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**Sustainability of Family Planning
Programs and Organizations:
Meeting Tomorrow's Challenges**

**A Paper Prepared by the OPTIONS Project
for USAID/Rabat**

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ACRONYMS

BKKBN	National Family Planning Coordinating Board of Indonesia
CSM	Contraceptive Social Marketing
CYP	Couple Year Protection
DHS	Demographic and Health Surveys
IE&C	Information, Education and Communication
MCH	Maternal and Child Health
MOH	Ministry of Health
MOPH	Ministry of Public Health
MORE	Maximizing Results of Operations Research Project
NGO	Non-Governmental Organization
NFPP	National Family Planning Program
PVO	Private Voluntary Organization
USAID	US Agency for International Development

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EXECUTIVE SUMMARY

In this paper, we provide an overview of the determinants of sustainability of family planning programs and organizations--the factors under the control of policy makers and managers that can make a difference in ensuring long-term viability. We examine the experiences of programs that are considered to have sustainable elements, and set forth ideas about policy options and donor actions that can enhance the sustainability of family planning efforts. We present case studies of family planning programs and organizations in three countries, chosen to elucidate approaches to the challenges of moving toward a financially and institutionally independent approach to delivery of family planning services. In providing an overview of sustainability, the paper is intended to guide the development of programs and implementation of policies that will help family planning programs and organizations attain increased capacity to respond to demand for information and services.

Definition of Sustainability

For our purposes, we define sustainability as the capacity of a national family planning program and the institutions within it to provide their current and potential clients with the information and services necessary to obtain the benefits of family planning--on a continuing basis and without external aid. Achieving sustainability is a process through which the program moves away from dependence on external sources of financial and managerial assistance, and toward self-determination and financial autonomy.

Sustainability is intimately linked to the ability of a program or organizations to generate a flow of resources to replace those which are expended in delivering family planning, broadly defined to include both direct services and the many support activities. This renewal of resources then allows the benefits of family planning to continue to flow to individuals and to society at large.

Programmatic: It is useful to consider the national family planning program as a system comprised of organizations providing information and services that are either self-supporting or subsidized, and are linked by flows of resources and information. While the system as a whole may be sustainable, some of the organizations in the system may require subsidies from within the system.

The ways in which resources and benefits flow characterize the sustainability of a family planning program. A program moving toward sustainability is a complete system of provision of services exhibiting the following attributes:

- ✓ **In general, those who receive the benefits of services contribute to covering the cost of production of those services. If individuals are receiving benefits, individuals pay the price. If society at large is receiving benefits, taxpayers (in aggregate) pay**

for at least part of the services.

- ✓ **Public financing supports family planning services for target populations** for whom reductions in fertility rates have significant social payoff, but who would not seek unsubsidized services--often the very-poor or specific high-risk populations, such as adolescents.
- ✓ **The public sector takes on the responsibility for a particular set of appropriate support activities.** These are activities for which it has a comparative advantage, which improve performance of a market-based system or service provision, and/or which benefit society at large, rather than identifiable individuals.
- ✓ Given the needs of both people who can pay and those who cannot, **a range of providers is accessible, corresponding to the appropriate financing of services.** In other words, there is an adequate supply of providers supported through client payments to meet the demands of those who can pay, and there is an adequate supply of subsidized services for those who cannot pay.
- ✓ **Services supported by public funds are delivered efficiently.** This means that targeting of government-financed benefits allows for as little "leakage" as possible to non-target groups. It also means that for every unit of service delivered, costs are held to a minimum.
- ✓ **Donors contribute little or nothing to the family planning program, or the benefits derived from activities that they sponsor could continue at the current levels if the donors were to reduce financial and technical support.**

Organizational: Organizational sustainability parallels programmatic sustainability in one key way: financial independence. A public sector service delivery organization, such as a Ministry of Health, that is achieving sustainability is one that is able to obtain a sufficient share of tax revenues to cover the costs of providing services to target populations. It is also one in which user fees are charged to those who can pay, in an effort to cover a portion of the costs of providing services and to enhance targeting.

A private sector organization that is achieving sustainability is one that can provide family planning services to the intended client population without utilizing funds or other resources from outside of the organization, with the exception of client payments. Some organizations are originally established as financially and institutionally sustainable. The best examples are for-profit or commercial providers, such as private physicians and pharmacies. For other

organizations (private voluntary organizations, or PVOs), sustainability, which may be a goal imposed by changes in the priorities of donors or other financiers, is of secondary importance to the main objective of service delivery. Sustainability initiatives may have the potential to be in conflict with the organization's fundamental mission unless care is taken to protect the poor.

Policies and Planning to Foster Sustainability

Political commitment provides programs with the required resources--human, physical and financial--to provide sustained benefits to the target populations. Political commitment also provides leadership for national programs and creates an environment for reform of policies that are impeding service delivery.

Political commitment is made concrete only when it is reflected in development of a strategic plan, and adoption and implementation of policies that direct adequate resources to family planning; that allow for the participation of all sectors (public, not-for-profit private and commercial) in delivery and support of family planning services; and that promote full access of families to methods and to service providers of choice.

Strategic Planning: Sustainability of a national family planning program depends critically on the ability of governments to target subsidies toward the populations that should receive publicly supported services (directly or indirectly through PVOs), and to ensure that commercial providers are able to service those who can pay. This implies the use of information to analyze the demand for family planning and development of a strategic plan to ensure that resources are targeted toward the appropriate populations. It also requires government support for development and implementation of the strategic plan.

Government Policies: Government policies that influence the allocation of resources to family planning programs include those determining the position and organization of the program within the government hierarchy, as well as those directly dictating the allocation and budgeting of resources. Another set of policies has effects on private sector activities, and on the breadth of choices available to family planning users. Government policies can affect access by denying services to specific populations or by imposing requirements that limit incentives to private provision, increase the costs of obtaining services and deny access to clients who cannot pay higher prices.

Structure and Locus of Authority

Program Structure: The ability to target public resources toward hard to reach populations (directly or indirectly) and to foster the commercial provision of services for the population that can pay requires that:

- The structure of the program and the organization of the institutions within the program be appropriate for the objectives

and strategic plan of the program;

- There is an effective network for coordinating program activities; and
- Linkages are in place to enable the program to respond to client needs and financing opportunities.

Decentralization: Responding rapidly to changing consumer demand is fundamental to the sustainability of a program. This requires that decisions are based on timely information about the preferences of the client population and that decision making occurs at levels within the program that are close to the point of service delivery. In this way, then, sustainability can be fostered by efforts to move away from only national-level control, and toward greater amounts of control at the local or regional level through decentralization.

Sustained Demand

Many demand generation activities fall squarely into the domain of government responsibility, and a government's commitment to investment in demand generation and maintenance is a key determinant of the long-term sustainability of a family planning program. At the same time, however, as the "provider of choice" for large segments of the population, the private sector has its own role to play in generating and maintaining consumer demand.

Three aspects of demand generation and maintenance that are critical to building a sustainable family planning program are:

- The role of the public sector in collecting information about current demand--knowledge, attitudes, and practice of family planning -- and using it to develop information, education and communication strategies to provide people with the information they need about family planning;
- The close relationship among quality of family planning services, consumer satisfaction and sustained demand for services; and
- The role of the private sector in responding to consumer demand.

Sustainability of the Public Sector Delivery Network

Despite the importance of the private sector, in much of the developing world, the public sector is the largest provider of family planning services and plays a special part in determining what the overall program looks like--and the ultimate sustainability of that program. If the public sector is solvent and meets the needs of the target population, prospects for programmatic

sustainability are bright. If, on the other hand, the public sector is falling short of its responsibilities, relies heavily on foreign donors and would be unable to meet the population's needs using only national resources, then the road to a sustainable program may be long indeed.

While each country represents a distinct challenge, there are a set of common determinants of long-term sustainability of a public sector service delivery system. These echo the determinants of the sustainability of the program as a whole. These are that:

- Services are targeted so that only those for whom the public sector has a special interest are supported with tax funding, and adequate tax-based resources are provided to serve poor/special population groups;
- Sufficient public sector funds are invested in family planning to meet demand of target groups;
- Users not eligible for free services pay user fees; and
- Services are operated in an optimally efficient manner.

Sustainability of Private Voluntary Organizations

The organizations that are most likely to face the new challenges of providing financially and institutionally sustainable services are not-for-profit institutions that have long been dependent on support from donors and, in some cases, from host-country governments.

We focus on private voluntary organizations for two main reasons: First, it is the private voluntary organization that faces the greatest challenges in moving toward sustainability. Such organizations are often established to operate in an inherently "unsustainable" fashion. For example, they may be set up as charitable institutions, taking it on as their mission to provide free or heavily subsidized services; they may be directed by individuals who have an interest in service provision, but not in running a business; and they may be inefficient in structure and function because they have been supported with donor funding since inception.

Second, it is important to recognize that there are limits to the ability of particular organizations to be financially independent. As stated earlier, non-profit providers that primarily serve the poor or others who would not seek services in the commercial sector may be unable to continue to deliver care to those clients if donor or other public support is withdrawn. In such cases, it is critical to evaluate the contribution that the organization makes to the program as a whole, and to determine whether public dollars should continue to flow to maintain it.

The "Sustainability Gap": In the simplest terms, the "sustainability gap" for any non-profit organization is the total costs of providing services minus the total revenues (excluding

public sector support). A financially sustainable organization that is independent of donors or the government, then, is one in which the sustainability gap is zero (or even negative, if surplus is being generated).

When faced with the new challenge of moving toward sustainability, organizations must determine the magnitude of the existing "sustainability gap," identify strategies to close it, and determine which of those strategies best fit the mission and characteristics of the organization. Long-term financial sustainability generally implies that managerial and other institutional structures are sound, reasonably efficient and responsive to change.

Promising approaches to closing the sustainability gap include: (a) generating more revenue for existing or expanded family planning services; (b) generating revenue from related services; and (c) increasing efficiency of service delivery.

The Donor Role

Movement toward a sustainable program or organization requires concerted efforts in planning, financial and managerial domains. Often existing national or institutional policies run counter to such efforts and reinforce unsustainable resource flows and institutional practices. For example, while a local public family planning agency may wish to collect user fees from clients who can afford to pay, the Ministry of Health may have a policy of providing universal access to free care. Or, the Ministry cost recovery policy may require that all revenues are sent to a central pool of funds; in this case, the local agency would have no incentive to enforce collection of user fees. Progress toward sustainability, then, would involve policy change at several levels.

Achieving policy change typically requires lobbying, targeted financial and other analyses, development of tangible incentives to promote change, dissemination of information and cultivation of a constituency. Once change has been achieved, implementation of new policies may require distribution of information about the change, retraining of staff, reorientation of operational procedures and other efforts.

Each stage--achieving policy change and then implementing the reform--can be facilitated by appropriate donor assistance. Donors can provide financial incentives, technical assistance and other resources to help governments and institutions make a transition toward a more sustainable family planning program.

Project Design: There are ways to take long-term sustainability concerns into account in project design, without sacrificing the ability of the project to have a positive short-term impact on contraceptive use. And many of these elements of project design have benefits even beyond creating an environment in which family planning services can become institutionalized and independent. By paying careful attention to demand and taking full advantage of the existing networks of services, family planning projects can achieve more with fewer resources.

Case Studies

It is possible to learn about sustainability from the experiences of specific countries. While the actions taken may be setting-specific, the general approaches--for example, how political commitment was generated--can be more widely applied. Thus, we have chosen three countries--Thailand, Indonesia and Colombia--to examine closely, and to illustrate specific ways in which progress toward sustainability has been made. All are "mature" countries, with relatively high levels of demand and widespread service delivery infrastructures. And each is attempting to move away from high levels of donor support, and toward full autonomy of the family planning program.

- △ Thailand: An examination of Thailand provides insights into how strong underlying demand, combined with concerted government action, can lead to high and sustained contraceptive prevalence. Though the Thai program initially received substantial amounts of donor support, it has moved to being a self-sufficient effort. The example of Thailand shows that if the national government has a strong commitment to the program, it can mobilize significant national resources to support public sector service delivery, even in the absence of donor support. In addition, the experience of the Thai program shows how operations research studies in pilot areas can lead to enhancement in the efficiency and effectiveness of family planning services.
- △ Indonesia: The Indonesian experience highlights the potential role that a strong and well-placed family planning coordinating agency can play in generating and maintaining political support. It shows how demand generation can contribute to sustainability. And it demonstrates the efficiencies that can be obtained through social marketing.
- △ Colombia: Colombia's program exhibits an example of an inter-sectoral collaborative effort among the public, private voluntary, and commercial sectors. In the Colombia case study, we focus primarily on the role of PROFAMILIA, a private voluntary organization that is recognized by the government as a provider to key target populations. Lessons can be drawn from PROFAMILIA's successful attempts to expand its base of financial support.

1. INTRODUCTION

What is a sustainable family planning program? Why is sustainability an important and attainable goal? What policies foster or inhibit program sustainability? And what steps can program managers, planners and donors take to create sustainable programs?

In this paper, we provide an overview of the determinants of sustainability--the factors under the control of policy makers and managers that can make a difference in ensuring long-term viability. We examine the experiences of programs that are considered to have sustainable elements, and set forth ideas about policy options and donor actions that can enhance the sustainability of family planning efforts. We present case studies of family planning programs and organizations in three countries, chosen to elucidate approaches to the challenges of moving toward a financially and institutionally independent approach to delivery of family planning services. In providing an overview of sustainability, the paper is intended to guide the development of programs and implementation of policies that will help family planning programs and organizations attain increased capacity to respond to demand for information and services.

The paper is organized into five sections:

- △ ***Definition and Dimensions of Sustainability:*** In this section, we provide a working definition of sustainability at the programmatic and organizational levels; describe why donors and host countries are increasingly paying attention to the issue; and outline the relationship between sustainability and demographic impact.
- △ ***Sustainability of a National Family Planning Program:*** We take a broad look at determinants of a sustainable national program, highlighting the need for political commitment and a favorable policy environment. Based on principles of public finance, we emphasize the importance involving a broad range of providers, spanning from publicly-supported services, such as in Ministries of Health, to private voluntary organizations, to private physicians and pharmacies. In particular, we emphasize the advantages of the private sector in responding to consumer demand and relieving the public sector of an unmanageably large financial burden. Finally, we examine issues of targeting and efficiency in public sector delivery of family planning services.
- △ ***Sustainability of a Non-Profit Organization:*** Looking at non-governmental organizations that traditionally have been dependent on public subsidy, we examine strategies that can be used to increase financial and managerial self-sufficiency.
- △ ***Donor Role in Enhancing Sustainability:*** We consider steps that donor organizations can take to encourage appropriate policy formulation and organizational reforms that lead to greater sustainability. We outline ways in

which donors can create project designs that provide the most favorable context for movement toward sustainability over the long run.

- △ **Case Studies:** We present three case studies--Thailand, Indonesia and Colombia--to illustrate distinct ways in which national programs have progressed toward stable and independent family planning programs. While no country's experience is directly applicable to other settings, the approaches taken by these three countries demonstrate the ways in which well-run public sector service delivery and public-private partnerships can place a family planning program on firmer financial and institutional footing.

In addition to citations for references used in the preparation of the paper, we include an annotated bibliography relevant to sustainability, for readers who are interested in learning more about specific issues discussed.

1.1. Definition and Dimensions of Sustainability

"Sustainability," a term now found in much of the development literature and in myriad donor consultant reports, rarely has been defined clearly and precisely. The definition of the sustainability of family planning services appears to vary with the task at hand and with the specific strategy being promoted--to design a cost recovery system in a private voluntary organization or to consider the long-term national resource requirements for expanding demand for services. To some, sustainability means the ability of a private voluntary organization (PVO) to support social welfare activities through sales of products. To others, sustainability implies the ability of governments to maintain and expand public provision of health and family planning services without external donor funding. Some organizations are described as sustainable if they cover all costs, including capital; others are labeled "sustainable" if they simply are able to generate revenue for recurrent costs. And while sustainability generally is taken to mean a program or project's financial well-being and independence, broader views also are taken. The literature discusses the importance of sustainability of demand for services, of management capacity, and of institutional structure (La Forgia and Heinig 1992, Bossert 1990, Honadle and VanSant 1985, White 1987).

Since a term that means all things to all people is of little use, we consider sustainability in a somewhat narrow way. We do this at the risk of excluding some dimensions, but with the intention of being able to make concrete and understandable statements about the determinants of a sustainable family planning effort.

Sustainability is the capacity of a national family planning program and the institutions within it to provide their current and potential clients with the information and services necessary to obtain the benefits of family planning--on a continuing basis and without external aid. Achieving sustainability is a process through which the program moves away from dependence on external sources of financial and managerial assistance, and toward self-determination and

financial autonomy.

Sustainability is intimately linked to the ability of a program or organizations to generate a flow of resources to replace those which are expended in delivering family planning, broadly defined to include both direct services and the many support activities. This renewal of resources then allows the benefits of family planning to continue to flow to individuals and to society at large.

At any given point, family planning programs or organizations are moving toward (or away from) sustainability. The environment for family planning is a dynamic one, with demand changing and expanding, objectives shifting, and costs and benefits changing simultaneously. A program or organization characterized as sustainable at one moment can be unsustainable the next. Therefore, we consider sustainability to be an underlying goal that good planners and managers are working toward at all times. We underscore that once sustainability is approached or even reached, efforts to maintain it continue to be required.

Throughout this paper, we are concerned the sustainability at two levels. One level of interest is the national family planning program--the full system of policies and institutions, in which some organizations provide services underwritten by the public sector, and others operate independently. The second level is a specific organization providing family planning services to a particular segment of the client population. Thus, at various points we will consider sustainability at the programmatic level, taking a holistic, national perspective; at others, we will turn to the organizational level, and examine challenges facing service delivery organizations.

1.1.1. Programmatic Sustainability

We take as a starting point that the central programmatic goal is not simply to have a family planning program. Rather, it is to reduce fertility that has undesirable individual and/or social consequences. These consequences range from poor maternal and child health to slowed economic and social development. To achieve that central goal, the program must attain the objectives of increasing prevalence, decreasing unmet need, and achieving a suitable match between the mix of methods and clients' medical and social needs. It is these *benefits* of the program that must be sustained over time, and not the program itself. From this understanding of overall program goals and objectives, we can consider the features of a family planning program that can provide a *sustained flow of benefits* to individuals and to the society as a whole.

