailand, which relied on other institutions to take the lead in organizing and managing their program, the IMA has always been in charge. Technical assistance to the association was provided by the family planning NGO, Sankalp Kiran, but IMA managed the program and took responsibility for its outcome. Clearly, IMA's level of interest and commitment has been higher than that of the Thai associations.

Equally clear, however, is the fact that IMA has some concerns about the future. The association has explored an arrangement in which several pharmaceutical manufacturers would supply participating doctors with orals at subsidized prices so that they can earn extra money, be more motivated to prescribe pills, and continue to support the program. It is not the intent of this paper to discuss the implications of this plan; however it does indicate that IMA has at least recognized that prospects for the long-term sustainability of this initiative may be linked to members' financial interests being met.

*Small Clinic Franchise Programs.* The inherent problem of the family planning's low profitability is illustrated in a different way in the small clinic franchise programs of **Fundación Mexicana para la Planeación Familiar A.C. (MEXFAM)** and **Asociación Dominicana de Planificación Familiar, Inc. (ADOPLAFAM)**. These two NGOs provided training and seed capital to unemployed physicians who opened small clinics in poor, underserved communities. Starting in 1986 with grants from several donors (including Enterprise), MEXFAM pioneered the concept of clinic franchising to expand the availability of family planning services. Ultimately, 300 clinics were established (30 supported by Enterprise). In 1988, Enterprise collaborated with a new NGO, ADOPLAFAM, to replicate the MEXFAM experience in the Dominican Republic. With Enterprise support, ADOPLAFAM was to have established 40 clinics.

The original MEXFAM model involved recruiting, training and deploying unemployed doctors to provide family planning services in small clinics on a fee-for-service basis. MEXFAM provided doctors with clinic space and equipment, and they repaid half of all start-up costs out of earnings. These community clinics also received subsidies for working capital and commodities until they were established operations, and then all subsidies were withdrawn. At this point, clinics were expected to run independently of MEXFAM.

MEXFAM later modified the model by adding child health services to improve clinics' earning

potential; these clinics were self-sustaining in a much shorter period of time. ADOPLAFAM took this later model of MEXFAM's and adapted it to fit the local environment. Various experiments were tried involving loan repayments and subsidy reductions. ADOPLAFAM found that if doctors were given equipment, supervision and training but were required to pay all other costs, clinics more quickly reached a break-even point and financial independence.

Due to ADOPLAFAM's relative lack of operational experience, it took longer than anticipated to open clinics, and these took a number of years to become sustainable. For example, by early 1991 (after about three years of operation), only 14 clinics had been opened, of which 10 were still operating; only three had fully repaid their debt. ADOPLAFAM also signed agreements with 12 existing community clinics which then integrated family planning services into their general practices. In 1993, 25 clinics were being supported, with 10 close to being self-sufficient and 15 continuing to receive heavy subsidies.

As it gained experience, MEXFAM was able to reduce the time it took for its clinics to achieve financial independence from four to two years. At the end of Enterprise's involvement, 28 out of 30 Enterprise-sponsored clinics were operating without subsidies. As records are now kept on the clinic population as a whole, it is difficult to ascertain the sustainability status of only the Enterprise-sponsored clinics. However, in 1993, out of the 300 clinics established since 1986, 30 were closed for non-performance and 10 were operating independently. Of the remaining 260, 135 continued to receive heavy subsidies, 72 were "affiliated" doctors who paid 80 to 100 percent of contraceptive costs and covered all other expenses, and the balance received slightly larger subsidies but were soon expected to become affiliated doctors with a subsequent reduction in financial support.<sup>7</sup>

Although the two clinic franchise programs are being sustained, some critical problems have surfaced. Foremost among them is the fact that once doctors are operating independently, they reduce or even stop providing family planning. Clinic doctors have discovered that more money can be made by providing health services, particularly curative care. As a result, less than 10 percent of an independent community physician's practice may be devoted to family planning.

To combat this problem, several measures have been taken. ADOPLAFAM has been recruiting midwives (as well as doctors) to operate clinics, as their income expectations are lower. MEXFAM, on the other hand, has come full circle and now discourages clinic owners from becoming fully independent. Instead, MEXFAM establishes a long-term partnership with the physician who is called an affiliate. No longer are equipment, instruments, and furniture being sold to the physician on a loan basis; instead, MEXFAM leases them. MEXFAM will continue this leasing arrangement indefinitely if the affiliated physician continues to provide family planning. Moreover, 15 to 20 percent of services provided by the practice must be for family planning. If the physician does not provide this level of service, MEXFAM withdraws its support. MEXFAM will also provide continuing education to upgrade the physician's skills if he or she continues to provide family planning services. It is interesting to note that MEXFAM does not provide many contraceptives

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<sup>7</sup> Data from I. Salas (MEXFAM), T. Williams (IPPF) and B. Janowitz and B. Gould, Options for Financing Family Planning, Increasing Private Sector Participation and User Fees, August 1993, Draft Document, Family Health International, p.7.

(which it receives free from donors) to clinic physicians, since contraceptives sales are not an important part of a clinic practice. This is due to the fact that contraceptives are easily obtainable at very low cost on the open market.