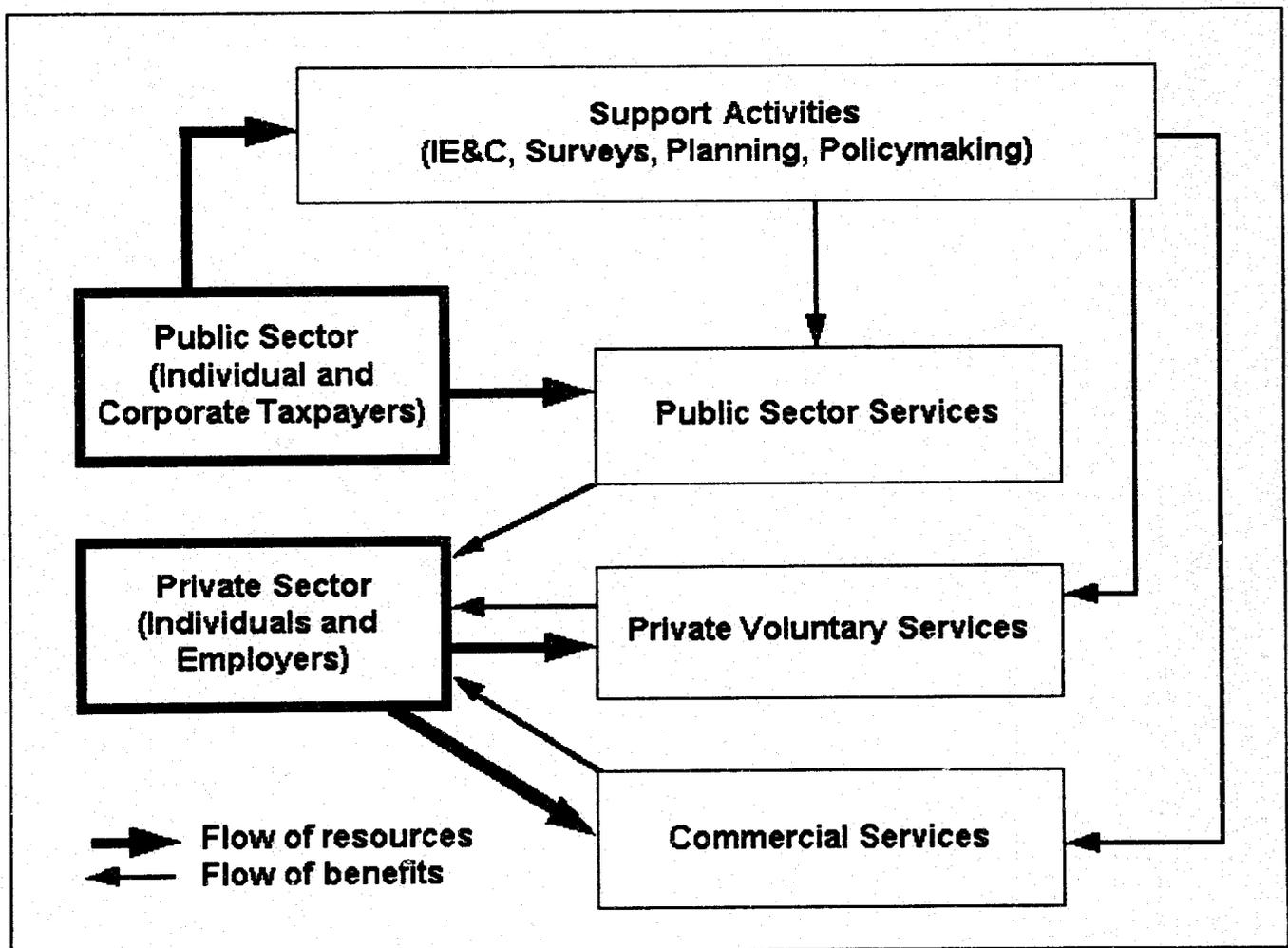
Contrary to intuition, perhaps, a family planning program that is achieving sustainability is not necessarily one in which all organizations providing family planning services are themselves financially independent. As in the larger health sector, all successful family planning programs require some flow of financial subsidies from public funds or from better-off users to provide care for those whose illness or excess fertility would have negative social consequences.

It is useful to consider the national family planning program as a system comprised of

organizations providing information and services that are either self-supporting or subsidized, and are linked by flows of resources and information. While the system as a whole may be sustainable, some of the organizations in the system may require subsidies from within the system.

As shown in Figure 1, and as described more fully in Section 2.2., the public sector (individual and corporate taxpayers) generally is the appropriate financier of activities that support family planning service delivery and benefit all providers; such activities include mass media campaigns, national-level data collection and formulation of policies affecting family planning. The public sector also bears the responsibility for financing and/or delivering services for important segments of the population when such support yields benefits to society, and other (private) sources of support are unavailable.

Figure 1 A Simplified View of the Flow of Resources and Benefits in a Family Planning Program



The flow of resources from the private sector (individuals and employers) are directly related to the flow of individual benefits. Assuming they have sufficient resources, individuals will invest both in time and money when they are deriving recognizable benefits. In Figure 1, this is depicted as the flow of resources (i.e., payments for services) from consumers to private voluntary and commercial services, and the flow of benefits (i.e., ability to control fertility through access to appropriate contraception) from private services to consumers.

The ways in which resources and benefits flow characterize the sustainability of a family planning program. A program moving toward sustainability is a complete system of provision of services exhibiting the following attributes:

- ✓ **In general, those who receive the benefits of services contribute to covering the cost of production of those services.** If individuals are receiving benefits, individuals pay the price. If society at large is receiving benefits, taxpayers (in aggregate) pay for at least part of the services.
- ✓ **Public financing supports family planning services for target populations** for whom reductions in fertility rates have significant social payoff, but who would not seek unsubsidized services--often the very-poor or specific high-risk populations, such as adolescents.
- ✓ **The public sector takes on the responsibility for a particular set of appropriate support activities.** These are activities for which it has a comparative advantage, which improve performance of a market-based system or service provision, and/or which benefit society at large, rather than identifiable individuals.
- ✓ Given the needs of both people who can pay and those who cannot, **a range of providers is accessible, corresponding to the appropriate financing of services.** In other words, there is an adequate supply of providers supported through client payments to meet the demands of those who can pay, and there is an adequate supply of subsidized services for those who cannot pay.
- ✓ **Services supported by public funds are delivered efficiently.** This means that targeting of government-financed benefits allows for as little "leakage" as possible to non-target groups¹. It also

¹ As discussed in Section 2.6.1., "leakage" of benefits is not the sole concern. There is a trade-off among coverage, leakage and administrative cost associated with obtaining information about clients served. Tight means-testing can reduce leakage, but perhaps only with high administrative costs and/or at the risk of excluding some potential clients who would be eligible if all information were available.

means that for every unit of service delivered, costs are held to a minimum.

- ✓ **Donors contribute little or nothing to the family planning program, or the benefits derived from activities that they sponsor *could* continue at the current levels if the donors were to reduce financial and technical support.**

Programmatic sustainability is manifested in the program's financial independence from external donors. While the financial aspect is the most obvious indicator of sustainability (see Box 1), it can occur only within a sound institutional context. Achieving financial independence at the programmatic level requires an impressive planning capacity, an understanding of good resource allocation, a finely honed ability to collect and interpret information about population characteristics and met and unmet need, and solid organizational and political skills.

1.1.2. Organizational Sustainability

Organizational sustainability parallels programmatic sustainability in one key way: financial independence. A public sector service delivery organization, such as a Ministry of Health, that is achieving sustainability is one that is able to obtain a sufficient share of tax revenues to cover the costs of providing services to target populations. It is also one in which user fees are charged to those who can pay, in an effort to cover a portion of the costs of providing services and to enhance targeting. And it is one in which services are delivered efficiently. As described in Section 2.6., the sustainability of a program as a whole often is intimately tied to the sustainability of major public sector service organizations.

A private sector organization that is achieving sustainability is one that can provide family planning services to the intended client population without utilizing funds or other resources from outside of the organization, with the exception of client payments. Typically, this is accomplished through pricing family planning goods and services at or above the costs of production, and/or through cross-subsidization of family planning services delivered at below-cost prices by other goods or services delivered at a surplus. Indicators of progress toward financial sustainability within an organization are highlighted in Box 1.

Inherent in the ability of an organization to be financially independent is the capability to maintain a stable structure, to allocate resources efficiently and to respond to or even generate demand for services. It is a rare organization that can achieve financial stability and independence without considerable managerial and institutional strength.

One can consider a couple of different types of private sector organizations that may take on sustainability as a goal. First, there are organizations that originally are established as financially and institutionally sustainable. The best examples are for-profit or commercial providers, such as private physicians and pharmacies. To these providers, sustainability may be

Box 1 Indicators of Progress Toward Sustainability

the *only* goal--sales of family planning services and products are a means to the end of maintenance or enhancement of the providers' financial well-being. As long as sales continue to result in adequate revenues, the services will be delivered.

The second type of private sector organization is that which originally is established with the goal of providing services, often to particular target populations. Sustainability, which may be a goal imposed by changes in the priorities of donors or other financiers, is of secondary importance to the main objective of service delivery. An example of such an organization would be a donor-supported not-for-profit provider whose mission has been to carry out family planning outreach activities among the rural poor. In such settings, sustainability may not only be a secondary objective, but it also has the potential to be in conflict with the organization's fundamental mission unless care is taken to protect the poor. (This issue is discussed in Section 1.3, below.)

1.2. Why Donors and National Leaders Are Concerned with Sustainability

Interest in the sustainability of family planning programs and organizations has increased as policymakers confront a basic fact: Public sector resources, both in donor and host countries, simply cannot be stretched to cover the current and increasing demand for family planning services. As the world's population grows, as more couples choose smaller family sizes, and as programs continue to push to provide services to the men and women who are the hardest (and most expensive) to reach, the total cost of providing services is increasing rapidly. At the same time, the contribution of international donors to family planning programs in developing countries is likely to shrink, in relative and perhaps even in absolute terms.

Currently, the total costs of family planning are estimated to be up to \$4.5 billion

Programmatic Sustainability: Indicators of programs that are moving toward sustainability can be developed from an analysis of the targeting of public sector monies to special population groups (low-income individuals, or other couples for whom provision of family planning services connotes social good). One can look at the flow of resources from taxpayers to beneficiaries, and measure the magnitude of the net gain that low-income populations experience. Another indicator of a program's progress toward sustainability can be the extent to which public sector resources devoted to family planning are sufficient to provide (or finance) services for target populations. Indicators can be developed to analyze changes in the proportion of all costs that are covered by donor funds.

Organizational Sustainability: Among the useful indicators of organizational sustainability are the trends in the proportion of recurrent and capital costs that are covered by donor funding. In parallel, one can look at the change in the proportion of costs that are covered through client payments. In general, an increase in revenues from user fees (as a proportion of total costs) indicates movement toward sustainability. Efficiency indicators include cost per user, cost per couple-year protection and cost per birth averted.

(including China and indirect costs such as surveys, training, communication and technical assistance). Of that amount, developing country governments are said to contribute between 60 to 75 percent, donors contribute 15 to 20 percent, and users' payments make up the remainder (10 to 17 percent) (Lande and Geller 1991).

Overall, the trend has been toward an increase in international spending in absolute terms, but a reduction in the *relative* contribution of donors, and an increase in reliance on local resources to fund family planning efforts in developing countries. According to Donaldson and Tsui (1990:25), "[i]n part this change reflects the increasing institutionalization of family planning activities, and in part it reflects the fact that countries with mature programs tend to be more economically advanced and thus better able to finance program operations."

It is important to note that there is tremendous variation among countries both in the proportion of all family planning resources that are provided by international donor organizations, and in the trends in donor spending. While many countries are supporting greater shares of family planning costs through local resources, some are moving in the opposite direction. For example, the relative contribution of donor spending to the public sector part of the Egyptian family planning program has increased in recent years, from 34 percent of total public family planning expenditures in 1988 to about 49 percent of expenditures in 1990 (Heilman et al 1993). In India, international assistance for family planning and related reproductive health activities increased in absolute terms more than three-fold between 1985 and 1989, and moved from 14 to nearly 28 percent of the total expenditures of the Family Welfare Program (Indian Ministry of Health and Family Welfare 1991).

The current worldwide public and private expenditures, though substantial, do not even meet current demand and fall far short of projected future requirements. It is estimated that an additional \$1.0 billion to \$1.4 billion are required now to serve married women who are not currently using modern contraception but who wish to space or limit births. And by the year 2000, the cost of providing family planning services has been projected to rise to up to \$11.5 billion (Lande and Geller 1991).²

Donors and national leaders have seen these figures and are acknowledging that financial and institutional constraints limit their ability to respond to growing demand and costs. As noted by Donaldson and Tsui (1990:28), "[a]lthough most international donors continue to be supportive, they cannot sustain previous increases in funding. This will create problems for many developing countries as they try to meet the expanding need for contraceptives. Developing country program managers are already being cautioned by international aid officials about the rise in the need for local financing of family planning because of the lack of additional international

² There are many estimates of both current and future costs of family planning. (See Lande and Geller (1991:4) for a detailed analysis and comparison among projections.) For the sake of discussion, we have taken the highest and most widely encompassing estimates (i.e., including China and all support activities); however, narrower estimates also suggest emerging problems.

resources and the increase in the numbers of contraceptive users."

Simultaneously, then, donors and host country governments are forced to reassess their priorities and target their spending to achieve the greatest social benefit. That is, they have powerful incentives to move toward a sustainable family planning program. Organizations that currently are sustainable, such as those in the commercial private sector, are viewed with increasing favor. And many organizations that have relied on donor or other public funding are asked to reorient their financing and management toward a more independent operation.

1.3. The Relationship Between Sustainability and Demographic Impact

Whether the goal of sustainability is "good" or "bad" can be assessed only by examining the consequences of the changes required to move closer toward a sustainable organization or program. Specifically, it is useful to determine whether the goal of sustainability conflicts with--or helps to foster--the goals of increasing prevalence, decreasing unmet need and ensuring that the mix of methods corresponds to the health and social needs of the populations served.

First, we look at the organizational level. On the surface, it would appear that any reduction in public (donor and other government) funding to a service provider organization would impair that organization's ability to deliver services. However, this may not be the case, at least in terms of the numbers of individuals served. For example, the organization may make changes that increase its dependence on client payments. Such changes typically result in greater responsiveness to demand forces, which can be reflected in an increase in quality and a more acute interest in consumer satisfaction. Or the organization could find ways to become more efficient, lowering the average unit cost of services through more rational use of personnel, for instance.

A valid concern is the effect of a reduction in public funding on the ability of organizations to serve specific target populations, such as the very poor or specific high-risk populations. If a particular non-governmental organization, for example, is best able to provide services to a target population that cannot afford unsubsidized care, greater reliance on client payments without protecting the poor might have the undesirable effect of reducing utilization by the target population. In some cases, then, a push toward sustainability may impair the organization's ability to fulfill its original mission (Harvey 1991).

The discussion above suggests a critical link between institutional and programmatic sustainability. Programmatic sustainability implies that governments can distinguish between target populations that should receive publicly-supported services and those that should pay for services themselves. Therefore, if information is available about *which* population is being served by a specific organization, decisions can be made about whether public funding of the organization advances the program as a whole toward sustainability. That is, whether public support moves the program toward a situation in which the public sector is subsidizing *only* the target populations for whom reductions in fertility rates have significant social payoff, but who

would not seek unsubsidized services.

We now turn to the question of whether progress toward programmatic sustainability has a positive or negative effect on the ability of the nation to attain the central goal of reducing undesirable fertility. This is a particularly pressing issue in countries where historically high levels of donor funding will not continue far into the future and host country governments fear that progress toward lower fertility levels will be eroded.

The answer to this question turns on the existing demand for services. If existing demand for family planning services is weak and heavy public investments in mass media and other efforts are required just to maintain the low level of demand, governments face a daunting task in the absence of donor funding. It would be extremely difficult for a government to focus on targeting its resources on a limited population if there is insufficient demand to induce other actors in the program, such as the commercial private sector, to play a significant role.

If, on the other hand, existing demand for services is sufficiently strong and widespread for private providers to produce family planning services, then policymakers at the national level can move toward a program that is *both* sustainable and achieves demographic and other goals through careful targeting of public funds and fostering of private sector involvement. In fact, a family planning program that is relatively independent of donor involvement may have the distinct advantage of being more stable and better able to respond to local needs than does one that is heavily donor-financed.

In sum, the demand for family planning services and the program's responsiveness to this demand ultimately determine the sustainability of a program. Without adequate levels of demand for family planning, it is unlikely that a program will attain sustainability. Where demand is high, however, it is the mix of policies regarding government support for family planning and private sector participation which determines the speed with which a program moves towards sustainability and succeeds in maintaining it.

2. ELEMENTS OF A SUSTAINABLE NATIONAL FAMILY PLANNING PROGRAM

In its most simplified form, a national family planning program consists of *policies*, ranging from goals for population growth to regulations about which providers are authorized to deliver clinical methods of contraception; *activities that support family planning*, such as mass media campaigns; *public sector service delivery*, such as family planning units in a Ministry of Health; and *private sector service delivery*, including the work of both the commercial sector (private physicians and pharmacists) and the private voluntary organizations. All components of the program operate within a larger social, political and economic environment. In this section, we examine the relationship between parts of a national program and sustainability.

2.1. Influences of the External Environment

Family planning programs operate in dynamic environments, in which external factors often beyond the direct control of policy makers greatly influence the functioning of the program. For example, on the negative side, severe economic crises may prevent the government from making new ventures in family planning service delivery, despite the long-term payoff of that such investments would bring. On the positive side, the process of economic development may bring about use of family planning services far in excess of the demand that can be generated by family planning programs alone. Box 2 summarizes important external factors and the impact they can have on national family planning programs. While these factors cannot be readily changed it is important that they be considered in the design of programs and policies. Measures can be taken to reduce their negative impact and capitalize on their positive effects.

2.2. Policymaking and Planning to Move Toward a Broad Base of Support and Services

Policies and large-scale planning activities specifically related to family planning are powerful determinants of the long-term viability and sustainability of a national program. Relevant policies encompass a broad range--from the government's stated commitment to lowering the rate of population growth, at the highest level, to the operational-level regulations governing allocation and generation of revenue within public sector service delivery agencies, and supply of privately provided services.

2.2.1. Political Commitment and a Family Planning Constituency

Most of the world's population lives in countries where the government is, at least on paper, committed to reducing the rate of population growth. As of 1989, 47 percent of all developing nations, representing about 82 percent of the world's population, had official policies to slow the rate of population growth through lowered fertility rates. Approximately 50 developing countries, on the other hand, had no specific antinatalist policies, and 18 countries had policies designed to maintain or increase fertility rates (Donaldson and Tsui 1990).

While many countries have developed strong programs without strong government support at the highest levels, political commitment strengthens a program's sustainability. It is particularly important in countries in which the social setting is not conducive to economic development and the adoption of family planning (Mauldin and Sinding 1992).

Political commitment provides programs with the required resources--human, physical and financial--to provide sustained benefits to the target populations. Political commitment also provides leadership for national programs and creates an environment for reform of policies that are impeding service delivery.

Political support can be motivated initially by determining the mission of the program, which may range from enhancing maternal and child health, to lowering the rate of population

Box 2 External Influences on Sustainability

The domestic economic environment affects program sustainability through such factors as inflation, overvalued exchange rates, and income levels and distribution. Inflationary conditions erode the value of the domestic currency and can result in increased program costs, thus impairing program sustainability. They also can adversely affect domestic demand for contraceptive products by making products more expensive to consumers. Through the disparities between real and nominal interest rates, inflation also can reduce investment incentives. On the other hand, if income levels are rising, this can promote sustainability through increases in client ability and willingness to pay for contraceptive goods and services. To some extent, this also is dependent on whether income distribution is highly skewed, as is frequently the case.

Elements of the macroeconomic policy environment may contradict progressive family planning efforts. For example, controls on foreign exchange can subvert incentives for both importers and exporters of contraceptive products; the presence of such controls may have the effect of shrinking the size of the overall domestic commercial market. If importers are restricted, they are likely to import only pharmaceutical products that yield high profit margins, thus excluding contraceptive products. Restrictions on repatriation of in-country earnings also may reduce incentives for investment by foreign manufacturers, particularly if investment opportunities are poor to start. Statutory price controls can lead to disincentives for investment in, and distribution of contraceptive products and services, since markups and profit margins will be lowered.

The domestic political system affects the program through the common problems of political instability and inadequate administrative capacity. Political instability can weaken the overall authority of the central government, thus compromising the legitimacy of leadership and jeopardizing high-level commitment to development policies and programs. The lack of administrative capacity can severely handicap a family planning system, given the heavy human resource requirements of service delivery.

Finally, long-term trends condition the impact of a family planning program and contribute to (or detract from) its effectiveness. These societal influences involve factors such as the expansion of education and literacy, urbanization, decline in infant and child mortality, rise in the status of women, and changes in religious beliefs. While those concerned with family planning cannot affect these influences directly, likely impacts on future demand and program sustainability must be anticipated.

growth in order to promote economic development. The mission must be appropriate for the environment in which the program operates and is generally determined by the perceptions of the benefits of family planning, the acceptability of family planning in a culture, the demand for family planning, and the government attitude towards family planning. In Latin America, for example, the mission of improving health status has been most effective in generating support for fertility reduction policies. And, in fact, the medical profession played a key role in

stimulating the adoption of these policies. In other regions, including much of Asia, arguments presented by economists about the potential negative effects of rapid population growth on economic development have been effective in motivating government support (Mauldin and Sinding 1992).

Once policy makers and program planners have established the most appropriate mission for the program, steps can be taken to inform government leaders, such as legislators and ministers in other sectors, of this mission. In Thailand, for example, family planning gained government support because leaders understood the mission of the program to be reduction of population growth to promote economic development. A cost-benefit analysis of the program convinced them to invest resources in family planning and generated strong political commitment (Chao and Allen 1984). Similarly, analyses demonstrating the health benefits of family planning have been instrumental in building consensus and government support. These analyses have been effective in Africa, where desired fertility is high, infant mortality is high and recognition of the benefits of family planning for reductions in infant and maternal mortality lead to persuasive arguments in support of family planning.

2.2.2. Translating Political Commitment into Services

Political commitment by national leaders is an important component of a program that is stable and self-sufficient over the long term. However, the commitment is made concrete only when it is reflected in development of a strategic plan; and adoption and implementation of policies that direct adequate resources to family planning that allow for the participation of all sectors (public, not-for-profit private and commercial) in delivery and support of family planning services; and that promote full access to methods and service providers of choice.

2.2.2.1. Strategic Planning for Participation of the Public and Private Sectors

Strategic planning is a process in which the roles and responsibilities of major service providers are articulated. It is a useful means to develop an ample foundation, with a broad base of support, and good use of a wide and diverse network of service providers and sources of financing. This ample foundation is essential to building a family planning program that can achieve independence from external sources of support over the long run.

Good strategic planning requires an understanding of the basic roles of the public, not-for-profit private sector and commercial sector. This is no easy task, and can be complicated in settings where the state and the private sector are deeply intertwined, such as where parastatal pharmaceutical manufacturers operate partly as public entities and partly as commercial enterprises. Despite the complications, planners must try to sort out the appropriate roles of the various sectors, so that they can then assess their capabilities and the demand for their services, identify gaps in resources and coverage, and devise a means of filling those gaps.

Some general guidelines are useful in defining roles and responsibilities. As described

in Box 3, principles of public finance suggest that the government is best suited to take responsibility for large-scale planning, regulation and standard-setting, financing services for the poor, collecting information, and undertaking demand generation activities. The role of the commercial sector is variable, but in general is to provide goods and services to individuals who can finance care themselves, either through out-of-pocket payments or through third-party financing. Third-party financing may mean private insurance, or it may mean that the employer is sponsoring services--directly at workplace clinics, or indirectly through contributions to social security systems that deliver family planning services. Similarly, the role of the not-for-profit sector (private voluntary organizations) varies among settings. In some instances, there may be considerable overlap between the activities of the public sector and of PVOs. Typically, though, PVOs are particularly well situated to reach target groups that are unlikely to use publicly delivered services.

Box 3 The Role of the Government

Using the principles of public finance, we can identify five arenas in which public action is desirable in provision and support of family planning services.

- **The government takes the lead in strategic planning.** Taking a national perspective, public policymakers bring together key participants in the family planning program and develop a common understanding of which providers can deliver services to particular populations.
 - **The government creates the regulations that ensure sufficient quality of family planning goods and services.** The government has a clear role in establishing standards of quality for goods and services. It may also be appropriate for the public sector to develop and enforce laws that prohibit monopolies or other forms of unfair competition in the commercial sector.
 - **The government finances and/or delivers services to individuals who would be unable to obtain services in the private sector.** This usually means that public support is provided to the very poor and target groups in which society has a special interest, such as adolescents. This can be done directly, for example through Ministry of Health clinics, or indirectly, through private voluntary organizations or through contracting to the commercial private sector.
 - **The government collects information for planning and demand generation activities.** The public sector is the appropriate entity to undertake large-scale data collection, since it typically has a "comparative advantage" in doing so, and no individual provider would be willing to pay for collecting data that would benefit all providers.
 - **The government supports demand generation activities.** Just as for collection of information, the public sector supports important demand generation efforts that no single provider would be willing to finance.
-

As stated earlier, a sustainable family planning program is likely to be one in which there is a broad base of both public and private support. Sustainability of a national family planning program depends critically on the ability of governments to target subsidies toward the populations that should receive publicly supported services (directly or indirectly through PVOs), and to ensure that commercial providers are able to service those who can pay. Planners can work toward achieving this by using information to analyze the demand for family planning, and developing a strategic plan to ensure that resources are targeted towards the appropriate populations. The government must then support for development and implementation of the strategic plan.

Strategic planning is a continuing process that uses information about the population and its demand for family planning to establish goals, set priorities, allocate resources, evaluate progress and provide direction for the program. Donors, program managers, policy makers and service providers all participate in this process.

Information from the Demographic and Health Surveys or other household surveys can identify the major market segments, gaps in the program's ability to meet existing demand, and areas where increased demand generation is warranted. For example, an analysis of the DHS can tell planners whether knowledge about contraception is widespread or limited; these data can indicate, in general terms, what sort of IE&C activities should be supported with public monies and/or whether the private sector should be encouraged to increase dissemination of information about contraceptive methods. The data can be used to arrive at an estimate of the proportion of public sector clients who are not low-income; this information, in turn, may indicate room for improving the targeting of subsidies and/or stimulating growth of the private sector. Similarly, analysis of information on the source mix can define the special roles played in the program by large PVOs--and the areas of overlap with the public and commercial sectors.

Combined with demand-side analyses, supply-side information on the number, characteristics, distribution and financing of various types of public and private providers can be used to see what resources are in place--and where resource gaps exist. For example, learning that private doctors are heavily concentrated in particular urban settings, and yet also finding that middle-income women are seeking public sector services in those areas, may indicate that there is a need to stimulate private sector activity through targeted training or other incentives.

All of these analyses and considerations of policy options fall under the rubric of strategic planning, which provides a framework that helps to ensure that the program is responsive to client needs and that resources are used efficiently. By analyzing characteristics of the population, client demand for family planning, and trends in service utilization, strategic planning enables the program to respond to the changing needs of the client and to provide services that clients will want to use.

Under optimal conditions, program-level strategic planning is multi-institutional; the roles and responsibilities of donors, policy makers, program managers and providers evolve during a

strategic planning process. Donors and decision makers in ministries address the overall scope of the program and identify the key issues. The central family planning coordinating organization conducts technical analyses and plays a lead role in implementing and evaluating the strategy. Program managers and service providers develop alternative technical approaches and provide feedback as the strategy is implemented and evaluated over time. These roles must be understood and fulfilled for the strategy to be effectively implemented.

Strategic planning is a multi-step process, as outlined in Box 4. In it, donors, program managers and service providers agree upon a strategy for targeting program resources to different organizations to provide a range of services to meet the range of demand.

Planning for resource needs to meet client demand improves efficiency of the program by assigning clear roles and responsibilities to each of the organizations in the program and eliminating duplication of efforts. And, since strategic planning is an ongoing process, it ensures that resources continue to be used efficiently.

Finally, a strategic approach requires program managers to plan and mobilize the financial and human resources needed for the program to reach its goals. At the national program level this means that policies are in place that ensure that organizations obtain resources they need when they need them.

2.2.2.2. Policies Affecting Resource Allocation to the Public Sector

In all countries, the public sector has fundamental responsibilities in ensuring that family planning services and support for those services are available. To fulfill that responsibility, significant financial investments of tax dollars are usually required. Therefore, the ability of a program to mobilize public funds is a determinant of the potential for independence from donors.

Government policies that influence the allocation of resources to family planning programs include those determining the position and organization of the program within the government hierarchy, as well as those directly dictating the allocation and budgeting of resources.

Coordinating Agency: Many countries have developed technical units or coordinating bodies within the government hierarchy that are charged with implementing the national population policy and/or coordinating resources allocated to population activities and family planning service provision. The position of these entities and the quality of leadership within the government power structure determine their effectiveness, the visibility of population within the political arena, and in turn the amount of resources allocated to population activities. Clearly, the closer a coordinating agency is to the highest national leadership, the better the program will fare as it competes for support with other sectors.

Program Structure: Public sector family planning programs may be established as vertical

(1) Assess the environment and outline objectives: Assessing the state of the program involves analysis of data on contraceptive prevalence, present and desired fertility levels, as well as service utilization patterns to estimate current levels of demand and unmet demand. Information from surveys such as the Demographic and Health Surveys and analytical tools such as the TARGET-COST model, which projects the resources required to achieve changes in contraceptive use, can assist in this process.

After analyzing the demand for family planning in terms of geographic needs, method mix, and socio-economic status, the supply of family planning services should also be assessed. This involves analyzing service delivery modes such as public hospitals and clinics, private clinics, private physicians, nurses, midwives and pharmacists, employer based systems, etc., to determine their accessibility, method mixes, efficiency, and current and appropriate client population.

(2) Identify alternative strategies to achieve program goals: The second stage requires framing alternate strategies, and estimating the costs of each in human, material, and financial terms. The focus throughout should be on practical plans to reach objectives that can be achieved within current and anticipated resource levels. This strategy includes determining which providers should provide services to which population; what providers need (training, materials and staff); and how to meet these needs of the providers and ensure that there are mechanisms which direct the required needs to the appropriate providers.

(3) Select the optimal strategy for achieving program goals and ensure commitment of key actors: The third step is to select the best scenario and build support for it among key actors in the country. These efforts are especially important since all actors may not have been involved in the process from the start. Building consensus involves identifying the important actors, whether ministers and high public officials or the technical staff of institutions and program managers who will actually run the national program. It also involves developing an effective action plan for implementation, including resources requirements, plans for resource allocation and evaluation criteria. At this point, it is critical to develop and employ a communication strategy to inform decisionmakers about the strategy and the role they will play in its implementation. This involves building consensus and informing all actors of the role they will need to play.

(4) Periodic evaluation of program performance: The final step is to conduct routine monitoring and evaluation to ensure that program goals are being reached. Evaluations should be conducted at all levels of the program and revisions made where necessary. Evaluations should be conducted periodically to guarantee that the strategy is appropriate for its changing environment.

programs that promote family planning outside of the provision of other health services, or family planning services may be integrated into existing health services. Vertical programs require a larger investment and ensure that resources are directed specifically to family planning activities. Integrated programs include the delivery of family planning in the provision of several maternal and child health interventions. Adding family planning to the responsibilities of already overburdened health care providers can limit the resources that are actually allocated toward family planning provision. The real strength of the program in either structure is determined by the political commitment to family planning, the ability of the population unit or coordinating body to link with the family planning service provider, and the overall ability of the program to plan strategically, and to procure and use resources effectively. (This is discussed in more detail in Section 2.3.)

Resource Allocation Process: In addition to the structure of the family planning program, the resource allocation process itself may limit available resources. Many health budgets do not include a line item for family planning commodities and other needed inputs. Since programs have often received contraceptives, training and other inputs from donors, they have not needed to introduce line items into their budgets, let alone develop capabilities to plan for and procure them. While the existence of a line item in the budget may not ensure that financial resources will be made available for these needs, it does guarantee that a mechanism exists to make money available to obtain them.

A related obstacle arises from the fact that government health budgets are often created by adding a fixed percentage to last year's allocations. Failure to plan strategically and use information about the needs of clients, as well as past service utilization, in resource planning can seriously impede a program's ability to meet growing demand.

2.2.2.3. Policies Affecting Provision of and Access to Family Planning Services

Another set of policies has effects on private sector activities, and on the breadth of choices available to family planning users. Government policies can affect access by denying services to specific populations or by imposing requirements that limit incentives to private provision, increase the costs of obtaining services and deny access to clients who cannot pay higher prices.

Proscriptions Against Charging User Fees: In many countries, access to health care is considered a universal right and public resources are directed to the delivery of free services to all clients regardless of their ability to pay. Often, in an attempt to guarantee access and promote contraceptive use, governments proscribe the charging of fees in public facilities.

Paradoxically, such policies often have the effect of reducing, not expanding access. Policies that prohibit the imposition of fees for health and family planning services eliminate opportunities to recover costs; by doing so, they reduce the government's ability to support service expansion in the long run. And, although no direct fee is charged for the service, clients

Box 5 The Commercial Sector and Program Sustainability

do incur many costs. They incur indirect costs such as wages foregone while they wait for care in overburdened health facilities, travel costs, and the costs of accepting lower quality services. In addition, they often are required to pay unofficial or side payments to obtain services.

Policies that prohibit user fees may reduce possibilities for rational targeting of public subsidies, and may "crowd out" private providers of family planning. This has the distinct effect of reducing the supply and range of service providers, and it hampers progress toward a sustainable program. (See Box 5 for a brief discussion of the importance of the commercial sector for sustainability.)

To foster a sustainable program, then, there should be no prohibitions on charging for services in public institutions, or on changing prices as conditions change. Policies regarding fees for services should change over the life of a program and vary among settings. In countries where demand for family planning is low, in general fees for services may be minimal in order to promote demand. As demand grows, fees can be increased in order to generate resources to target harder to reach populations. In Indonesia, for example, fees were not charged for services in the early stage of the program in order to strengthen demand. The program did not lack resources, however, because the government and donors were highly committed and allocated sufficient resources to it (see Case Study 2). Now the program is at a stage where demand is high, donor support is declining and fees and private sector provision of services must be introduced to generate additional resources so that existing resources can be targeted to the harder to reach populations.

It is important to note that the relationship between overall demand and price of services may not be a simple one. It may be that the first couples to adopt family planning--the vanguard--are highly motivated, and would be willing to pay substantial amounts for goods and services. Price may be a minimal obstacle for use of services. As demand becomes more widespread, yet not completely institutionalized, the prices charged may have a greater influence on willingness of typical couples to adopt contraceptive practice. Then, as demand becomes institutionalized, price may once again not be a deterrent to use.

Price Controls: In addition to policies prohibiting fees for services, those which establish price controls or ceilings reduce opportunities for the private sector. Price ceilings applied by

Participation of the commercial sector increases program sustainability in several ways:

- The commercial sector increases available resources. By providing services to clients who are willing to pay, the commercial sector enables the public sector to channel resources toward those segments of the market that are unable to pay.
 - The commercial private sector is highly responsive to changes in demand, and often is perceived by clients to offer higher quality services.
 - Commercial providers have incentives to be efficient, and often can provide services at lower unit costs than do public institutions.
-

health ministries or national pricing boards may be so low as to prevent suppliers from covering their costs. Price controls affect the supply of services from both the private commercial and voluntary sectors.

Import Restrictions and Taxes: Other government policies eliminate opportunities for commercial providers by making the cost of providing services prohibitively high. These policies take the form of duties and taxes levied on contraceptives themselves or on the materials required for their manufacture. In Egypt, for example, duties levied on the materials required to produce contraceptives, combined with tight price controls, have inhibited commercial domestic manufacture.

User and Provider Restrictions: There are many different types of restrictions on who can provide which type of services, and to whom. First, for example, there may be restrictions on who may receive services, including requirements that a woman be of a certain age, parity or marital status to receive family planning. Requirement of the husband's written or verbal consent also falls into this category. Second, there may be restrictions on distribution of methods, such as policies requiring prescriptions for obtaining contraceptives or policies requiring clients to make frequent visits to health centers in order to obtain supplies. Third, there may be restrictions on who is authorized to distribute services and which outlets are authorized to distribute commodities.

Restrictions on Advertising: There may be restrictions on who can distribute information. These include bans on advertising--by brand, method, or generic information about family planning. Also, there may be restrictions on the type of media which can be used to reach people such as bans on advertisement through the newspaper, television or radio.