The low profitability of family planning services may have repercussions on:

- the volume of family planning services provided and resulting acceptor numbers: Until recently, clinic franchises seemed to be an excellent way to attract large numbers of acceptors. For example, ADOPLAFAM serviced about 8,000 continuing users in 1991, and 15,000 in 1992 (cost per acceptor declined from \$13.50 in 1991 to \$10.41 in 1992).<sup>8</sup> By early 1991, the 30 Enterprise-sponsored MEXFAM clinics had attracted more than 64,000 acceptors. (More recent acceptor data were not available.) Today, although MEXFAM still believes these clinics are greatly benefiting poor communities, the program does not meet MEXFAM's projected CYP target goals. As a result, MEXFAM no longer insists that family planning services yield high revenues or many CYP, although it still requires that doctors supply a minimal level of this service.
- the ability to sustain clinic franchise programs in the long-run: Currently, both NGOs receive heavy donor support for their core programs, particularly from USAID. The way these clinic franchise programs are structured, the NGOs do not recoup the real costs of establishing franchises, and continuous donor support is required to keep them running. In 1993, ADOPLAFAM signed a new agreement with USAID that will ensure funding for some years to come. MEXFAM, however, will see its USAID support end in 1997. As a result, it is evaluating whether and how it can continue to open new community clinic franchises. As part of this evaluation, no new clinics were opened in 1993 (there are plans to open 10 to 20 clinics in 1994).

In exploring other sustainable ways to generate many CYP, Mexfam has developed a new program that works with established clinics to expand family planning services. For a fee, MEXFAM provides training, equipment and contraceptives. This strategy, called "collaborating" doctors, is a less formal arrangement between the two parties, is less expensive to set up and administer, requires less monitoring, and is very productive in terms of generating CYP.

- ii. *Integrating health with family planning services may help to increase the profitability of market-based ventures, especially when services are geared toward middle-income clientele. However, this type of venture may also fall short of earnings expectations.*

**New Business Opportunities.** Ingenious business plans were developed by several of Enterprise's market-based partners to solve the problem of the low income-generating potential of family planning. Usually non-profit NGOs, these partners were interested in establishing commercial ventures such as full-service clinics, diagnostic units, and HMOs that were geared to higher-income

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<sup>8</sup> Based on an exchange rate of \$1.00 = DR 13.50.

clientele, willing to pay premium prices for high quality services. Once these ventures were profitable, it was anticipated that their surplus income would subsidize their family planning programs for the poor and underserved. Expected profits from HMOs were to be used differently: these were not meant to subsidize other programs such as family planning for the poor but to pay sufficient returns to attract investors. The HMO itself would achieve good family planning coverage by providing family planning services to a large number of pre-paid plan members.

Enterprise funded a number of such commercial ventures -- laboratories, infertility clinics, diagnostic centers, MCH centers, general care clinics -- particularly in Latin America. (None of Enterprise's work with HMOs got past the feasibility study stage.) By the end of Enterprise, some of these ventures had failed, but others were profitable enough to cover costs and subsidize family planning programs. Although most of these ventures had not yet reached a break-even point, it was anticipated that most would eventually become profitable. At that time, the largest determinant of success seemed to be the partner's business acumen as demonstrated by the correctness of its initial assessment of the market, its level of entrepreneurship, and its ability to adapt to ever-changing market forces.

The post-Enterprise study analyzed one HMO study and two commercial ventures of the seven ventures and four HMO feasibility studies funded by Enterprise: the HMO feasibility study and business plan prepared for Sankalp Kiran in India; the Istanbul-based clinic of the Turkish Family Health and Planning Foundation, which offered a full range of women's reproductive health services; and the full-service outpatient clinic of the family planning NGO, Yayasan Kusuma Buana (YKB), based in Jakarta.

*HMO Feasibility Study.* The **Sankalp Kiran** study examined the feasibility of establishing an HMO to serve the employees and dependents of 26 large and medium-sized companies in South Delhi. The study concluded that the concept was feasible, provided that potential clients could be convinced to switch from direct payment to a pre-paid plan for health services. To be viable, the HMO would have to propose relatively modest premiums, and it would have to depend on large subscriber volume and cost control. Ten to fifteen thousand of the low-to-middle-income clients would have to be enrolled. Even so, the return on investment was not very attractive, and a minimum of five years were required to reach a break-even point. Required start-up capital was steep, about \$1.5 million. As a result, no investors have come forward; this is not surprising considering the risky nature, long payback period, and modest returns of this investment.

*Full Service Clinic Programs.* The **Turkish Family Health and Planning Foundation** clinic has also encountered difficulties. Since it was opened in 1988, the Foundation's clinic has struggled to cover costs and meet acceptor targets. Although providing high quality women's health and family planning services in an exemplary facility, the clinic has faced two major problems: competition from the nearby social security hospital's cheap and readily available women's health and family planning services, and the Foundation clinic's lack of a highly demanded service -- abortion.

Turkey has had a high rate of family planning knowledge but a low rate of correct use of effective methods. The high demand for abortion may be largely due to high failure rates. It was difficult for the Foundation to compete in a family planning marketplace that offered legal, affordable, and safe abortion services, despite its superior service quality and level of cleanliness. To attract more

clients, the Foundation's clinic has augmented its women's health service mix (diagnostic, episodic, and emergency services, and prenatal care).

The Foundation's main concern is that it offers its middle- and low-income clientele "quality services at social prices," including free services for those who cannot afford to pay. For most, however, the clinic charges a fixed fee that was increased from \$7.50 in 1991 to \$11.30 in 1992.<sup>9</sup> Although higher than the government social security hospital, these prices are less than half of those charged by other local private providers. Since the Foundation receives free family planning supplies from donors, by law the NGO may not charge for them.