2.3. Designing a Structure that Fits the Setting

As emphasized above, programmatic sustainability rests largely on the ability to plan strategically and target public resources toward hard to reach populations (directly or indirectly), and to foster the commercial provision of services for the population that can pay. This requires that:

- The structure of the program and the organization of the institutions within the program be appropriate for the objectives and strategic plan of the program;
- There is an effective network for coordinating program activities; and
- Linkages are in place to enable the program to respond to client needs and financing opportunities.

The organizational structure determines the ability of the program to respond efficiently to changes in the environment, and to streamline decisionmaking to respond effectively to client needs and improve efficiency of resource use. The structure that best meets a programs needs is determined by environmental characteristics such as the density of the population; existing health care service delivery infrastructure and opportunities to use it to provide family planning; the demand for family planning; political stability in the country and political support for the program; and the goals of the program.

The appropriate structure for the program will differ by setting and will change as the program moves through stages and strives to achieve new goals. A vertical program has often been used for the introduction of family planning and the generation of demand for services. This structure gradually is replaced by integrating family planning into the provision of maternal and child health (MCH) services. And, finally, a linkaged program incorporates community organizations into the program to build community support for the program and increase its sustainability. Some programs are a blend of these structures. In Thailand, for example, the National Family Planning Program is a vertical program which has not integrated family planning into the delivery of MCH services. While the staff and infrastructure of the Ministry of Health is used for delivery of family planning services, the program has been designed to deliver family planning almost to the exclusion of MCH services (Bennett et al 1991). Using Ministry of Health facilities has reduced the cost of service provision and increased the network of family planning service points.

There is much regional variation in the structure of programs. In many Latin American countries, the government has not been supportive of family planning and has not played a large role in service delivery. Since demand for services is high, linkaged programs have developed in which PVOs and the commercial sector are important participants. In many African countries, political instability would suggest that the public sector should not be relied upon for service provision and that the commercial sector and PVOs should play a large role. However, since demand for services is low, public resources are needed to generate demand and opportunities for PVOs are limited. Consequently, many African programs are vertical, dependent upon donor support.

Finally, in Asia, both political stability and government support have been fundamental to the success of programs, for example in Indonesia and Thailand (see Case Studies 1 and 2). These began as vertical programs when resources were available for building strong programs to increase demand in dense, fairly accessible populations. These structures are now evolving into less centralized and more responsive structures which can more effectively meet the needs of current demand and target special efforts towards hard to reach populations.

There are situations in which a resource-intensive program is necessary and the goal of sustainability must be subordinate to other program goals. For example, in sub-saharan Africa, where demand is low and services are weak, a vertical program that requires large subsidies is needed in order to build demand and put services in place. As the program develops and demand

grows a more sustainable structure may become appropriate.

Structures that require fewer public sector resources and tend to be more sustainable are linked, incorporating commercial and private voluntary providers into the program. Three of the best examples of ways in which the government can work with private service providers and financiers are social marketing of contraceptives, employer-based family planning projects (Townsend 1991).

Social Marketing: Social marketing of contraceptives--the distribution of subsidized contraceptive products and information about their use through private pharmacies and other retail outlets--allows the public sector to reach key populations of potential contraceptive users at relatively low cost. It takes advantage of the existence of widespread networks of private distribution outlets and consumer preferences for commercial providers. Just as programs as a whole evolve over time, so do social marketing efforts, moving from dependence to sustainability (see Box 6).

Employer-Based Services: In some settings, it makes financial and political sense for large employers to directly provide or to finance family planning services for workers and their dependents, particularly within the context of existing workplace-based health care. From the employers' perspective, providing services can reduce costs associated with pregnancy and childcare (maternity leave, reproductive health care, employee absenteeism to care for children, etc.). From the employees' perspective, it may be convenient to obtain services in the work setting, and the cost may be substantially less than if they were purchased on the open market. And from the government's perspective, any privately financed care reduces the burden on the overstretched national budget (Rinehart et al 1987).

Limited Support for Private Clinics: Another way to take advantage of existing networks of services is to assist private physicians obtain training and management skills so they can better deliver family planning services. For example, in a "community doctors" approach, a physician receives training, IE&C materials, technical assistance and support in the form of a loan for furniture and equipment. He or she also may receive a per-client fee from the sponsoring agency for every low-income client, rent subsidies or other assistance. During a set period of time--for instance, two years--the doctor is required to "generate enough income to achieve a degree of financial self-sufficiency which will allow him or her to cover all of the operating costs of the clinic, pay back the loan, and satisfy personal income needs" (Busquets-Moura et al 1991: iii).

2.4. Ensuring that the System Responds to Local Needs and Draws on Local Resources

The ability to respond rapidly to changing consumer demand and to take advantage of local resources is fundamental to the sustainability of a program. This requires that decisions are based on timely information about the preferences of the client population and that decision making occurs at levels within the program that are close to the point of service delivery. In this way, then, sustainability can be fostered by efforts to move away from only national-level

Contraceptive Social Marketing (CSM) has shown tremendous potential to use existing private sector networks to promote and distribute affordable contraceptive goods, as well as information about their use. In the past, most CSM projects have been supported largely by international donors, who have provided heavily subsidized contraceptive commodities, technical assistance and operational funding for distribution agencies. While CSM has proven to be a cost-effective means of distribution, it has depended on significant levels of support from donor agencies.

Now, many CSM efforts are evolving into new generation, increasing their organizational, technical and financial capacity so that they can continue with minimal donor support. In doing so, CSM projects have even greater potential to contribute to a national family planning program's movement toward sustainability.

The key to sustainability of CSM efforts is maximizing the use of private sector infrastructures. Such projects are managed by the commercial sector. As a consequence, the majority of administrative costs are covered by privately financed infrastructures and the social marketing work is institutionalized within financially sustainable organizations.

So-called fourth generation social marketing projects do require particular types of donor support, but they are relatively self-sufficient. According to Cisek and Maher (1992:4), "fourth generation social marketing provides donor investment in a market-building activity to strengthen product demand and the private sector's interest in supplying contraceptives at affordable prices. It does not provide any resources to support the private sector management of the effort. Fourth generation projects procure all products through the commercial sector using either locally available or commercially purchased products, so there are no commodity costs for the donor. Prices are established that incorporate all project costs and provide an adequate profit margin to the distributors and retailers to maintain their interest in the product."

control, and toward greater amounts of control at the local or regional level.

Decentralization--the transfer of "authority to plan, make decisions and manage public functions" (Rondinelli 1981:137) from the center to local or subnational level (Conyers 1984, Rondinelli 1983, Rondinelli and Nellis 1986)--can make this possible. Decentralization is a process and exists along a continuum, with some states more decentralized than others. According to Lacey et al (1993:1), "[t]here are various approaches to decentralization, including: (a) deconcentration, where selected administrative functions are shifted from a central government ministry to its field staff in regional or district offices; (b) devolution, where the central government transfers to local governments decision-making authority, select public sector development activities and the power to secure resources and/or make expenditure decisions; (c) delegation to parastatal organizations, or non-governmental institutions, where decision-making and management authority for specific functions are delegated to organizations that are not part

of the central government; and (d) privatization, where government functions are transferred to the private sector." Guidelines for decentralization are shown in Box 7, and are described in detail in the companion "state of the art" paper with case studies of decentralization.

Box 7 Decentralization Guidelines

To develop decentralized family planning programs or redesign existing efforts, government officials at the national level should consider the following:

- **Identify the level and to whom authority will be transferred:** Powers can be transferred to regions, districts, states or local governments. Within the level of government, decentralized functions can be transferred to elected leaders or councilors, political appointees, local government employees, non-government organizations or a combination of actors. The selection of an appropriate administrative level and actors should be determined by the potential capabilities of individuals and organizations to plan and implement decentralized functions at the selected level. The smaller the administrative area, the less likely it is to have both the financial resource base and the skilled personnel required for implementation (Conyers 1990).
- **Select strategies to transfer power, authority and resources:** Early in the process of decentralization, national officials should explore alternative strategies to transfer responsibility. Mechanisms for transfer can be through legislation or non-legislative activities. Legislative mechanisms include constitutional and ordinary legislation, the former being common in federal systems. Non-legislative mechanisms include political directives and administrative devices, including financial and public service rules and regulations, and ad hoc instructions from headquarters staff to their officers in the field (Conyers 1990). Legislation is likely to be more effective and more permanent than political or administrative directives. However, legislation is less flexible because it is more difficult to change.
- **Identify the types of training required to build the capabilities to plan, implement and evaluate projects and programs:** The decentralized unit, whether local government officials or non-government organizations, must assess the supply and demand for services and develop and implement plans to meet needs within the community. Therefore, local officials need skills to: 1) identify problems and opportunities, 2) identify or create possible solutions to these problems, 3) make decisions and resolve conflicts, 4) mobilize, allocate and monitor resources effectively, 5) manage and coordinate agencies involved in local implementation activities, and 6) gain political support among government and traditional leaders at the local level to promote program implementation.

(This is excerpted from Lacey et al 1993: 5-6.)

The relationship between decentralization policies and the sustainability of large scale donor assisted projects in low-income countries has been recognized for quite some time (Ostrom et al 1990). Both Cernea (1985) and Uphoff (1986) point to empirical evidence showing that when those who benefit from services participate in decision-making, they are likely to invest substantially towards the success of these projects. Their investments may take the form of commitments of time, labor and monetary resources.

Four factors make decentralization an important determinant of the sustainability of family planning programs.

- Regional differences in the needs for health and family planning result from urban/rural and cultural differences. Although centrally organized and managed family planning programs may be designed to capitalize on economies of scale, the costs of adapting centrally directed programs to meet local requirements can be greater than the economies of scale. Decentralizing a national program allows localities to design programs to match local needs. By bringing decisionmaking closer to the client, this has the potential to improve the quality of services, strengthen demand and improve efficiency.
- Decentralization provides incentives for sustained local participation through local resource mobilization. When tax payers in the locality perceive that they are benefiting directly from services supported by their tax payments they have a greater sense of participation and involvement in the program. This requires that at least a portion of local tax collections be retained at the local government level for local expenditures.
- Decentralization allows programs to flexibly use resources that exist within communities. For example, if one region has a surfeit of private physicians, while other areas are experiencing physician shortages, appropriate strategies can be used to employ or develop these different local resources. In the area with sufficient medical manpower, the public sector can contract with private physicians to serve low-income populations. In areas with physician shortages, the public sector itself may have to take the lead in creating and staffing health care facilities.
- Decentralization promotes sustainability by employing and developing managerial and technical skills and expertise at the local level. Organizations that exist at the local level can be tapped to supply the managerial talent necessary to run a family planning

program at the local level (see Ostrom et al 1990, for examples).

2.5. Sustaining the Program by Nurturing Demand

If the flow of benefits of family planning are to be maintained over time, then a steady and even increasing number of couples must seek and use family planning services. Because of this, demand generation and maintenance are integral to a sustainable family planning program, and responsibility for it falls on the shoulders of many institutions.

Many demand generation activities fall squarely into the domain of government responsibility, and a government's commitment to investment in demand generation and maintenance is a key determinant of the long-term sustainability of a family planning program. At the same time, however, as the "provider of choice" for large segments of the population, the private sector has its own role to play in generating and maintaining consumer demand.

Demand generation and maintenance efforts occur at all levels of the program--national, community and individual. At the national and community levels, they raise awareness of the importance of family planning and inform people of the availability of services. At the individual level, they enable people to choose the method which best meets their needs. Demand generation and maintenance activities recruit new acceptors and users into the program, improve the quality of services provided to current users, and inform and direct users toward more appropriate and effective methods.

Three aspects of demand generation and maintenance that are critical to building a sustainable family planning program are discussed in this section. They are:

- The role of the public sector in collecting information about current demand--knowledge, attitudes, and practice of family planning -- and using it to develop information, education and communication (IE&C) strategies to provide people with the information they need about family planning;
- The close relationship among quality of family planning services, consumer satisfaction and sustained demand for services; and
- The role of the private sector in responding to consumer demand.

2.5.1. The Public Sector's Role in Generating Demand

The government has a strong interest in (and central responsibility for) supporting activities that generate and maintain consumer demand for family planning. These activities include collection of information about need and demand for services, and design of mass media and other campaigns to increase awareness of (and generate demand for) family size limitation.

Such activities fall under government auspices for several reasons. First, as the largest service provider in many settings, the Ministry of Health or comparable agency typically has a strong interest in learning about the knowledge, attitudes and practices of a large share of the population so that it can design the most appropriate services. Second, government agencies in developing countries are usually in a better position to launch large surveys (e.g., through the census bureaus or other offices) than are private firms. Third, governments generally are in the best position to carry out information, education and communication activities. The public sector often controls much of the mass media and can quickly introduce targeted messages. And fourth, both information gathering and IE&C activities provide benefits to society at large, not to individuals (or even individual providers). Therefore, they fall to the public sector.

Just as information is used for strategic planning, information collected at the national level through DHS surveys, and at the individual level through household and clinic-based surveys, focus groups and other types of research can provide critical insight into understanding and practice of family planning. For example, national or regional surveys can allow program managers to measure the magnitude of demand for particular methods or sources of services, to distinguish among major segments of the contraceptive market, and to identify significant gaps in service coverage. In addition, such surveys can provide information on the population's exposure to mass media and awareness of particular contraceptive methods and where to obtain them.

Once current attitudes are known, messages can be developed and an IE&C campaign implemented to inform and educate people. A sound IE&C campaign includes a variety of messages disseminated through more than one communication channel to ensure that broad segments of the population are reached.

The most pervasive form of IE&C activity is the mass media promotion campaign. Television, radio, the press and other channels are utilized to reach the greatest number of potential acceptors in the shortest possible time. Mass media can be highly cost-effective. In Turkey, one campaign covered more than 6 million women of childbearing age at an approximate cost of \$0.04 per woman. In terms of cost per new acceptor of modern contraceptive methods, the amount expended was only \$0.97. In Nigeria, a mass media campaign conducted for six months raised the awareness of over two million women at an individual cost of less than a dollar each. The Nigerian campaign is particularly instructive since it was part of a five-year project explicitly designed to favor IE&C strategies over all others. Preliminary results show that the project impact has been greater than envisaged, but at a relatively low cost per person cost.

A second IE&C strategy involves using influential members of the community as spokespersons for the program. These groups are known to potential and current users, are accessible, and speak the same language. An excellent example of this strategy is the Trishul Rural Communications Project in Bangladesh, which relied heavily on community information centers called "jiggashas" where both counseling and contraceptives were imparted with the help of community leaders and the informal social network.

At the lowest level, IE&C activities involve one-on-one counseling in which imparting knowledge to the client increases consumer satisfaction through informed choice and improved quality of care. This aspect of IE&C plays an important role in affecting knowledge and attitudes as well as changing individual contraceptive behavior. Two examples from sub-Saharan Africa illustrate the potential for this activity. In Ogun state in Nigeria, evaluation of a training program found a significant difference in contraceptive behavior between those clients counseled by trained nurses and those counseled by untrained nurses. Similarly, a research study in Ghana using "mystery clients" concluded that trained nurses provided better counseling than untrained nurses (Huber 1993, Bulatao 1992).

IE&C strategies and needs will change over the life of the program. When demand is low investments in IE&C are required to raise awareness and generate demand. As demand increases, IE&C campaigns must shift their orientation towards targeting messages to hard to reach groups and providing more detailed information about different methods in order to meet the needs of current users and generate new users. They can also be used to direct users towards more cost-effective methods and consequently increase the sustainability of the program.

2.5.2. Quality, Consumer Satisfaction and Sustained Demand

Demand is a function both of factors external to the program -- a societal shift in attitudes toward small family size, for example, or an increase in the costs of bearing and raising children -- and of characteristics of the program itself. Among the most important characteristics of the family planning program are its responsiveness to clients' perceived needs and the technical quality of services provided: Do women who come to a provider receive the attention, choices and services with which they are satisfied? Do the services provided offer the most appropriate method, foster correct use and follow-up to ensure good health outcomes? In short, the quality of services provided strongly determines the effectiveness of family planning method use, whether women return for care when needed, and whether they recommend family planning to friends and relatives. Each of these responses is a reflection of sustained demand.

While "quality" of health and family planning services is a difficult concept to define and measure, it has long been cited as one of the most important reasons for the success (or failure) of health and family planning programs. Seemingly small matters that have little to do with the technical quality of services, such as long waits and the gender of provider, have been shown to have major impact on family planning outcomes, such as contraceptive use. As Keller et al (1975) state, long waiting times are "one of the most important factors in explaining the relatively high rates of program and method discontinuation ... and may also discourage would-be acceptors from seeking program services." Particularly in family planning, where client motivation and continuation of method use are so closely tied to program impact, treating one client well may be more important than recruiting 10 new clients.

The relationship between the quality of services and the sustainability of those services is mutually reinforcing. Poor quality of care hampers an organization's ability to move toward

sustainability. Services of poor quality discourage use, and therefore cannot generate the political constituency or revenues from users that are required for long-term sustainability of a family planning program. This is manifested in innumerable public systems, where severe budget constraints have led to decay of facilities, and low pay and lack of incentives for client-centered care have created services that fail to generate client satisfaction with the quality of care.

On the other hand, good quality of care can aid in an organization's move toward sustainability: If clients receive services that respond to their felt needs, and for which the individual benefits are apparent, they often are willing to pay at least a portion of the costs. More indirectly, good quality family planning services can meet the needs of political constituencies, and be assets to policymakers who support them.

Organizations that are financed in an inherently unsustainable fashion--for example, those that depend entirely on donor support and have no means to generate other revenues--tend to have few incentives to ensure that clients are satisfied with the quality of services. That is, if employees know that their salaries are secure, regardless of the volume of services provided or consumer satisfaction, they may pay significantly less attention to some elements of quality of care than will employees whose job security and wages are more closely tied to consumer demand and satisfaction.

On the positive side, however, efforts toward sustainability can lead to enhancement of quality of care. When organizations introduce user fees to generate revenue, for example, the quality of services becomes a critical issue: Adequate quality and responsiveness to clients' felt needs must be maintained and improved to generate "paying customers"; at the same time, user fee revenues can be earmarked to support quality-enhancing renovations of the physical surroundings, or other improvements.

2.5.3. The Role of the Private Sector in Responding to Consumer Demand

As noted earlier, the commercial sector has the distinctive feature of being sustainable, by definition. Private doctors and clinics that do not generate sufficient income soon find themselves out of business. The necessity of bringing in paying clients implies that private family planning providers must pay considerable attention to consumer satisfaction. In particular, they must provide services that, from the client's perspective, are "better" than lower-cost alternatives, including the public family planning services. Such features as closer proximity to the home, shorter waiting times, nicer facilities, more convenient hours and greater attentiveness to good doctor-client communication often are cited as reasons why women prefer private doctors to the less expensive public family planning system.

The demand for private sector family planning services is evidenced by extensive use of pharmacies and private physicians in developing countries. In Senegal, for example, nearly half of all users of contraceptive methods seek their services in the for-profit private sector. In Egypt, nearly three-quarters of all users are private sector clients. And in Mexico, 40 percent of all

services are provided by the commercial private sector (Cross et al 1991).

The for-profit private sector is a provider of choice not only among the better-off, urban segments of the population, but also among poorer and rural couples. For example, in Ecuador in 1987, about 35 percent of all urban users of modern contraceptive methods obtained family planning services in the for-profit private sector; at the same time, in the rural areas, nearly 30 percent of all users were private sector clients. And in the Dominican Republic in 1986, while 57 percent of all women with at least some secondary school education who used contraceptives relied on private doctors or pharmacists, that figure was also sizeable (44 percent) among women with only some primary education (Cross et al 1991).

Two lessons for sustainability can be drawn from observations of consumer demand for for-profit private sector services. First, there is a lesson for organizational level sustainability: Non-profit organizations and public sector entities that are attempting to move toward sustainable operations may be able to increase volume and consumer "willingness to pay" by replicating some central features of the for-profit private providers. Toward this end, consumer surveys, focus groups or other types of market research can identify characteristics that "signal" good quality to specific groups of consumers.

Second, there is a lesson for programmatic sustainability in the apparent demand for for-profit private services: Widespread consumer preferences and profit incentives can benefit the sustainability of a national program, since the for-profit private sector can be provided with the opportunity (and even encouraged) to serve all clients who can afford private fees. The public sector and organizations whose mission it is to serve the poor can then efficiently target their resources toward needy populations.

2.6. The Public Sector as Service Provider

Until this point, our discussion has identified ways in which the public sector plays a role in determining the long-term sustainability of family planning program efforts through its planning and policymaking activities, and through its function in generating and maintaining consumer demand. Throughout, we have highlighted the benefits of including the commercial private sector as a full and active player in service provision. We now turn to the public sector's role in providing family planning services.

In much of the developing world, the public sector is the largest provider of family planning services and plays a special part in determining what the overall program looks like--and the ultimate sustainability of that program. If the public sector is solvent and meets the needs of the target population, prospects for programmatic sustainability are bright. If, on the other hand, the public sector is falling short of its responsibilities, relies heavily on foreign donors and would be unable to meet the population's needs using only national resources, then the road to a sustainable program may be long indeed.

While each country represents a distinct challenge, there are a set of common determinants of long-term sustainability of a public sector service delivery system. These echo the determinants of the sustainability of the program as a whole. These are that:

- Services are targeted so that only those for whom the public sector has a special interest are supported with tax funding, and adequate tax-based resources are provided to serve poor/special population groups;
- Sufficient public sector funds are invested in family planning to meet demand of target groups;
- Users not eligible for free services pay user fees; and
- Services are operated in an optimally efficient manner.

2.6.1. Targeting for Efficiency and Equity³

In many countries, as noted in Section 2.2.2.2., public family planning services are available to all consumers, often at little or no charge. Two basic rationales form the basis for offering highly subsidized public family planning services. First, in settings where rapid population growth is hampering economic growth, reduction in fertility is thought to provide tangible benefits to society at large, in addition to the individuals. Therefore, the government is willing (and sometimes even eager) to expend public resources to extend family planning services, and policymakers may believe that contraceptive use would decline if public services were unavailable. Second, in many countries the government takes responsibility for providing universal subsidized health services under the assumption that this policy enhances equity, particularly in areas where people are considered to be too poor to pay for private care. Family planning is just one of many free services, often provided in the same outlets and by the same personnel who deliver health services such as prenatal and well-baby care.

Increasingly, however, universal access to government-subsidized health and family planning services is being recognized as infeasible and undesirable. Such a system is infeasible because few countries possess adequate public resources to finance the entire health system. The result is a public system suffering from low morale among poorly paid staff, deteriorating infrastructure, and shortages of key inputs, such as drugs and supplies.

The system is undesirable because it often reinforces existing inequitable distribution of resources. While governments may believe that universal subsidized health care promotes equity, in reality untargeted free or very low-cost public health programs have had the opposite effect.

³ Portions of this discussion are adapted from Levine et al (1991).

Untargeted subsidies tend to provide much greater access to services in urban, relatively well-off areas, at the expense of the poor and rural areas. Further, resources have been diverted toward high-cost, hospital-based services, which tend to benefit few, and away from lower-cost services, which benefit larger populations (Birdsall 1989, Jimenez 1987). And untargeted subsidies typically create opportunities and incentives for government providers to charge unofficial side payments, and/or lead to long lines at service outlets. From both efficiency and equity perspectives, then, a feasible and desirable alternative to delivery of universal free family planning services is a targeted approach.

Conceptually, the "best" targeting mechanism would reach all of those defined as "poor"⁴; at the same time, no benefits intended for the poor would be received by non-poor households or individuals. In other words, it would achieve full coverage with no leakage.

However, there is a price attached to identifying the poor; obtaining information about eligibility, and administering the exemption mechanism is costly. In general, given a fixed information or administrative budget, a tradeoff exists between the ability to reach the poor (coverage) and ability to exclude the non-poor (prevent leakage) (Besley and Kanbur 1989). Design of a good targeting system, therefore, involves the weighing of the benefit of achieving complete coverage of the target group against the cost of allowing the non-poor to receive subsidies. An additional consideration is that the cost of the targeting mechanism reduces funds available for service delivery, and if more services are delivered at the cost of greater leakage, social welfare may be improved relative to eliminating all leakages and providing fewer services.

On one extreme of the continuum, an untargeted or universal program, such as free public health services or a general price subsidy, allows full access to the poor (in concept), thereby maximizing coverage. Because no eligibility information is required, it implies no extra administrative costs. At the same time, such a program will provide many of the non-poor with the equivalent of a net income transfer--an ineffective use of a government's poverty alleviation budget. On the other extreme, a very tightly targeted program may do well at excluding those who have adequate resources, minimizing leakage. But it incurs high administrative costs to obtain and verify eligibility information and, if not perfectly implemented, runs the risk of excluding those who are eligible to benefit from free services.

In addition, there are important political considerations: Besley and Kanbur (1989), Gill et al (1990) and others note that the ideal targeting scheme would restrict program benefits to the poor--just the population that is least likely to be able to generate sufficient political support. Thus an economically efficient system may not be politically feasible, and some leakage may be required to maintain a constituency for a social service among the more powerful segments of the population. This consideration is the source of the adage that the government must help the rich to help the poor.

⁴ The target group may be the poor, or may be other special populations such as adolescents.

- Self-selection by economic signals. This approach uses price signals and associated service characteristics to provide incentives for those who can and want to pay more to select themselves into higher priced, unsubsidized services. A family planning program could offer special types of services for clients willing to pay a user fee, and only basic accommodations for non-paying clients.
 - Targeting the poor by aiming at characteristics correlated with low income. This approach implies that we can identify characteristics of the poor versus the non-poor, and that those characteristics can be used to design services. In settings where the poor are concentrated in certain urban neighborhoods and/or in rural settings, the public system could provide universally free access in those geographic areas, while charging fees (or providing no services) in areas where more affluent families live.
 - Identifying the poor by establishing income cut-offs for subsidies and determining eligibility based on direct measurement of income (self-reported by the client, through tax or payroll records, or through investigation of the client). This "means testing" approach is clearly a more difficult type of system to administer, and must meet several criteria. First, the means test should differentiate well between those who qualify for lower charges and those who do not, to minimize leakage of subsidies. If a certifiably rich person enters a clinic, that person should always qualify to pay the full price, not a reduced fee. Second, the means test should be economically efficient. Although a test could be made so tight that the non-poor never sneak through, there is probably some level of leakage that minimizes the net cost of the operation, which includes delivering the health service, paying for the means test, and losing the revenue of people who sneak through. Third, a targeting program (although not necessarily the means test itself) should achieve thorough coverage of the poor. Thus someone who is poor should receive some benefit from the subsidy.
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While the policy challenge is to determine the acceptable trade-offs between coverage and leakage, the technical challenge confronting program designers is to develop innovative targeting strategies that distinguish between the poor and the non-poor at relatively low cost (see Box 8). Regardless of the targeting mechanism deemed appropriate, the objective is to diminish public subsidy to individuals and couples who can pay for services, and to allow the government to focus resources on the key populations in which it has a special interest.

2.6.2. Resource Mobilization and User Fees

The public sector responsibility for delivering (or financing) services for a target population implies that national governments will devote a portion of tax revenues to supporting family planning services. In fact, this is the case in most countries. At current levels, national

(or host-country) governments spend a total of approximately \$3.5 billion on family planning, making them by far the largest source of total expenditures (Lande and Geller 1991).

Despite the sizeable contributions of governments to family planning, there is room and need for expansion of public sector investment. The current level of spending amounts to only 0.4 percent of their total public expenditures, on average. Clearly, increasing even tiny proportions of their budgeted expenditures could go a long way toward funding program costs (Lande and Geller 1991).

Given a growing recognition of the limitations of government resources, and the competition between health and family planning with other ("productive") sectors, policymakers may be willing to consider alternatives. Among the most promising is the implementation (or increase) in user fees for at least some family planning goods and services, as long as they do not reduce overall demand for family planning or result in hardships to the poor. User fees can bring several benefits:

- User fees can generate revenues for financially strapped health care facilities and systems. In concept, those funds can then be used to establish services in underserved areas, or to subsidize care for poorer clients. In addition, if retained at the facility, user fee revenue can be used to improve the quality of care and amenities.
- User fees can increase efficiency in consumption of family planning services if prices are used as signals to consumers to encourage use of the least resource-intensive sources or methods of family planning services (e.g., health posts versus outpatient departments of hospitals; less costly pills versus more expensive ones).
- User fees have the potential to improve the equity of health service delivery, by channelling (or freeing) resources to populations that traditionally have been underserved (the poor and/or those in rural areas).
- User fees ensure that use of family planning services is voluntary on the part of clients.

A central concern when user fees are instituted and/or enforced is the effect on demand. How sensitive to prices are family planning users (or potential users)? There is a growing body of empirical evidence to answer this question. Lewis (1986) reviewed 13 studies containing information on consumers' responses to changes in contraceptive and sterilization prices. The central findings were as follows: First, demand is similar for low- or moderately-priced contraceptives as for free contraceptives. Second, as price rises, the effect of price changes on demand increases. That is, there may be little change in demand as prices rise at the low end of the price range, but significantly greater effects as prices of more expensive goods and services rise. Third, large jumps in prices tend to have major effects on demand. And fourth, demand

among the poor is more likely to be affected by price changes than is demand among higher-income groups.

More recent studies generally have reinforced these findings. For example, in a study in Thailand, researchers found that demand for all forms of contraceptives provided through the Ministry of Public Health was relatively insensitive to price changes. The study concluded that: "It is possible for the MOPH to save substantial subsidy budget through price restructuring. Specifically, the subsidy budget can be reduced from Baht 62 million (US \$2.5 million) to Baht 51 million (US \$2 million) per month without affecting effective protection Contraceptive use would be minimally affected when government increases contraceptive prices" (MORE Project 1992).

2.6.3. Efficiency of Service Production

In all settings, there is potential to increase the efficiency (or cost-effectiveness) of the provision of family planning services. Staff can be reorganized and volunteers can be enlisted to increase effective outreach; commodities can be obtained in a more timely manner; and the volume of clients seen in clinic settings can be increased, thereby making the most of expensive facilities and driving down the unit costs.

Level of Outlet and Staff Mixes⁵: In general, programs use resources most efficiently when the lowest possible level of provider is used to deliver a particular method. Just as it would be inappropriate to perform tubal ligations in most rural health posts, it is an inefficient use of resources to require that pill users see a physician for resupply. While quality of care demands that a wide range of methods be available to the potential user, it is not necessary that all outlets provide all methods. It is intuitively clear that non-clinical outlets and providers should not provide clinical methods. It is less obvious that employing scarce clinical facilities and personnel to deliver methods that could be equally well provided in simpler settings represents an inappropriate use of resources.

Condoms and spermicides can be distributed safely by non-medical personnel, including community workers and retail sales workers. Non-medical personnel also can safely re-supply oral contraceptives and if trained to screen for principal counter-indications can safely prescribe orals as well (different countries have different norms regulating the initial prescription of orals; however, in practice, pills are available over the counter in most developing countries). Any facility (including pharmacies) that routinely offers injections can administer injectables.

Clinical methods (IUDs, sterilization, implants) require more highly trained personnel and minimum standards of hygiene, which are usually found only in organized program settings. Nurses and midwives can be trained to insert IUDs and need only a clean table with a privacy

⁵ This section is drawn from Foreit and Levine (1993).

screen, clean water, and sterile instruments. These requirements can be met in most health posts. Voluntary sterilization and implants require more extensive staff training and a closed surgical area, and for those reasons can usually be supplied only at the secondary (health center) and tertiary (hospital) levels.

In this area, as in all reforms, it is incumbent on program managers to be cautious. No change in staffing patterns should be made that impairs the delivery of high-quality services.

Pharmaceutical Purchases: One realm in which there typically is considerable latitude for reducing costs is in the area of pharmaceutical purchases. Some countries take advantage of services provided by international agencies that use worldwide tendering and pass on low bulk prices to national programs. Others, however, do not use international tendering and/or have restrictions on pharmaceutical imports in an attempt to protect national industries. And still others depend on donor-provided commodities. The result is tremendous variation in retail prices for contraceptive commodities. Condoms cost only \$2 to \$3 per 100 in China, Egypt and Tunisia, but \$15 to \$30 per 100 in Costa Rica, Ecuador and Mexico and more than \$70 per 100 in Brazil, Burundi, Myanmar and Venezuela (World Bank 1993).

It is in the long-term interest of the family planning program to keep commodity costs to a minimum. Depending on the setting, this may imply instituting a more effective tender and procurement process, opening the doors to foreign manufacturers and/or encouraging local production by the commercial sector.

3. ELEMENTS OF A SUSTAINABLE ORGANIZATION

We have discussed the sustainability of public sector service delivery systems, and the de facto sustainability of the for-profit private sector. We now turn to the organizations that are most likely to face the new challenges of providing financially and institutionally sustainable services. These are not-for-profit institutions that have long been dependent on support from donors and, in some cases, from host-country governments.

Our focus is on private voluntary organizations for two main reasons: First, it is the private voluntary organization that faces the greatest challenges in moving toward sustainability. Such organizations are often established to operate in an inherently "unsustainable" fashion. For example, they may be set up as charitable institutions, taking it on as their mission to provide free or heavily subsidized services; they may be directed by individuals who have an interest in service provision, but not in running a business; and they may be inefficient in structure and function because they have been supported with donor funding since inception.

The second reason for our focus on PVOs is that it is important to recognize that there are limits to the ability of particular organizations to be financially independent. As stated earlier, non-profit providers that primarily serve the poor or others who would not seek services

in the commercial sector may be unable to continue to deliver care to those clients if donor or other public support with withdrawn. In such cases, it is critical to evaluate the contribution that the organization makes to the program as a whole, and to determine whether public dollars should continue to flow to maintain it.

Before judging whether a particular PVO should be asked to become financially independent of donors, it is essential that the PVO, the government and the donor agencies clarify the organization's mission. If the non-profit provider is serving a segment of the population that cannot be reached through the existing public sector network and/or is able to provide such services in a more cost-effective manner than the public sector, *and* those clients would not seek services through the commercial sector, then public support of the PVO probably is warranted.

In most cases, however, a detailed examination of the PVO's mission and capabilities will show that there is at least some room and rationale to decrease, if not eliminate, public support. In this section, we discuss specific measures that such an organization can consider when faced with a decline in donor (or other public sector) support. This is not intended to be an all-encompassing list; rather, it is intended to outline the major strategies that can be considered. We highlight several issues, or concerns, that managers may have when seeking ways to move toward sustainable provision of services. Finally, we describe several indicators that program managers and donors can use to assess organizations' potential for, and progress toward, sustainable operations. This section is augmented by information presented about the PROFAMILIA organization in Colombia, which has successfully implemented many approaches to generate resources on its own, and to reduce costs of production of services.

3.1. Strategies to Close the Sustainability Gap

In the simplest terms, the "sustainability gap" for any non-profit organization is the total costs of providing services minus the total revenues (excluding public sector support). A financially sustainable organization that is independent of donors or the government, then, is one in which the sustainability gap is zero (or even negative, if surplus is being generated). And, as stated earlier, long-term financial sustainability generally implies that managerial and other institutional structures are sound, reasonably efficient and responsive to change.

When faced with the new challenge of moving toward sustainability, organizations must determine the magnitude of the existing "sustainability gap," identify strategies to close it, and determine which of those strategies best fit the mission and characteristics of the organization. These are not easy tasks.

3.1.1. Measuring the Sustainability Gap

Non-profit organizations are notoriously lax about cost accounting, and it may be difficult to obtain a quick estimate of the actual costs of providing family planning services. For obvious reasons, this is particularly true in cases where family planning is just one of many services that

an organization provides and/or where budgets are separated among projects sponsored by various donors and subcontracts. It may be necessary to carry out a cost study specifically for the purposes of estimating both the total and the unit costs of family planning service provision.

While generally more straightforward than cost accounting, it may also be difficult for organizations to identify the many sources and amounts of cash and in-kind revenues that they receive. For example, non-profit family planning clinics that appear to be entirely funded by donors may in fact be using buildings and supplies that belong to (or are subsidized by) a host organization or even the government; or some personnel assigned to provide family planning may receive salaries and/or benefits from other parts of the organization. These in-kind revenues, though often invisible on the balance sheet, are important to include in an overall estimate of resources currently available to the organization, since they represent expenditures that would have to be made in the absence of such contributions.

Once reasonably accurate estimates have been made of the total costs of providing family planning services and of the total revenues, by source, a manager can estimate the difference between total annual (or monthly) costs and total non-donor, non-governmental revenues. That difference is the "sustainability gap," representing the total amount of funds that would have to be provided in the absence of donor and/or public sector support.⁶

3.1.2. Identifying Strategies to Close the Sustainability Gap

Several avenues are open to non-profit organizations as they seek to close the sustainability gap and move toward a more financially sustainable operation. These are:

- ***Generate more revenue for existing or expanded family planning services***

This approach can take several forms, including imposing user fees on at least a portion of clientele, increasing the prices currently charged for specific high-demand family planning services, and working with health insurers and/or employers to include family planning at the organization within a benefits package, for a fixed annual fee or on a cost-reimbursement basis. The most common form is a user fee for at least some services.