Income and expenditure data since the end of Enterprise indicate that family planning costs represented about 35 and 29 percent of the total operating budgets for 1991 and 1992. Although family planning costs rose only by 20 percent over this two-year period, the clinic's operating budget jumped by 40 percent, rising from \$25,128 in 1991 to \$41,610 in 1992. Revenues generated from all services climbed by only 20 percent over this same period, from \$9,276 to \$11,586. Although clinic fees were increased, clinic utilization dropped. Thus, whereas revenues covered 36 percent of total operating costs in 1991, they covered only 27 percent in 1992. The Foundation subsidizes clinic losses out of excess revenues accrued from other programs.

Visits for all services declined slightly, from 2,808 in 1991 to 2,536 in 1992. The number of family planning users was 619 in 1991, and 505 in 1992 -- representing 22 and 20 percent of all visits respectively (this figure may be understated since users likely visited more than once). As a result of increasing costs and declining acceptor numbers, family planning cost per acceptor rose from \$14.21 in 1991 to \$24.68 in 1992.

To save costs, the Foundation has contracted out some of its auxiliary services such as laboratory and specialist services. On the revenue side, the NGO has not been idle in seeking out new opportunities: the clinic has a contract with the Turkish Cancer Association for cervical cancer screening, it is participating in a Norplant and injectable-contraceptive study with the Ministry of Health, and it has signed a protocol with a nearby private hospital for secondary health services. These are opportunities that the Foundation would not have been able to take advantage of without the existence of the clinic.

Although the Enterprise-sponsored clinic has not done as well as anticipated, another Foundation clinic established the same year (funded by Pathfinder) has done better. Providing family planning and highly demanded pediatric services to middle-income families, the clinic generated sufficient revenue to cover 70 percent of its operating costs after only two years. This does indicate that under the right conditions, commercial clinics run by the Foundation do have earning potential. Although the Enterprise-sponsored clinic has been operating in a very difficult market, the Foundation is confident that one day it will be profitable and attract more acceptors. The Foundation is committed to subsidizing the clinic indefinitely until it is self-sustaining, and currently has more than adequate revenue reserves to do so. In the meantime, the Foundation seems content to carry on, meeting its social agenda of providing high-quality services at affordable prices. Although this is hardly

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<sup>9</sup> Based on an exchange rate of \$1.00 = TL 10,638.00.

entrepreneurial, it is a calculated risk that the Foundation seems willing to take.

**YKB's Klinik Keluarga Buncit Raya** is an outpatient clinic catering to middle-class clients, particularly working women. Staffed by both doctors and nurses, it offers a full range of health and family planning services, including VSC. The clinic has a catchment area of 200,000 people. A third of its clients are covered by institutional contracts with insurance companies, a women's magazine, a few factories and offices. YKB also operates six smaller family planning clinics staffed by nurse-midwives for low-income clients in Jakarta, and a large parasite-control program for local schools.

Fees at the Buncit Raya clinic are charged according to the service provided, from a low of \$.50 to a high of \$12.00 for a service like Norplant.<sup>10</sup> The clinic is open five 8-hour days, and one-half day on Saturday. Contraceptives are provided free to YKB from the government family planning agency, BKKBN.

The clinic was opened in 1987 in a high growth commercial area of Jakarta where very few health services were offered. Within six months, however, a number of private clinics opened in the area, and currently there are at least seven operating within walking distance of each other. This and skyrocketing rent costs have hurt the Buncit Raya clinic, which was opened to generate surplus revenue for other YKB programs. YKB has responded with a number of initiatives, including marketing campaigns, extending the lucrative parasite-control program to more public and private schools -- patients generated through this program are referred to the clinic for check-ups and treatment -- and adding dental services. YKB has also opened a Center for Education which provides lectures to students on prevention and health at the clinic. Finally, because there are doctors at the Buncit Raya clinic, complicated cases arising at YKB's other family planning clinics are referred there for treatment. This cost is largely covered by YKB.

Revenue and expenditure data provided by YKB indicate that the clinic generated \$2,035 in monthly revenue in 1991 and \$2,422 in 1992. The clinic's monthly operating budget was \$2,907, meaning that about 83 percent of its planned expenses were being covered by revenues. Utilization data were available only for 1991, when the clinic provided services to 4,609 clients, 380 of whom (8 percent) were family planning users. On the positive side, YKB is covering nearly all of its costs. On the negative side, after seven years of operation, the NGO must still subsidize the clinic to keep it open. Moreover, a relatively small proportion of clinic clients are family planning acceptors.

On the surface, it would seem that this clinic, which serves middle-income people who can afford to pay, is being subsidized by YKB at the expense of poor family planning acceptors who cannot. It would also seem that unless this financial picture soon changes, YKB's best interests would lie in closing the clinic and turning its clients over to its local private competitors.

However, many other considerations may be influencing YKB's decisions. First, it is difficult to obtain an accurate picture of the Buncit Raya clinic's financial position because of record-keeping systems that mix cost and revenue data from clinics and programs, the difficulty of properly

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<sup>10</sup> Based on an exchange rate of \$1.00 = Rp 2,064.

calculating and applying overhead, and the fact that purchases and salaries for all YKB operations are paid centrally. In addition, YKB directors, like many business people around the world, are reluctant to reveal precise profit information to outsiders. Those who are very familiar with YKB find it difficult to believe that its management would continue a money-losing operation without doing something about it. (In another instance, YKB entered into a contract to provide pre-paid health services to a large hotel. Within six months, YKB canceled the contract because management did not think it was earning sufficient revenue.) Finally, there are the intangible factors such as the prestige this acclaimed clinic is bringing to YKB, the new business opportunities it is attracting, and the fact the NGO uses it as a main referral and education center. These all have influenced management's decision to keep it open.