The key to a workable user fee (or third-party reimbursement) system in the private sector, as in the public sector (described in Section 2.6.2.), is to understand the dynamics of consumer demand, and to set prices accordingly. The prices may be applied to existing services,

⁶ It is important to acknowledge that this is a "quick and dirty" methodology for estimating a "sustainability gap." In practice, organizations make different decisions about what services they choose to provide and what clientele they choose to serve, depending on availability of donor funding. Therefore, this measure of a "sustainability gap" specifically refers to the amount of funds that would have to be generated to continue to provide the same type and level of family planning services as is currently done with donor support.

or to new method choices, for evening or weekend (high-demand) hours, or for other desirable services. Similarly, PVOs with large networks can consider charging higher prices in urban areas, where demand and income are likely to be higher, and keeping services low-cost in rural settings.

The advantages of generating additional revenue in this manner are obvious: First, dependence on client payments can make an organization more responsive to consumer demand. Second, revenues can be reinvested in improving the quality of service delivery. And third, by definition client payments will make the organization less dependent on other sources of external assistance.

The disadvantages are equally obvious: The total revenue generated must significantly exceed the cost of administering a workable user fee system, which may be substantial if there is an elaborate means testing mechanism to waive fees for the poor. In situations where demand is highly sensitive to changes in price, imposition or increases in user fees may decrease the volume of clients.

Recent observations highlight the importance of devising a workable waiver mechanism when user fees are imposed, if the objective is to continue to serve the poor. The Association for Voluntary Surgical Contraception retrospectively examined the impact of an increase in user fees for sterilization services at 17 nongovernmental family planning clinics in Mexico, the Dominican Republic and Brazil. It found that, "In all but three of the 17 clinics, the increase in fees was met with a decline in caseloads. Moreover, at nine of the 17 sites, the fee increase effected a change in client mix; anecdotal evidence suggests that more middle-income and fewer lower-income clients were using sterilization services" (Haws et al 1992). The suggestion of such changes are cause for concern and may inhibit clinic leadership from supporting movements toward sustainability. Thus, care must be taken to protect the poor from establishment or increases in user fees.

- ***Generate revenue from related services***

Some private voluntary organizations have found it desirable to diversify the services that they provide beyond just family planning services, and to charge for the related services. The revenues would then be used to cross-subsidize and support the family planning activities. For example, an organization could provide and charge for lab tests, ultrasound, infertility treatment and other services that are in high demand.

Again, the advantages and disadvantages of such an approach are apparent. On the positive side, availability of ancillary services can attract new clients. Pricing arrangements in which family planning services are free while other services entail a cost to clients may signal them to obtain family planning services.

On the negative side, organizations can become overly concerned with obtaining and

generating income from costly "high tech" health inputs, overlooking a primary mission of providing high quality family planning services. Indeed, clinicians may even have incentives to "overprescribe" ancillary tests to generate income for the organization, and payment for such tests can become an obstacle to access to family planning services.

- *Increase efficiency of service delivery*

All of the suggestions for improving the efficiency of service delivery in the public sector, described in Section 2.6.3, apply equally to private voluntary organizations. However, PVOs may have even more flexibility than do public sector providers in organizing their service delivery.

To reduce the unit costs of delivering family planning services, an organization can increase efficiency by making such reforms as shifting to a lower-level mix of staff, and increasing the productivity of workers. Each organization faces unique questions about the most efficient means of achieving its goals, and those questions often can be answered through careful operations research (Jensen 1991).

In Thailand, for example, program managers wished to know the most cost-effective means of increasing contraceptive use within the Thailand Family Planning Health and Hygiene Project of the Population/Community Development Association, and found that activities that focused primarily (or entirely) on family planning are more cost-effective than were activities that also provided other health services. Distribution systems for contraceptives only cost 46 bhat per acceptor, while distribution of contraceptives with household drugs and orientation for health services and referrals cost more than twice as much per acceptor, or 97 bhat (MORE Project 1992).

In another study, the Materno-Infantil y Planificacion Familiar de Ciudad wanted to evaluate the cost-effectiveness of alternative strategies for delivering family planning services for factory workers in Ciudad Juarez, Mexico. The basic question was whether a program that used volunteer plant workers as family planning promoters was more or less cost-effective than a program that employed plant clinic personnel to deliver the services. The study found that, "[t]he promoter program was more expensive (overall costs were 33 percent greater for the promoter program), but also more effective than the clinic program. The promoter program was 22 percent more cost-effective than the clinic program (cost per CYP was \$16.37 in the promoter program versus \$20.29 in the clinic program)" (MORE Project 1992).

In Paraguay, the Centro Paraguayo para Estudios de Poblaciones studied the cost-effectiveness of two models of family planning service delivery--establishment of community posts in marginal neighborhoods, and service provision through clinics, with increased promotional efforts. They found that the cost per couple-year protection was significantly higher for the community posts than for the clinics (\$12.33 compared to \$8.49) (MORE Project 1992).

In the private sector, as in the public sector, the costs of service production can be

lowered by measures other than increasing the productivity of staff. An additional approach is to lower the costs of purchasing commodities and other inputs. This can be done by making a concerted effort at competitive bidding (tenders) for supplies, and by teaming up with other providers to make bulk purchases.

3.2. Starting Conditions for Organizational Sustainability

The chances of a PVO moving from complete dependence on a donor or charitable organization to independence, and reliance on client payments, are greatly enhanced by favorable starting conditions. In most cases, progress toward sustainability can be more rapid when the following are true:

- ✓ Strong demand for services exists.
- ✓ The organization is institutionally strong and autonomous, with a management structure that responds rapidly to changes in demand and in the external environment.
- ✓ The organizational structure and practices are sufficiently flexible to allow incentives to be put in place to collect fees and increase efficiency.
- ✓ Both the organization and donors have a long-term commitment. The donor is willing to provide a reasonable level of financial support and technical assistance, while the PVO makes progress toward sustainability. The donor is also willing to recognize when such progress is not being made rapidly enough. And PVO managers recognize the value of independence from donors and are willing to seek creative alternatives to donor subsidy.

4. THE DONOR ROLE AND POLICY OPTIONS TO PROMOTE SUSTAINABILITY

Movement toward a sustainable program or organization requires concerted efforts in planning, financial and managerial domains. Often existing national or institutional policies run counter to such efforts and reinforce unsustainable resource flows and institutional practices. For example, while a local public family planning agency may wish to collect user fees from clients who can afford to pay, the Ministry of Health may have a policy of providing universal access to free care. Or, the Ministry cost recovery policy may require that all revenues are sent to a central pool of funds; in this case, the local agency would have no incentive to enforce collection of user fees. Progress toward sustainability, then, would involve policy change at several levels.

Achieving policy change typically requires lobbying, targeted financial and other analyses,

development of tangible incentives to promote change, dissemination of information and cultivation of a constituency. Once change has been achieved, implementation of new policies may require distribution of information about the change, retraining of staff, reorientation of operational procedures and other efforts.

Each stage--achieving policy change and then implementing the reform--can be facilitated by appropriate donor assistance. Donors can provide financial incentives, technical assistance and other resources to help governments and institutions make a transition toward a more sustainable family planning program.

In this section, we highlight the relationship among the elements (or determinants) of sustainability at the program and organizational levels, the policy options that governments and organizations can pursue, and the donor role in supporting policy change and implementation. The discussion is summarized in Table 1. As we suggest promising types of donor intervention to promote independence, we review some of the main determinants of a sustainable program.

4.1. Options for Program Sustainability

The elements of program sustainability described in earlier sections of this paper are: favorable host-country health and family planning policies, good strategic planning and resource allocation at the national level, decentralization and responsiveness to local and regional needs, participation of the private sector in delivery of family planning services, generation and maintenance of demand for appropriate family planning goods and services, and solid targeting and efficiency in public sector service delivery. For each of these, governments can assess the relevant policies currently in place and, if necessary, take steps to improve the policy environment. Examples of policy changes associated with each of these elements are listed below. Also described are the ways in which donors can provide support for policy change and implementation.

- ***Favorable host-country health and family planning policies, laws and regulations***

Many countries have developed explicit national population policies that highlight both the demographic imperatives of reducing the rate of population growth, and the related social needs of increasing women's education, improving access to and quality of reproductive and other health services, and increasing equity in the distribution of the country's economic resources. In some settings, however, explicit policies are absent, or existing population policies focus exclusively on the relationship between population growth and economic development, and are mute on the topic of the rights of individuals and the welfare of poor families. In these cases, it may be useful to develop or expand the national population policy to put the national government "on record" as supporting a balanced and strong effort to make good quality family planning services available to those in need.

Table 1. Examples of Donor Assistance to Move Family Planning Programs and Organizations toward Sustainability

Level	Element	Policy Option	Donor Role
Program	host country health and family planning policies	<ul style="list-style-type: none"> -- develop explicit national population policy -- develop integrated/vertical family planning/health programs -- reform import/export environment 	<ul style="list-style-type: none"> -- RAPID-type and cost-benefit analyses to inform, motivate policymakers -- technical assistance, including South-to-South communication, to develop policy -- observation tours to see other country settings -- technical assistance to analyze and reform laws, regulations and service guidelines
	demand generation and maintenance	<ul style="list-style-type: none"> -- sponsor mass media and other IE&C activities -- focus on improved quality of service delivery -- increase access to female education, health care, other resources 	<ul style="list-style-type: none"> -- technical assistance and funds for IE&C -- training and technical assistance for expansion of method options and improvement of service delivery quality -- examinations of policies indirectly related to family planning demand
	resource allocation	<ul style="list-style-type: none"> -- allocate additional resources for family planning 	<ul style="list-style-type: none"> -- provide analyses to show short-, medium- and long-term demand and resource needs -- cost-benefit analyses to inform, motivate policymakers
	strategic planning	<ul style="list-style-type: none"> -- plan for meeting anticipated future demand -- recognize role of private sector actors -- direct public sector services to its target market 	<ul style="list-style-type: none"> -- provide analyses to show short-, medium- and long-term demand and resource needs -- operations research to identify cost-effective means of service delivery -- legal and regulatory analyses to identify barriers to broad supply of services
	private sector participation	<ul style="list-style-type: none"> -- target public sector resources to populations in financial need -- reduce obstacles to entrepreneurs -- establish favorable environment for insurance market 	<ul style="list-style-type: none"> -- analyses of current constraints to private sector development -- technical assistance and access to commodities for private providers -- awareness-raising about value of market approach

Level	Element	Policy Option	Donor Role
Program (cont'd)	public sector targeting, resource mobilization and efficiency	<ul style="list-style-type: none"> -- identify target group(s) and waiver mechanism -- implement user fees with waivers -- rationalize use of service delivery points -- improve staffing mix -- decrease costs of commodity purchases 	<ul style="list-style-type: none"> -- technical assistance and applied research to develop targeting system -- technical assistance and training for design and adoption of user fee system -- technical assistance, operations research and training for more cost-effective production of services -- technical assistance for development of tendering system
	decentralization	<ul style="list-style-type: none"> -- shift authority, planning, resource mobilization to regional/local level 	<ul style="list-style-type: none"> -- technical guidance to organize decentralization activities -- aid for pilot tests of decentralization strategy
Organizational	measuring the sustainability gap	<ul style="list-style-type: none"> -- estimate costs -- estimate revenues 	<ul style="list-style-type: none"> -- applied research to carry out cost and revenue studies
	increased revenues	<ul style="list-style-type: none"> -- impose user fees on family planning services -- impose user fees on related services -- seek alternate revenue sources -- use cross-subsidization to achieve organizational mission 	<ul style="list-style-type: none"> -- applied research to carry out demand studies -- technical assistance to develop price schedule and waiver mechanism -- technical assistance for financial management -- technical assistance to identify alternate funders
	decreased costs	<ul style="list-style-type: none"> -- improve staffing mix -- increase staff productivity -- decrease costs of commodity purchases 	<ul style="list-style-type: none"> -- training for staff and managers -- technical assistance, operations research and training for more cost-effective production of services -- technical assistance for development of tendering system
	improved management capacity	<ul style="list-style-type: none"> -- plan strategically -- improve management systems (personnel, management information system, decentralized management, etc.) -- increase financial management capacity 	<ul style="list-style-type: none"> -- technical assistance and training for development of management capacity

Donors can assist host-country governments in development of sound population policies at the national level in several ways. First, RAPID-type analyses that show the burden on the health, education and other services resulting from rapid population growth can increase the awareness of policymakers. Second, technical assistance, including South-to-South communication and assistance, can aid development of national population policies appropriate to the country (e.g., where child spacing and maternal health are concerns, the policies made can reflect that focus). As part of such efforts, donors can organize and finance observation tours so that key decisionmakers can talk with and understand how other countries have written workable national policies. At this point, cost-benefit analyses can be used to demonstrate the extent to which current investments in family planning can result in long-term economic benefits.

Beyond the level of national population policy, there are other issues that donors can help to analyze and foster policy reforms. For example, donors can sponsor reviews of legal and regulatory barriers to participation of the commercial private sector in delivery of family planning services. They can then assist local counterparts develop strategies to change those regulations, when they are deemed to have negative effects on access to services. Analyses of medical barriers can help to identify service practices in the public and private sectors that unnecessarily inhibit access. These may include requirements for spousal consent, prohibitions against sterilization, and other restrictions.

- ***Good strategic planning and resource allocation at the national level***

Examples of strategic planning and thoughtful resource allocation are rare, both in industrialized and in developing countries. However, such planning is required if a program is to chart a course toward increasing sustainability. Policies that foster strategic planning and more targeted resource allocation include requesting that Ministries of Health and Finance allocate sufficient funds (current and future) for family planning. In this case, "sufficient" means the amount required to serve the entire population in need of subsidized services, rather than the amount required to maintain the current level of services. In addition, strategic planning implies that the role of the private sector is recognized. A strategic planning process of national program as a whole will flourish if strong working relationships exist among the key players who grow to rely on the data and analysis, and who undertake joint decisionmaking to solve common problems.

To assist in strategic planning and appropriate resource allocation, donors can fund analyses of short-, medium- and long-term demand and resource requirements. These analyses can estimate the resources required to support various levels of contraceptive prevalence, and various source and method mixes. Donors can sponsor studies of the various providers of family planning services, to help planners understand the current and potential contributions of commercial outlets and private voluntary agencies. In addition, donors can provide technical assistance and operations research to identify cost-effective means of service delivery for various segments of the population.

- ***Decentralization and responsiveness to local and regional needs***

In most countries, decentralization of health and family planning services requires policy change at both national and local levels. In particular, existing policies about who makes decisions, who has control over resources, and who is accountable for program inputs and outputs often must be analyzed and changed to make decentralization work.

Donor assistance in decentralization efforts includes direct technical assistance to rewrite policies, based on experiences in similar settings. Donors can bring consultants to assist the government in clarifying the roles and responsibilities of various actors. In addition, donors can provide training, particularly in the areas of budgeting and planning, and other assistance for implementation of decentralization. Donors also can provide support for pilot tests in experimental areas.

- ***Participation of the private sector in delivery of family planning services***

One of the most important dimensions of a sustainable family planning program is involvement of the private sector in delivery of family planning goods and services. The private sector can serve nearly all segments of society, and can be a valuable partner in expanding access to services and in social marketing of contraceptives. A range of policies affect the willingness of private providers to deliver such services and commodities. One of the most important ways in which national policy can promote private sector participation is to target publicly subsidized services to those who would not otherwise seek services from the private sector (e.g., those who are too poor to pay). Targeting of free or below-cost services can shift users who can pay to private providers, and create a significant demand for additional private services. In many instances, the demand for services will induce an expanded supply. In addition, governments can provide low-interest loans to entrepreneurs who are willing to provide services in currently underserved areas. Governments also can loosen restrictions on insurers and other financing agents to promote coverage of family planning services.

Donor assistance in fostering a favorable environment for private sector services includes funding analyses of current constraints on the private sector (e.g., unfavorable import restrictions and tariffs); and technical assistance to develop a low-interest loan or insurance program. In addition, donors have extensive experience in assisting with the organization of social marketing projects, and either can initiate such activities with technical assistance and donated commodities, or they can help to move existing CSM projects to new levels of self-sufficiency by integrating them with commercial procurement and distribution agents.

- ***Generation and maintenance of demand for appropriate family planning goods and services***

One of the central roles of the public sector is to generate and maintain demand for family planning goods and services, particularly at the early stages of a program's evolution. Policies directly related to family planning that may require creation or modification include those related to advertising restrictions, and public funding for mass media and other promotion of family planning. On a broader plain, the government may find that it is important to modify policies related to the social environment. For example, increasing attention and funding for girls' education, increasing expenditures for reproductive and child health care, and changing inheritance laws may all have important implications for generation and maintenance of long-term demand for family size limitation.

Donors can assist with both the direct and the indirect aspects of demand for family planning services. For example, donors have a long history of providing technical assistance and funding for development of information, education and communications campaigns that are culturally appropriate. Donors also can provide funding and technical assistance for expansion of female education and improvement in all types of basic health care.

- ***Public sector targeting, resource mobilization and efficiency***

To increase sustainability of service delivery through the public sector, three of the primary requirements are a functioning targeting mechanism, mobilization of financial resources, and reductions in inefficiencies. Each of these may represent undertaking major policy and operational reforms, such as instituting a user fee system with waiver mechanisms for the poor, or reorienting staffing practices.

There are several contributions that donors can make in this arena. For example, technical assistance and applied research can be undertaken to identify the principal target groups and develop sound targeting mechanisms. Implementation issues that may have to be resolved before start-up, including: how to keep funds at the local levels if the law requires them to go to the central treasury; how much to keep; how to secure funds; and how to account and have accountability.

Implementation of a user fee system can be enhanced through careful demand studies initially, and then on-going assessment of changes in utilization. Training can be provided to financial managers as they assume new responsibilities for collecting and managing revenues. And technical assistance can assist program managers identify opportunities for quality improvements with revenue that is generated.

To assist program managers decrease the costs of production, donors can provide

technical assistance to design training to lower-level workers to increase their ability to counsel and/or deliver services. And they can directly aid in developing competitive tender mechanisms to decrease commodity costs.

In all areas of efficiency, donors can sponsor operations research to answer specific questions about the most cost-effective means of information dissemination and service delivery.