The experiences of the Turkish Foundation and YKB clearly illustrate the caution which must be exercised when exploring the feasibility and investment potential of any commercial venture. If eventually profitable (and they very well may be), the two clinics could be good income earners.<sup>11</sup> To date, however, costs have been relatively high, numbers of family planning acceptors modest, and profits have not yet materialized. On the other hand, these ventures have provided a new mode of operation for the two NGOs, enabling them to attract new (and potentially lucrative) business opportunities that would otherwise have been impossible. Nonetheless, complex commercial ventures such as these demand careful attention and swift corrective action when the costs plainly outweigh the benefits.

- iii. *A smaller-than-expected market, along with public sector subsidies on family planning meant to promote use, may be contributing to low earnings and impeding prospects for long-term financial independence.*

*Markets, Competition and Public Subsidies.* Why has it taken so long for Enterprise-sponsored market-based initiatives to achieve financial self-sufficiency? In the early years of operation, two factors that impeded progress were the relative inexperience of many Enterprise-sponsored partners in the commercial marketplace and the complex and often risky nature of most market-based initiatives. Although important, over time these two factors have lost some of their significance as market-based partners have gained experience and have sharpened their business skills.

Of more long-term concern is the actual size of the market subproject partners are targeting. Typically, the market targeted by subprojects was employed persons (most often women) who could pay for family planning but could not afford most services available in the private sector. The experiences of some subprojects such as the YKB and Turkish Foundation clinics suggest that this market may be smaller than was originally estimated. Exacerbating the problem is the fact that most subproject partners have faced stiff competition from other providers in both the public and private sectors. Another long-term concern is the low profit-making potential of family planning. As has already been discussed, low profitability may be inherent to some kinds of family planning ventures. However in many countries, low profitability may also be caused or exacerbated by public sector subsidies to family planning service and commodity prices. Designed to promote family planning

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<sup>11</sup> MEXFAM is experimenting with this model to generate income and has established a full-service clinic which is profitable enough to subsidize 20 of its community family planning programs.

use, these subsidies are actually distorting the marketplace by artificially holding down prices.

The problems of intense competition for a narrow market and low profitability can be seen in the difficulty subproject partners such as MEXFAM, ADOPLAFAM, YKB, the Turkish Foundation, YKM, and the Health Insurance Organization have had in pricing their services. The goal was not to take away clients from other private providers (there would result in no net gain in services in the private sector), but to go after family planning non-users and public sector clients. However, in all the countries where these partners were operating, there were heavy public sector subsidies for family planning services and commodities. In Mexico, for example, 80 percent of all family planning services are provided free in the public sector. Commodities and services provided by public facilities in India, Thailand, Indonesia, Turkey and Egypt are free, or virtually free. To further complicate pricing decisions, targeted non-users were often poor, difficult to access, and expensive to serve. And therein lies the dilemma: subproject partners could not charge too much for services or they would be priced out of the family planning market. At the same time, fees charged had to be high enough to cover costs and generate a sufficient return on investment. To attract non-users and public sector clients, subproject partners usually priced their services somewhere in between other private providers and the public sector.

*Pre-paid Health Insurance and Subsidized Family Planning.* The subproject with the **Health Insurance Organization (HIO)** in Egypt illustrates some of these problems. A parastatal, HIO provides insured services to 4.8 million employed persons in both the public and private sectors. Both employers and employees contribute to premium payments with employers picking up three-quarters of the cost. HIO does not act as a third party administrator between the insured and health care providers. Instead, the organization actually provides a full range health care to subscribers through its own extensive network of clinics and hospitals located in the industrial centers of the country.

With funding support from a multi-year, USAID/Cairo-sponsored project, family planning was added to HIO's package of insured services in the late 1980s. Enterprise supplied technical assistance to HIO to help it develop a marketing program, cost identification and pricing strategies for self-sufficiency, and clinic family planning program performance evaluation systems.

Being a parastatal, HIO chose to charge fees for family planning services that were fairly close to those charged by the 3,000 Ministry of Health/System Development Project outlets. The Ministry of Health heavily subsidizes service and commodity prices at these outlets, and fees charged are very low. Thus, HIO's fees were lower than most other family planning service providers in the country, including the Ministry-owned Cairo Health Organization and teaching hospitals, as well as private providers. However, fees charged were not expected to cover family planning costs. HIO could afford to subsidize family planning services and not increase premiums because shortfalls would be met from expected savings in health costs elsewhere in the organization. Moreover, HIO had accrued very large revenue reserves over the years.

In terms of the market for its services, HIO had a tremendous advantage: large subscriber numbers and a resulting "captive" market for family planning services of around 1.2 million married women of reproductive age. HIO even allowed non-subscribers to obtain family planning services from its

facilities, although non-subscribers had to pay a fee of two Egyptian pounds (about \$.60)<sup>12</sup> for an examination while subscribers paid nothing. Both subscribers and non-subscribers were charged the same price for contraceptives (donated to HIO by USAID).

Acceptor targets for 1991 and 1992 were 60,000 for each year; actual acceptor numbers were 29,423 for 1991 and 44,389<sup>13</sup> for 1992. Although a disappointment for HIO, the number of acceptors greatly exceeded that of most other market-based subprojects. Slower-than-expected service start-up, a failure to vigorously market services, and stiff competition from both the public and private sectors were responsible for these lower-than-expected acceptor numbers.

In addition to public facilities, there is an extensive network of private sector facilities and physicians providing family planning throughout the country: for example, the 1,500 obstetricians participating in the Pathfinder-funded Private Practitioners Family Planning Project, the 450 clinics of the Egyptian Family Planning Association, the 112 clinics of the USAID-funded Clinic Services Improvement Project, and numerous outlets throughout the country sponsored by religious groups. Like HIO, many of these practitioners and programs were going after same market, employed women who could pay but were not wealthy enough to afford more expensive private services. It would be interesting to know what impact HIO's subsidized prices have had on the client load and revenues of its many private competitors fighting over the same market.

Fee revenue generated by HIO for family planning services since program start-up through March 1992 was \$58,366. Actual family planning expenditure for 1991 and 1992 was \$196,322 and \$258,695<sup>14</sup> respectively. Large as these figures are compared to fee revenue, they do not include external support from donors. For example, through 1992, Pathfinder supported 40 of HIO's 65 polyclinics providing family planning. Costs in 1993 will have increased as Pathfinder funding was phased out, and HIO had to assume financial responsibility for family planning in all of its clinics. Under normal circumstances, revenue shortfalls would not present a major problem because of HIO's large savings reserves. However, nearly three years ago the Ministry of Health transferred these savings to other health service programs, and this was followed by a rapid increase in the price of pharmaceuticals. As of early 1993, HIO had serious cash flow problems and was unable to pay its drug suppliers on time. To solve this problem, HIO has had to ask the Egyptian Government to increase its premiums.

The fact that HIO offered family planning at highly subsidized prices did not plunge the organization into financial difficulty -- family planning represented only a very small part of HIO's health service system. Moreover, it is anticipated that family planning service provision will eventually result in overall savings from reduced maternity costs. Nonetheless, HIO's subsidy policy raises two concerns: first, given its financial situation, can HIO now afford to pay large subsidies for family

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<sup>12</sup> Based on an exchange rate of \$1.00 = EP 3.318.

<sup>13</sup> The "actual" acceptor number for 1992 is an estimate based on nine months data (January 1 to September 30, 1992).

<sup>14</sup> Because actual expenditure data for 1992 were not available, "actual" 1992 expenditure was estimated based on a percentage of the amount budgeted for family planning for that year.

planning services (especially if costs grow and premiums stagnate)<sup>15</sup>?; and second, from a policy-making standpoint, what has been the impact of HIO's pricing policies on its private sector competitors?

*Subsidies and Hospital-based Family Planning.* The subproject with **Yayasan Kesejahteraan Muslimat (YKM)** in Indonesia is an interesting example of how one health facility has managed to overcome some of the difficulties of a subsidized marketplace. YKM was the welfare arm of the Muslimat Foundation (Indonesia's largest organization of Muslim women), which in turn was part of the 12-to-15-million-member Nudhlatul Ulama (NU), Indonesia's foremost religious organization. On behalf of NU, YKM coordinated a network of health care facilities which provided services to NU members. The majority of YKM's clientele were low-middle to low-income earners (mostly farmers and cottage industry workers) who were residing in peri-urban and rural communities. With regard to family planning, YKM's main competitor was government hospitals and health centers. There were many private providers of services, but relatively few offered family planning.

YKM ran its network of 30 clinics and hospitals like a charity, financed mainly by donations and fund-raising. Few, if any, family planning services were provided. Thus, the goal of the Enterprise subproject was to enable YKM to develop a strong, network-wide family planning program while strengthening its capacity to cover its costs by (1) upgrading productivity, operating efficiencies and cost control, and (2) instituting a formal schedule of fees for services.

Since the end of Enterprise, YKM's network has grown to 42 facilities. As part of this study, data were collected from one of the facilities Enterprise supported, the Sitihadjar Hospital. In addition to curative care, the Sitihadjar Hospital provided reversible family planning methods (including Norplant) and VSC. After Enterprise funding ended, the hospital received in-kind support (equipment and IEC materials) from BKKBN. Free and low-cost contraceptives were also obtained from the government and the local SOMARC distributor.

Sitihadjar Hospital had numerous competitors operating nearby, including one government hospital, three government clinics, one private hospital, and ten small private clinics. To increase acceptor numbers, the hospital began providing outreach services in the surrounding districts from a mobile unit two times a week. Although fees were charged for health services, fees for family planning services were not introduced until 1992. Depending on the service, these charges varied: some services were subsidized while others were priced at full cost. Like the other facilities in YKM's network, Sitihadjar Hospital charged less than private providers but more than the government for health and family planning services.

Most of its clients were low income, and the hospital had to ensure that prices were both competitive and affordable. Nonetheless, when fees for family planning services were first introduced at Sitihadjar, many clients objected. The new fees did not affect utilization rates, however; acceptor

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<sup>15</sup> At the request of USAID/Cairo, HIO has already begun this process by examining whether it can afford to continue with incentive payments given to family planning workers that were formerly paid by Pathfinder.

numbers grew from 427 in 1991 to about 570 in 1992.<sup>16</sup> Data were not available on the size of the market for family planning nor on the hospital's target number of acceptors. Thus, it is impossible to judge how well the hospital is doing in terms of acceptor rates.