4.2. Options for Organizational Sustainability

The elements of organizational sustainability described in earlier sections of this paper are: developing an accurate estimate of the sustainability gap, and then instituting various measures to increase revenues and/or decrease costs of delivering services. This can be done only within a sound institutional context that is responsive to consumer demand. As is true at the national level, for each of these elements organizational leadership can assess the relevant policies currently in place and, if necessary, take steps to improve the organizational environment. Examples of changes in operations that are associated with each of the elements are listed below. Also described are the ways in which donors can provide support for organizational reform.

- ***Measuring the sustainability gap***

Managers of private voluntary organizations can take several steps to estimate the revenues they will need if and when public sector subsidies cease. These include carrying out a careful cost study and/or budget analysis, and assessing all sources of cash and in-kind revenue.

Donors can be of assistance as organizations undertake this "diagnosis"; specifically, they can provide technical assistance to aid PVOs to establish cost and revenue baselines, and develop a business plan for closing the "sustainability gap."

- ***Increased revenues***

There are several means of generating revenues. User fees can be imposed for family planning and/or for related services. Toward this end, donors can sponsor market research efforts to assess demand; provide technical assistance to develop reasonable price schedules; and provide training in financial management.

In addition, organizations may have to put into place an explicit policy of seeking funding from a wider range of sources. Donors can fund technical assistance to aid with identification of alternate revenue sources, analyses of the ability of the organization to tap those sources, and development of a strategy to attract sources of private funding. Donor funds may even be available for the promotional materials required for fundraising campaigns.

- ***Decreased costs***

Myriad operational policies may require modification to promote an environment in which efficiency and quality of service delivery is rewarded. For example, there is often a need to reform personnel policies, so that they are more flexible and allow reward for merit rather than simply for seniority. There may be a need to change bureaucratic procedures to ease the paperwork burden on line workers and managers. And it may be necessary to devolve some authority from top level program managers to staff closer to the operational level.

Donors can provide technical assistance for rewriting of personnel and other operational policies within organizations, following an analysis of the advantages and disadvantages of the policies currently in place. Again, they can fund operations research to identify the most cost-effective means of services delivery. Once those modes of delivery are identified, donors can provide training and financial support to aid in implementation of new ways of delivering services.

- ***Increased management capacity***

To improve the financial management and planning at the organizational level often requires a change in policy from incremental to strategic budgeting. To plan effective strategies to achieve sustainability, and to adapt to changing circumstances, organization managers need to have a constant flow of information about the efficiency of service delivery, the performance of personnel, the satisfaction of clients and the unmet demand for services. Obtaining such information may require a revamping of existing systems of data collection and use of monitoring information.

To assist with these efforts, donors can provide management consultation and training in strategic planning and budgeting. Donors can provide technical assistance, training and management consultation to establish and maintain functional monitoring, evaluation and feedback routines.

- ***Improved quality of services and responsiveness to consumer demand***

One of the most immediate problems facing organizations as they try to move toward sustainability is the need to generate client payments and greater demand. The willingness of clients to use services, and particularly to pay for services, is closely related to the actual and perceived quality of care provided. As organizations move away from reliance on donor funding, and toward a more private sector approach, they often must reorient their delivery of services to satisfy current clients and attract potential clients. This may require such operational reforms as providing tangible incentives for service providers to improve their responsiveness to clients' felt needs, changing working hours so they are more convenient for clients and improving amenities in clinics.

Donors can assist organizations by carrying out studies to identify consumer preferences and indicators of quality, from the clients' perspective. They can assist with training of staff to improve relations with clients. And they can finance clinic renovations, if necessary.

4.3. Designing in Sustainability

Too often, evaluators of international donors' bilateral population projects conclude that, however worthy the efforts undertaken, there is little chance that the benefits of the projects will continue to be generated after the project expires. They often note that without donor funding, technical assistance and enthusiasm, the doors of a private voluntary organization will close. They predict that in the absence of large shipments of donated contraceptives, the public sector will be unable to stock its shelves and meet the demand that has been generated. And they project that the need for international assistance by organizations and programs as a whole will only increase if the project is continued into the future.

In making such gloomy predictions about the lack of sustainability of donor-initiated and/or -funded efforts, evaluators may cite several design flaws that make the organizations receiving funding inherently unable to operate independently. This may range from failure to institute a user fee mechanism, to a lack of incentives for efficiency, to a "crowding out" of commercial domestic manufacturers of contraceptives.

All too often, designs for donor-funded family planning projects omit important elements that would increase the chances that the project will contribute to the long-term goal of increased sustainability of the family planning program. Concerns about institutionalizing management capacity and fitting into a functioning market for goods and services are overshadowed by more immediate perceived needs to build up the public system, support the good works of non-profit organizations, and increase overall demand and prevalence.

Fortunately, there are ways to take long-term sustainability concerns into account in project design without sacrificing the ability of the project to have a positive short-term impact on contraceptive use. And many of these elements of project design have benefits even beyond creating an environment in which family planning services can become institutionalized and independent. By paying careful attention to demand and taking full advantage of the existing networks of services, family planning projects can achieve more with fewer resources.

In this section, we provide some basic and simplified guidelines for project designers to consider as they develop plans for sectoral activities and/or for individual PVOs. These are by no means intended to be comprehensive; rather, they are intended to constitute the *minimum* that is required to ensure that project design takes sustainability concerns into account.

4.3.1. Sectoral Project Designs for Programmatic Sustainability

When full sector projects are designed, the main task is a strategic one: to assess the current and potential roles of each of the types of family planning providers, and seek ways to encourage the most cost-effective and appropriate mix.

1. Carry Out Demand and Supply Studies in Preparation for the Project Design

- Assess the current demand for family planning services, by type and method. Demographic and Health Survey or similar data provides rich information on who is seeking services, and from whom. This will provide a sense of whether demand is low or high, increasing rapidly or holding steady. It also will show how large a role the various sectors (public, not-for-profit and commercial) currently play in contraceptive prevalence. These, in turn, will provide basic information about the potential for moving toward sustainability. In countries (or regions) where demand is relatively high and/or steadily increasing, and there is considerable participation of private sector actors, the potential is high. Project designers should actively seek out ways to take advantage of the existing demand for private services, to relieve the public sector of having to deliver services to those who can pay for their own care.

A "market segmentation" study can define the key segments of the family planning market--i.e., the very-poor, who are candidates for publicly-sponsored services, the low-to middle-income, who may be appropriate consumers of socially marketed contraceptives, and the upper-income, who should obtain unsubsidized services from commercial providers. This sort of study is a key input into any targeting effort.

- Assess the supply networks for family planning services. Supply analyses would examine how many public and private outlets are delivering family planning services, and describe what type of services they are providing. Again, this will give useful information about the potential reach of public and private providers. Clear geographic differences may appear, suggesting that there is room for dependence on private services in one region, but not in others. Again, this can be important information for public sector targeting.
- Analyze legal and regulatory constraints. Since the key to a sustainable program is likely to be the existence of a broad set of family planning providers, it is useful to identify any legal or regulatory constraints to participation of the private sector. Information from such an analysis can be used to develop project activities that have the intent of promoting regulatory reform.
- Estimate public and private expenditures on family planning. Using both household survey data, and government and donor budget information, it may be possible to estimate total expenditures on family planning, by public and private sources. This type of analysis will indicate whether the program currently is broadly based, or whether it is

disproportionately dependent on the public sector.

2. Target Public Monies.

Donor spending, like all public funding, must be carefully targeted to the population groups deemed of most importance who would not seek family planning services in the absence of a subsidy. Using the information from the studies listed above, project designers can determine, in general, the best delivery systems to support. That is, which providers are serving important target populations *and* require outside support to continue to do so?

It is critical to note that just as host-country governments can distort the market with universal subsidies, so can international donors. Donors, like host-country governments, can "crowd out" the private sector. The example of donated contraceptives shows this most clearly. In countries that have received large shipments of "free" contraceptive commodities, the incentives for domestic commercial manufacture have been reduced.

3. Generate Political Support

In large sectoral projects, particularly those involving Ministries of Health or similar institutions, there is no chance that the project will continue without donor funding *unless* political leaders perceive that the project brings tangible benefits. This implies that such leaders should be fully informed about the successes of the project as it is underway. Designers can build into the project a means of disseminating information and generating a political constituency for the work.

4. Allow Host-Country Governments to Diversify their Funding

Project designs should have as few restrictions as possible on alternative sources of funding for the project activities. That is, governments should be permitted (and encouraged) to find other donors and additional public support, and to generate revenues with user fees and similar mechanisms. No (or few) prohibitions should be placed on instituting user fees, and targeted technical assistance should be provided to assist governments as they seek alternative sources of funding.

5. Use Local Resources

The supply analyses described above will provide a picture of the existing public, not-for-profit and commercial providers of family planning and support services. With this information, project designers should be asked to arrive at creative ways to use those local resources, rather than creating entirely new structures. A central objective of project design should be to make investments *at the margins* to achieve increased access to services for key population groups.

6. Develop Benchmarks for Sustainability

Even when sustainability is not a central objective of a project, it should be recognized as an important long-term goal. It is useful to build in a few evaluation indicators that measure the extent to which the project has increased or decreased overall dependence on external assistance.

4.3.2. PVO Project Designs for Organizational Sustainability

When projects for individual private voluntary organizations are designed, the main task should be to clarify the mission of the organization, ensuring that it is appropriate for public financing. Then, the design can enhance the organization's ability to operate independently by building in incentives for efficiency.

1. Carry Out Utilization and Management Studies in Preparation for the Project Design

- Assess the current use of family planning services, by type and method. Service statistics, household survey and other data can be used to figure out which population(s) are being served by the organization seeking funding. This will help to clarify whether the organization is filling a special niche, or whether it is competing with the public and/or commercial sectors.
- Assess the management capacity of the organization. Movement toward sustainability is impossible, or at least unlikely, in the absence of functional and responsive management. Therefore, it is very useful to conduct an assessment of the extent to which the current management is able to run an efficient operation, allocate resources appropriately, monitor activities, and perform other management functions. If deficiencies are noted, it would be important for the project design to build in management-strengthening components, including appropriate technical assistance.
- Analyze the financial status of the organization. To the extent that data will allow, it is extremely useful to estimate the size of the "sustainability gap"--the difference between the revenues generated from non-donor sources and the costs of providing services. In doing so, it may become apparent that there are major efficiency savings to be made, and/or that there is considerable potential for additional revenue generation.

2. Clarify the Organizational Mission

Any organization that is receiving public funding should be able to state, in concrete and quantitative terms, what target population is being served that would not otherwise seek services, either in the existing public or the commercial sectors. The organization and the donor must be able to agree on this mission, and use it to set performance targets for the duration of the project.

3. Encourage the Organization to Save Money Diversify Its Funding

As is true at the national level, there should be few restrictions placed on instituting efficiency-enhancing measures, imposing user fees, seeking other donor funding, or taking any other approach to raising money to cover operating and capital costs, *if* such steps are taken in such a way that they do not impede the organization ability to serve the target groups identified. Toward this end, operations research and other pilot efforts built into projects can help to provide information on how to save money and take advantage of consumer demand.

4. Develop Benchmarks for Sustainability

Again, even when sustainability is not a central objective of a project, it should be incorporated into the project monitoring and evaluation. Decreasing dependence on donor funding should be recognized as a significant accomplishment; lack of movement toward independence should be seen as cause for concern, and perhaps rethinking of project design.

4.4. Conclusion

In the main body of this paper, we have attempted to present an overview of the elements and determinants of a sustainable family planning program. We also have described the major ways that private voluntary organizations can seek to close the "sustainability gap," and move away from over-dependence on donor support. We have highlighted some ways in which donors can promote long-term autonomy--and avoid some of the common mistakes in project design.

In our effort to present a clear picture of important aspects of sustainability, we may have downplayed the difficulties. As the following case studies will show, there *are* success stories in programmatic and organizational sustainability--but there are no easy answers. Each setting presents its own set of challenges, and progress may be slow. In every country, however, donors can provide *opportunities* for the recipient government or organization to best use local resources to meet local needs.

DRAFT FOR MISSION REVIEW

**Sustainability of Family Planning
Programs and Organizations:
Meeting Tomorrow's Challenges
Case Studies**

**Prepared by the OPTIONS Project
for USAID/Rabat**

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INTRODUCTION

Choosing appropriate subjects for case studies of the sustainability of family planning programs has proven to be no mean feat. The difficulties are several:

- First, it is challenging to arrive at representative cases or generalizable lessons. No two settings are identical in the prevailing cultural, economic and political environments; fertility and health conditions; contraceptive prevalence; method and source mixes; consequences of rapid population growth; and supply of services. Therefore, options that are feasible in one country may be unthinkable in another.
- Second, there are few countries about which we have information that are sustainable, in a meaningful sense. Most of the information available pertains to countries in which international donors have had an active interest. Therefore, almost by definition, many countries we know about have made limited progress toward sustainability.
- Third, sustainability is a relatively recent concern of donors and governments. As such, there have been few experiences in moving toward financially and institutionally independent operations--successes or failures. There are very few countries in which there is a sufficient track record with user fees, efficiency improvements, concerted targeting efforts, and other approaches.

Despite these obstacles, it is possible to learn from the experiences of specific countries. While the actions taken may be setting-specific, the general approaches--for example, how political commitment was generated--can be more widely applied. Thus, we have chosen three countries to examine closely, and to illustrate specific ways in which progress toward sustainability has been made. These are Thailand, Indonesia and Colombia. All are "mature" countries, with relatively high levels of demand and widespread service delivery infrastructures. And each is attempting to move away from high levels of donor support, and toward full autonomy of the family planning program.

- △ Thailand: An examination of Thailand provides insights into how strong underlying demand, combined with concerted government action, can lead to high and sustained contraceptive prevalence. Though the Thai program initially received substantial amounts of donor support, it has moved to being a self-sufficient effort. The example of Thailand shows that if the national government has a strong commitment to the program, it can mobilize significant national resources to support public sector service delivery, even in the absence of donor support. In addition, the experience of the Thai program shows how operations research studies in pilot areas can lead to enhancement in the efficiency and effectiveness of family planning services.

- △ Indonesia: The Indonesian experience highlights the potential role that a strong and well-placed family planning coordinating agency can play in generating and maintaining political support. It shows how demand generation can contribute to sustainability. And it demonstrates the efficiencies that can be obtained through social marketing.

- △ Colombia: Colombia's program exhibits an example of an inter-sectoral collaborative effort among the public, private voluntary, and commercial sectors. In the Colombia case study, we focus primarily on the role of PROFAMILIA, a private voluntary organization that is recognized by the government as a provider to key target populations. Lessons can be drawn from PROFAMILIA's successful attempts to expand its base of financial support.

CASE STUDY 1: THAILAND

This section reviews the experience of the Thailand National Family Planning Program and examines the long term prospects for the sustainability of its activities. While many have attributed the success of the Thai program to factors which are unique to the Thai culture and the events of the last three decades in Thailand, it is useful, nevertheless to examine the Thai experience for insight into programmatic policies and actions which contributed to a strong, successful program independent of donor support.

Thailand has achieved one of the most rapid fertility declines experienced by any country (Bennett et al 1991). The total fertility rate declined from 6.3 in the early 1960s to approximately 2.4 today. The total population grew from 26.4 million to 53.6 million during this same period. (See Table I for an overview of conditions in Thailand.)

Because of the rapid decline in fertility, the current population of Thailand is several million less than would have been the case had fertility remained at high levels. What are the reasons for this dramatic change in people's reproductive behavior? And how has the Thai government succeeded in meeting the strong demand for family planning to make this change possible?

The success of the Thailand National Family Planning Program (NFPP) has been attributed to the very high demand for family planning of the Thai people (Bennett et al 1991). Decreases in fertility were evident amongst the urban population in the early 1960s and among the rural population in the late 1960s. The NFPP became fully operational in the early 1970s.

The declines in fertility have been attributed to rapid improvements in education, increasing mobility and awareness of the population, as well as significant reductions in the levels of infant and child mortality (Bennett et al 1991). The political commitment to efforts to address rapid population growth was critical, however, to mobilizing the resources and providing access to the services required to meet the growing demand for family planning. This strong political commitment has built and continues to support a strong and effective family

Table I A Statistical Overview of Thailand

Population ^a	57.2 million
Per Capita Income ^a	US\$1,580
Female Persistence to 4th Grade ^b	71%
Infant Mortality Rate ^a	40 per 1,000
Contraceptive Prevalence Rate ^a	64%
Total Fertility Rate ^d	2.4 births per woman
Method Mix (Methods over 10%) ^c	FVSC, pill, injection, IUD

SOURCES

- a Population Reference Bureau 1993
- b World Bank 1991
- c Based on calculation of all methods adding to 100% of utilization

planning program.

The NFPP has grown rapidly in the past two decades. Overall prevalence in Thailand has increased from 8 percent in the 1960s to 64 modern method prevalence percent today. Challenges to the program still remain in promoting family planning use among hard to reach populations. The NFPP provides services to four of five family planning users in Thailand. Consequently, the government shoulders a large burden for the costs of the program. This burden has increased both with the growing demand for family planning and the increasing proportion of program support provided by the Thai government. In 1982, the government began to take on the program support previously provided by donors. As of 1990, the NFPP received minimal donor support.

While the NFPP has achieved tremendous success both in terms of meeting high demand for family planning with quality services and providing government support for program activities, there are still large challenges before the program in continuing to provide these services. The government is the primary supporter of the program and bears substantial costs for providing services. From 1985 to 1990, the cost to the government doubled as costs of the program grew and as the government increased its share of program funding. While future cost increases will not be as great, costs to the government will continue to be significant.

To ensure the sustainability of the program, efforts must be undertaken to diversify its financial base. Opportunities for generating resources for the program from alternative sources through client payments or increased private sector delivery have not been explored due to the government commitment to ensuring access to services. Currently, there is some cost recovery in terms of fees charged for contraceptives, however, it is quite limited. The private sector plays an important, though very restricted role in service delivery. In the future, as government resources become increasingly strained, client payments will need to be imposed to ensure the long term sustainability of the program.

Improvements in the efficiency of resource use will also be needed. The program is currently undertaking efforts to improve efficiency both in terms of resource management and increasing the cost effectiveness of the method mix. These efforts will also strengthen the sustainability of the program and ensure its continued success. The following overview of the experience of the Thailand National Family Planning Program provides insight into the policies and actions which enabled the program to attain its current independence from donor support.