Since the early 1990s, the Sitihadjar Hospital has seen its financial position improve markedly. Traditionally, the hospital has depended on donations from NU and fees to cover operating costs. Donations and fees have grown, but the largest increases have come from a new contract obtained from the government insurance company, ASTEK. Sitihadjar is one of ASTEK's service providers, and the hospital receives a flat fee of about \$290 per insured client for both inpatient and outpatient services. ASTEK also reimburses Sitihadjar for family planning services. In 1990, monthly revenue from all sources was about \$7,000; by 1992, monthly revenue had grown to \$36,000<sup>17</sup>.

Although Sitihadjar has instituted strict cost control measures, particularly on inpatient services, the hospital's annual operating budget grew from about \$311,000 in 1991 to about \$506,000 in 1992. In spite of this, revenues collected in 1992 covered about 85 percent of Sitihadjar's annual budget versus 27 percent in 1991. Fees from family planning made up only a small percentage of revenues collected; however, Sitihadjar's sizeable operating budget allowed losses from one service (e.g., family planning) to be more easily absorbed by cost savings elsewhere (e.g., inpatient services).

Although still dependent on donations, the Sitihadjar Hospital's sustainability prospects seem encouraging. Its potential to generate large numbers of acceptors is less clear: given the size of Sitihadjar's operating budget which is, for example, 12 times that of the clinic in Turkey, acceptor numbers seem low (505 in Turkey compared to about 570 for Sitihadjar in 1992). Nonetheless, the hospital has priced its health services competitively, has obtained lucrative government contracts, and has practiced cost control, all of which have paid off in terms of good revenue volume. As did Enterprise's other market-based partners, the hospital enhanced its competitive position by obtaining subsidized goods and services offered by the Indonesian Government to non-profit entities providing family planning.

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<sup>16</sup> 1992 figure extrapolated from nine months data (January through September, 1992).

<sup>17</sup> Based on an exchange rate of \$1.00 = Rp 2,064.

## IV. CONCLUSIONS AND FUTURE DIRECTIONS

### Conclusions

This study focussed primarily on sustainability outcomes and the conditions or circumstances that most influenced these outcomes. Although the study lacked enough financial data to form conclusions on the relative cost-effectiveness of program initiatives or funds leveraged from the private sector, there were sufficient data to examine how well most subprojects attracted family planning acceptors.

### Sustainability

Most of the 25 subprojects analyzed for this study -- 16 out of 25 subprojects -- coped reasonably well after the withdrawal of Enterprise support and have continued operating their programs. In most cases where follow-on funding was required (from either internal or external sources), it was in place by the time of Enterprise's departure. In six cases, however, subprojects suffered an almost immediate and negative impact from the phase out of Enterprise's funds -- COMATEX (and indirectly, AMPPF's company service vendor program), AIOE, ICC, Thai Pharmacists, and BCS. ICC and AMPPF have managed to carry on with support found from other donors; the other four subproject cases were not sustained. In three additional cases which were not sustained -- Benguet, CFU, and the HMO feasibility study in India -- the withdrawal of Enterprise funding had little impact on subproject outcomes. Benguet went bankrupt, CFU canceled part of its program in reaction to a policy decision made by government, and in the case of the HMO feasibility study, investment funds did not materialize.

Nearly all employment-based programs that were sustained covered program costs out of company earnings. One subproject partner (PDA) relied on in-plant commodity sales to generate income to cover program costs. Employment-based programs that were more likely to be sustained had committed company managers, had family planning programs that were seen by managers as benefiting companies in a tangible way, had strong linkages with competent sources of technical and logistical support, and were in reasonably good financial health. In addition, sustained programs had access to low cost or free family planning commodities (some also purchased from SOMARC distributors, whose commodity prices are closer to real market prices). These findings are consistent with those made by Enterprise at the conclusion of its employment-based program work.

Almost all market-based subprojects were sustained, but their family planning revenues were not yet covering costs. Subprojects that were being sustained and seemed to have the best prospects for covering their costs:

- integrated low profit-making family planning with more lucrative health services;
- had large operating budgets that allowed losses from one program area to be covered by savings (or income earned) from another;
- were efficient and controlled costs;

- set competitive prices for services;
- met, or had the potential to meet, the partner's financial objectives; and
- took advantage of any subsidized goods or services offered in the family planning marketplace.

In short -- as Enterprise found -- market-based partners with sustained programs were entrepreneurial. When Enterprise funds were phased out, partners followed a number of strategies:

- some covered earnings shortfalls out of surplus corporate revenues;
- some aggressively pursued other business opportunities to supplement earnings;
- some relied on external grants and donations; and
- some used a combination of all three.

Only one (The Turkish Family Health and Planning Foundation) raised its fees for goods or services sold.<sup>18</sup>

Interestingly, almost all of the market-based partners in the sample were non-profit NGOs that demonstrated a tenacious will to carry on with their programs in spite of losses. This behavior was consistent with another of Enterprise's findings: being exempt from paying taxes on earnings, having greater access to low- or no-cost sources of capital, and being more willing to forego a higher profit margin in the interest of achieving social objectives, an NGO was more willing to take on risk and tolerate losses than a for-profit partner. The only market-based operation that was not sustained was with for-profit pharmacist and drugstore retailers in Thailand.

### Acceptor Rates

Also consistent with Enterprise's earlier findings was the fact that subprojects attracting the largest numbers of acceptors had:

- large company work forces or employee/beneficiary populations (Lonrho, Triangle, Hippo Valley, and JEDB);
- a large number of service points (ADOPLAFAM and MEXFAM);

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<sup>18</sup> In fact, raising fees could be counterproductive. Evidence from another study (Haws, Jeanne, et. al., "Impact of Sustainability Policies on Sterilization Services in Latin America", Studies in Family Planning, vol. 23, n. 2, March/April 1992, pp. 85-96) suggests that raising fees for VSC services in reaction to funding cutbacks results in lower case loads and a change in client mix from low- to middle-income acceptors.

- umbrella organizations acting as service vendors to a large number of companies under contract (FEMAP and PDA); or
- a large pool of insured beneficiaries (HIO).

Least successful at attracting acceptors were the full-service clinics or hospitals (YKM, YKB and the Turkish Foundation).

In the group of sustained subprojects where acceptor rates either declined or did not grow as quickly as anticipated, rates did not seem as much affected by the phase out of Enterprise funds as by other factors, for example:

- company layoffs or transfers (Hippo Valley, Triangle and Lonrho),
- a movement away from family planning by private providers (MEXFAM and ADOPLAFAM),
- smaller-than-anticipated markets and/or intense competition for available markets (YKB, HIO, the Turkish Foundation, and possibly YKM), and
- a family planning program which had reached its saturation point with nearly complete coverage (JEDB).

### **Impediments to Sustainability and Expansion**

Some Enterprise subproject partners' relative inexperience, questionable commitment, and/or lack of entrepreneurship were causes of concern during the early program years, but these barriers are much less common today. Many subproject partners that had these characteristics have either changed, gone out of business, or have stopped providing family planning. Now, other impediments to sustainability are emerging, and some of these are also affecting acceptor rates. Many of these impediments are linked to the low profitability of family planning -- a problem recognized early on by Enterprise -- and include:

- a longer than anticipated time to reach a break-even point of covering costs,
- stiff competition for a smaller-than-expected market, and
- subsidized family planning services that artificially keep prices down in the marketplace.

Furthermore, in many countries the financial stability of the private sector in general is being undermined by falling world prices for commodities produced, political unrest, poorly managed economies, drought and/or the sheer difficulties of doing business in a world market. Ultimately, these factors, rather than traditional resistance to family planning may have more impact on the ability of the private sector to sustain or expand family planning services.

## Remaining Issues

The experiences of Enterprise subprojects, both during the program and afterwards, yield important information on the problems and opportunities of working in the private sector and should prove a valuable resource to program planners and donors. Additional field experience and research are needed, however, to fully answer some critical questions still requiring attention. These issues relate directly to donor concerns regarding subsidies, target audiences, demographic impact, and cost-effectiveness.

### 1. What level of long-term subsidy from the public to the private sector is justified?

The issue of providing long-term subsidies (both in-kind and monetary) to private sector partners is complex; it is also tied to larger public policy issues concerning the availability of affordable services to encourage family planning use and the prevention of sexually transmitted diseases such as AIDS. Public and private sector partnerships that share family planning costs currently seem to be the norm. This policy raises important questions, however, that need further study:

- Do the marginal benefits of supporting private sector family planning programs in terms of numbers of new acceptors covered or resources saved by the public sector exceed the marginal cost to the public sector of these subsidies?
- Can market-based partners effectively compete without receiving subsidies, particularly where the family planning marketplace is heavily distorted by large subsidies on goods and services in the public sector?
- If subsidies are passed on in the form of lower prices to consumers by a private provider of family planning services, how will this effect its private sector competitors?
- If employment-based partners no longer had access to subsidized contraceptives, would cost savings to companies from family planning investment still be significant enough to encourage company management to participate?
- How feasible are cost-recovery schemes such as charging higher fees for contraceptive services in employment-based programs, particularly in countries where subsidized contraceptives are widely available?

### 2. What is the actual size of the market for market-based providers of services?

Conservative market assessments should be performed before investing in any commercial family planning venture. Although many of Enterprise's market-based partners made careful assessments of the market (and of the competition for this market), during implementation some projects still found that the market for their services was smaller than anticipated. As a result, these subprojects have been stymied in their efforts to generate positive cash flow and/or large acceptor numbers.

3. How effective are private sector programs in transferring family planning users from the public to the private sector? Does the support of private sector initiatives actually reduce the public burden for family planning?

Enterprise was unable to definitively answer these questions; more data must be gathered to determine the prior service history of clients patronizing market-based initiatives. Unless it can be shown that private providers attract clients who were either non-family planning users or who formerly used public sector services, there will be little positive impact on public utilization and expenditures for family planning.

## KEY TO TABLE I.

NA: Not Applicable

ND: No Data

### NOTES:

A: Maquiladoras

B: PROMAQ

C: 604 Factories

- 1: COMATEX: Only one-half year data available for 1992 (January through June 1992).
- 2: IBL: 1992 acceptor figure an estimate based on 9 months data (January through September 1992).
- 3: CFU: Beneficiary population is for Nyanzura only.
- 4: CFU: Acceptor data for Nyanzura only: 1992 an estimate based on 9 months data (January through September 1992).
- 5: ICC: Based on the original 4 companies covered in the subproject contract.
- 6: PDA: CYP of 89,000 represents combined total for years 1991 and 1992.
- 7: JEDB: Data extrapolated out of P.S. Lanka's acceptor data records (courtesy of Mrs. N.P. Weerakoon).
- 8: Benguet: Data were for last year available, 1989.
- 9: PMAP: Data were for last year available, 9/89 to 9/90.

**TABLE I**  
Employment-Based Subprojects

Subproject Name	Country of Origin	Industry or Assoc.	Duration		Funding		Coverage		1991		1992	
			Start Date	End Date	From Enterprise	From Partner	# of Employees	# of Dependents	# of Acceptors	CYP	# of Acceptors	CYP
BCS	Bangladesh	Tea Estate	2/90	7/90	\$27,236	ND	26,000	ND	NA	NA	NA	NA
COMATEX	Mali	Textile Mill	1/89	12/90	\$25,600	\$12,042	1,222	3,869	1,079	NA	222 <sup>1</sup>	NA
SONATAM	Mali	Tobacco	6/89	6/90	\$36,680	\$9,313	840	12,810	NA	372	NA	441
AMPFF	Mali	Family Planning	2/89	12/90	\$26,893	\$5,680	NA	NA	NA	NA	NA	NA
UBL	Uganda	Brewery	8/88	6/90	\$15,172	ND	712	5,014	455	NA	445 <sup>2</sup>	NA
CFU	Zimbabwe	Farmers' Assoc.	10/87	1/91	\$33,988	\$23,327	3,560 <sup>3</sup>	16,820 <sup>3</sup>	395 <sup>4</sup>	NA	369 <sup>4</sup>	NA
Triangle	Zimbabwe	Sugar & Bi-products	10/87	6/90	\$39,043	\$50,913	6,500	38,500	7,125	NA	7,844	NA
Hippo Valley	Zimbabwe	Sugar & Bi-products	10/89	9/90	\$35,600	\$62,029	4,302	34,349	14,249	NA	12,249	NA
Lanrbo	Zimbabwe	Gold Mines	1/88	9/89	\$60,760	\$86,506	6,500	30,000	21,761	NA	17,492	NA
AIOE	India	Many (Plus Informal Sector)	10/88	5/91	\$121,286	\$33,695	90,000	ND	ND	ND	ND	ND
ICC	India	Many, Manufacturing	8/90	3/91	\$15,713 <sup>5</sup>	ND	20,000 <sup>5</sup>	ND	ND	ND	ND	ND
PDA	Thailand	Many (All Types)	10/86	12/89	\$126,719	\$146,245	ND <sup>c</sup>	NA	NA	89,000 <sup>6</sup>	NA	89,000 <sup>6</sup>
FEMAP	Mexico	Many, Manufacturing	6/89 <sup>a</sup>	6/90 <sup>a</sup>	\$27,545 <sup>a</sup>	ND	NA	NA	ND	NA	NA	NA
			3/89 <sup>b</sup>	3/90 <sup>b</sup>	\$85,569 <sup>b</sup>	ND	NA	NA	ND	NA	5,000 vns	NA
JEDB	Sri Lanka	Tea Estates	10/87	9/90	\$145,809	ND	61,000	117,000	10,187 <sup>7</sup>	NA	8,318 <sup>7</sup>	NA
Banguet	Philippines	Gold Mines	1/88	12/89	\$82,933	\$71,520	5065	15,000	2,989 <sup>8</sup>	NA	NA	NA
PMAP	Philippines	Many (All Types)	10/88	3/91	\$58,000	ND	16,000	ND	2,665 <sup>9</sup>	NA	ND	ND

**TABLE II**  
Market-Based Subprojects

Subproject Name	Country Of Origin	Type of Market-Based Venture	Subject Dates		Subproject Funding		Number of Acceptors	
			Start Date	End Date	From Enterprise	From Partner	1991	1992
Health Insurance Organization	Egypt	Insurance	8/88	6/91	\$532,574	NA	29,423	44,389 <sup>1</sup>
Indian Medical Association	India	Individual Service Provider	3/91	6/91	\$72,000	\$10,000	ND	ND
Sankalp Kiran HMO Feasibility Study	India	Health Maintenance Organization	1/89	4/91	\$117,642	\$4,880	NA	NA
YKB	Indonesia	Full-Service Clinic	8/86	8/90	\$105,000	\$47,000	380	ND
YKM	Indonesia	Clinic and Hospital Network	7/89	3/90	\$160,203	\$50,000	427 <sup>2</sup>	570 <sup>2</sup>
Pharmacist and Retail Drugstore Associations	Thailand	Retail	7/89	12/90	\$109,569	\$22,476	NA	NA
ADOPLAFAM	Dominican Republic	Small Clinic Franchises	10/88	6/91	\$268,567	\$54,000	7,802 <sup>3</sup>	15,033 <sup>3</sup>
MEXFAM	Mexico	Small Clinic Franchises	11/86	6/91	\$252,044	NA	ND	ND
Turkish Family Health & Planning Foundation	Turkey	Women's Reproductive Health Clinic	10/88	2/91	\$105,061	\$60,000	619	505

NA: Not Available

ND: No Data

1: HIO: Based on 9 months data (January through September 1992).

2: YKM: Data on Sitihadjar Hospital only. Acceptor number for 1992 based on 9 months data (January through September 1992).

3: ADOPLAFAM: 1991 data cited cover the period 10/90 through 9/91; 1992 data cited cover the period 10/91 through 9/92.

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## JSI WORKING PAPERS

1. Schuler, Sidney Ruth, Dominique Meekers and Syed M. Hashemi. The Impact of Women's Participation in Credit Programs on Family Planning in Rural Bangladesh. September, 1992.
2. Schuler, Sidney Ruth and Syed M. Hashemi. Islamic Ideology, Contraception and the Emergence of Women in Bangladesh. December, 1992.
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