Background

Programmatic History. Up until the early 1960s, Thailand was a pronatalist country with fertility levels of approximately 6.3 to 6.6. Two events--the higher than anticipated results of the 1960 census showing the population to be 26.4 million and the recommendations of a World Bank Economic Commission linking population growth with economic development--stimulated an awareness of the importance of population growth and generated political commitment for

population activities. This culminated in the approval of a national population policy in 1970 and the formation of the Thailand National Family Planning Program.

Policymakers were committed to population efforts because of the economic rationale for family planning. They saw that a reduction in population growth was critical to the economic development of the country. This rationale built a broad-based consensus for the family planning program and ensured continuous political commitment for program activities. While it required seven years for a formal policy to be developed and approved by the cabinet, this period was critical for the program. During this time, the Potharam Experiment--a pilot project conducted in Potharam province in the 1960s--demonstrated that there was strong demand for family planning services in the rural areas and that ambulatory medical workers provided an effective means of distributing services to this dispersed population. The success of this project contributed to the dialogue and debate leading up to the promulgation of the National Population Policy and strengthened support for it.

The National Population Policy created the Thailand National Family Planning Program. Although, the NFPP is located under the Ministry of Public Health (MOPH), the program is organized as a vertical program. The Family Health Division of the MOPH was given managerial responsibility for the program. All bilateral and multilateral resources are programmed through this division and all program activities--including logistics, procurement, training, IE&C and research--are managed by this division. So many resources were directed to family planning that it soon became the priority of the Family Health Division at the expense of other maternal and child health interventions.

The MOPH infrastructure of hospitals, clinics and midwifery centers is used for the provision of family planning services. This has provided a large and extensive distribution network for services. This structure of using MOPH facilities while retaining control and management of family planning resources in a single division has provided the program with two distinct advantages. First, it provided access to a vast network of service distribution points in a very cost effective way. Second, it ensured that resources would be directed toward family planning efforts and that family planning would remain a priority rather than becoming one of many competing responsibilities within the health delivery system.

The goals of the NFPP have evolved over the life of the program. They are quantified in terms of targets for population growth and numbers of family planning acceptors and users which are included in the country's five-year development plans. In the early 1970s, the NFPP sought to provide services to those people who requested them. Because of the high latent demand, the emphasis was on providing services. By the late 1970s, this emphasis evolved to include demand generation efforts such as mass media radio campaigns. The current emphasis is on improving continuation rates and increasing the method effectiveness and cost effectiveness of the program. The 1991 development plan includes targets of 1.3 percent population growth and 6.6 million new acceptors.

Several aspects of the program have contributed to its ability to meet existing demand as well as generate new demand. Foremost among these is the provision of quality services. The NFPP has a large well trained staff which provides services competently. Training has always been emphasized in the program resulting in committed staff who perform their jobs effectively. Another factor contributing to the success of the staff is the high percentage of female nurses and ambulatory medical workers--this has been very attractive to clients. Delivery of a range of methods through an extensive network of facilities has also contributed to the success of the program. These facilities are accessible through the good road network in Thailand. Access to services has been expanded beyond this wide network of facilities by authorizing ambulatory medical workers to provide services and implementing extensive outreach efforts. Throughout the history of the program pilot projects have been used to test the effectiveness of program strategies prior to launching them on a large scale. Research is used in planning to ensure that target populations are identified, strategies for reaching them are tested, and resources are used efficiently. Finally, important contributions of dynamic leaders have strengthened the program and built broad support for its activities.

Source Distribution. The majority of family planning users obtain their services from the public sector. The 1987 Demographic and Health Survey (DHS) showed that 83.6 percent of family planning users received services from government run facilities, 14.8 percent used commercial providers, 0.8 percent NGOs and 0.8 percent other sources. Of family planning users using clinical methods, 92.9 percent obtained services from public facilities and only 7 percent from commercial providers. For users of supply methods these figures were 75.5 percent and 21.6 percent respectively. The private sector plays a very limited role providing condoms and pills through pharmacies and the injectable through private clinics. About 46 percent of condom users, 28 percent of pill users and 12.8 percent of users of injectables obtain their supplies from commercial sources.

Knowledge of private sector sources for family planning services is not as high as that of public sector sources. When asked of sources for the pill only 18 percent of women surveyed named private sector sources as compared with 75 percent who named public sector sources. These percentages were 81 percent and 12 percent respectively for the injectable and 65 percent and 20 percent for the condom.

While private sector provision is quite limited it plays an important role. In urban areas, the private sector is the primary source for women using the pill. In the rural areas, government health centers continue to be the main source. This is attributed to greater accessibility to private sector sources in urban areas and the increased importance of time and convenience to urban women (Siriboon and Saengtienchai 1989).

Fertility Changes and Demand for Family Planning

As stated earlier, Thailand has experienced a dramatic decline in desired family size and in levels of fertility. These declines in fertility and desired family size became apparent in the

early 1960s and have continued to the present date. In the late 1960s, rural women desired 3.2 children and urban women 3 children. This decreased to 2.4 children and 2.3 children in 1984. These numbers indicate the convergence between the urban and rural populations.

Discrepancies in fertility and desired fertility levels continue to be apparent, however, between the different religious groups. In 1987, 69.7 percent of Buddhist women surveyed were using family planning. This compared with only 35.1 percent of Muslim women. Responding to this, the NFPP has introduced an outreach program targeted towards Muslim women.

Fertility is currently estimated to be at replacement level. While much of this fertility decline has been attributed to improvements in education and general economic development, studies have demonstrated the important impact of the NFPP. An estimated 53 percent of the decline in fertility which occurred between 1962 and 1980 and 68 percent of the decline between 1972 and 1980 has been attributed directly to program activities (Chao and Allen 1984).

Method Mix

More than half of the users of family planning in Thailand are using long term methods. Currently, female sterilization is the most commonly used family planning method: 33 percent of women using family planning are sterilized, 30 percent of users are using the pill, 14 percent the injectable, 11 percent the IUD, 8 percent male sterilization, 2 percent the condom and 3 percent other methods (DHS 1987). As shown in Table II, this represents an increase, particularly in IUD use, compared to 1984.

The most popular methods have changed over the life of the program. From 1965-1969 the IUD was the most commonly used method. In 1970, it was female sterilization. From 1972 to 1984, the pill was the most used method and from 1984 to date female sterilization is the most popular method.

These shifts largely resulted from changes in the program. For example, initially the IUD was the most accessible method. In the early 1970s, authorization of ambulatory medical workers to distribute the pill resulted in increased use of the pill. The

Table II Contraceptive Method Mix, 1987

Method	1984	1987
Pill	19.8%	20%
IUD	4.9%	7.2%
Male Sterilization	4.4%	5.5%
Female Sterilization	23.5%	22.4%
Injection	7.6%	9.2%
Condom	1.8%	1.2%
Others	2.6%	2.0%
All Methods	64.6%	67.5%

SOURCE: Thailand Demographic and Health Survey 1987

recent increase in the use of the injectable has been attributed to the 1985 authorization of ambulatory medical workers to distribute the injectable.

Current program efforts are directed toward increasing the cost effectiveness of the method mix. This includes shifting the method mix toward long term methods, as well as determining the most cost effective means for providing them. By shifting users of the pill towards sterilization, recurrent costs of the program will be reduced. In addition, the decline in the age of acceptance of sterilization to 29 has increased the average period of protection for that method and consequently increased its cost effectiveness.

Government of Thailand and Donor Support

The NFPP has never been constrained by resource shortages. Historically, it received a great deal of support from donors and from the Government of Thailand. Initially, the program was heavily supported by donors. Now, however, the GOT supports more than 97 percent of the program cost.

Up until the mid-1980s, the program received significant support from donors. Initially, the World Bank raised awareness of the need for population activities. The United Nations provided important resources for the implementation of pilot projects. In the early 1970s, a \$60 million World Bank loan stimulated government investment in the development of rural health centers providing a critical boost to program efforts.

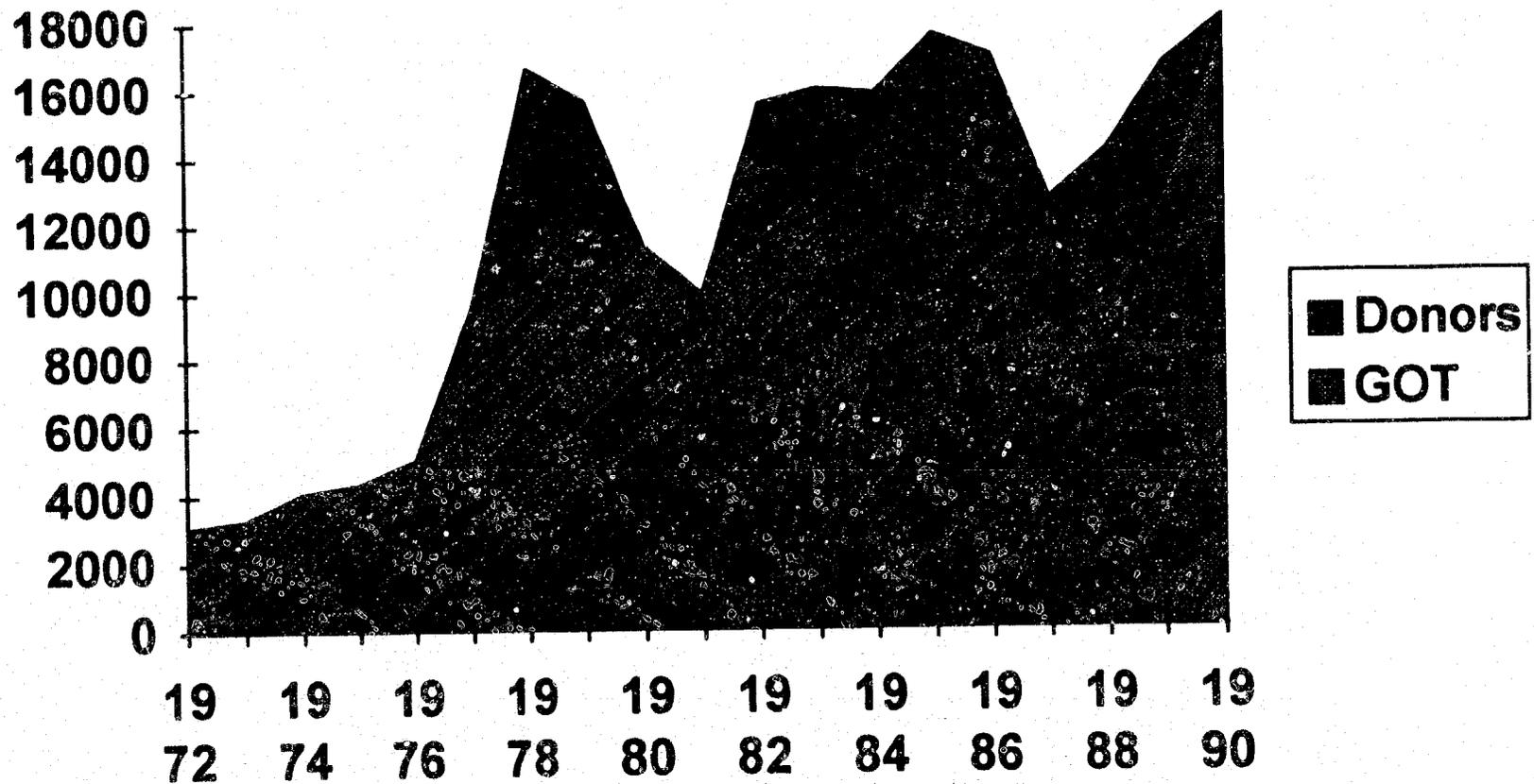
Thailand has been a very attractive country for donor investment. The ease of investing, the collaborative spirit of the people, and a reputation for successful donor supported projects have all contributed to attract significant support for development activities. USAID has provided half of foreign assistance funds to the NFPP, contributing approximately \$57 million since 1972.

Although much of the financial support was provided by donors, the Thais managed and coordinated all support and technical assistance. By directing all resources through the Family Health Division, the Thais maintained a firm hand in the management and coordination of activities. This ensured that activities were appropriate for the Thai environment and built a strong sense of ownership for the program.

In 1982, the Government of Thailand quadrupled its budget for family planning and began to procure its own commodities. From 1982 to 1989 the GOT share of program support increased from 51.5 percent to 97.8 percent of the program budget. In absolute figures, GOT spending increased from \$7,995,600 to \$17,588,000 during this period (see Figure 1). As a percentage of total health expenditures, family planning increased from 1.2 percent of health spending in 1980 to 2.81 percent in 1987. As a percentage of total government spending, family planning spending increased from .05 percent in 1980 to .12 percent in 1987. While this strong government support for the program has assured continued support, it has also greatly increased

FIGURE 1.

Thailand National Family Planning Program Budget (thousands)



Source: Bennett et al. 1991

the cost burden to the government.

Subsidization and Equity Issues

The Thai NFPP has been extremely successful in meeting high demand for services and providing good access to services. Knowledge of family planning is almost universal and contraceptive use is very high. While the program has had tremendous success in increasing prevalence, meeting the need for family planning and mobilizing resources to provide quality services, it must now shift its focus towards diversifying its financial base in order to ensure long term sustainability. Because of the government emphasis on providing free services, many people who could and would pay for services are obtaining them at the expense of the government.

Women in Thailand are willing to pay for family planning services. Up until 1976, fees were charged for pills, IUDs and sterilization procedures (Knodel et al 1984). A cycle of pills cost 5 Baht, an IUD insertion 20 Baht, a vasectomy 50 Baht, and a tubal ligation 20 Baht (20 Baht was the equivalent of \$1). These prices were in effect at the early stage of the program when family planning users were primarily women of higher socio-economic status. To reach a broader spectrum of the population, this pricing policy was modified. In 1976 the NFPP introduced a policy to provide pills free of charge in public outlets and IUDs and sterilization procedures for free at public sector outlets in rural areas. Despite this free pill policy, minimal fees are occasionally imposed for the purchase of pills from public outlets (Sanderson and Tan 1992). About 40 percent of users obtaining services from public outlets reported paying a fee in 1987. Urban women were more likely to report paying a fee than rural women.

Although fees charged in private sector outlets are more than a third of those charged in public sector outlets, urban women are more likely to purchase their pills from a private sector outlet. (Siriboon and Saengtienshai 1989). Convenience is clearly more important to urban Thai women than paying a minimal fee.

With the introduction of the free pill policy in 1976 there was concern that women would shift sources or methods--from one which required a fee to one which was subsidized--and that overall prevalence would not increase. In fact, this switching did not occur and prevalence increased with the availability of free pills. Clearly, women are willing to pay for family planning services.

While there is evidence that Thai women are willing to pay for services, there is limited information about the price they are willing to pay. Even imposing a minimal fee for public sector services, however, can provide substantial resources to the program. Analyses suggest that an increase in public sector fees for pills and sterilization procedures can reduce public spending for family planning services by 25 percent and not reduce prevalence (Ashakul 1989). Even if the minimal fee of 5 Baht--charged before the 1976 policy--were collected, \$2.25 million in public sector revenues would have been generated by pill sales in 1982 alone (Knodel et al

1984). While this figure does not reflect administration costs, it does highlight the potential for cost recovery in the Thai program.

Pricing policies can be used to recover a portion of the cost of services as well as direct users towards more effective and appropriate methods. In public sector outlets where fees are currently collected, the fees charged for IUD insertion and sterilization procedures are less than those charged for pills (Sanderson and Tan 1992). The relative price of each method can be used as an incentive to encourage the use of more cost effective methods. In addition, changing the pricing policy in the public sector would reduce the "crowding out" effect constraining the private sector (Sanderson and Tan 1992).

The private sector is greatly underutilized--providing less than 25 percent of the market for non-clinical methods. This share is smaller than the private sector share of the market for nonclinical methods in Bangladesh--a lower income country where one would expect the private sector market to be much less developed than in Thailand. Introducing these policies to generate additional resources for the program would improve the efficiency of the program and allow public resources to be targeted towards harder to reach populations.

Efficiency of Resource Allocation

The NFPP has taken very pragmatic approaches to achieving program goals by testing new strategies in pilot projects and conducting research to determine the most efficient means of delivering services. This has improved the efficiency of resource use. Current efforts to improve efficiency include decentralization of program management and efforts to increase the cost effectiveness of the method mix.

In the mid-1980s, the NFPP initiated pilot projects to test the feasibility of decentralizing authority for budgeting and planning from the central to the provincial levels (Kamnuansilpa et al 1992). Under the pilot study, decentralization was introduced in six provinces to test whether the NFPP would be supportive of decentralization and whether provincial level staff could plan and manage program activities effectively. The study was designed to determine the impact of decentralization in reducing the cost of service provision and increasing the speed with which program objectives of increasing the use of longer term methods could be reached. The results of the project were quite successful. Increases in the use of longer term methods were achieved more quickly in the test provinces and the costs per couple year of protection (CYP) declined more rapidly. In the test provinces the average cost per CYP was \$0.66 as compared to \$0.87 in the control provinces. Decentralization of program management is now being implemented in additional provinces.

The NFPP is currently working to improve the continuation rates of supply method use and encourage the use of long term methods. These efforts include improving counseling and quality of care to enable people to select the most appropriate methods to meet their needs and to use their methods effectively. The program has already achieved considerable success in

encouraging women to use long term methods.

Conclusions

The Thailand NFPP has been an extremely successful program. Success has resulted from the high demand for services, strong government commitment to meet this demand and the availability of donor resources to support program efforts. The extraordinary political commitment of the government continues to provide financial support for the program now that donor support has declined. As long as the government maintains its firm commitment and is willing to provide the resources the program will remain sustainable. Diversifying the financial base, however, will strengthen the long term sustainability of the program.

CASE STUDY 2: INDONESIA

This paper examines sustainability in the Indonesian context. The Indonesian family planning program is world-renowned for its innovative service delivery and information, education and communication efforts. Indonesia saw dramatic increases in contraceptive prevalence over the last two decades. Between 1971 and 1991, the total fertility rate fell by 2.6 births and contraceptive prevalence increased fivefold (Curtin et al 1992). These changes are especially striking in the context of Indonesia's low per capita gross national product (\$610) and its predominantly rural and Islamic population. (See Table I for an overview of conditions in the country.)

What ingredients have been critical to the success of the Indonesian program? The program has benefitted from: accompanying economic development, evidenced by significant increases in female educational attainment; strong political support, at the presidential and local levels; cooperation and involvement of the religious community; large and ongoing government commitments of financial resources; significant financial support from donors; innovative leadership within the family planning program; and the Javanese tradition of community participation and valuing the social good.

While the program has achieved tremendous progress, contraceptive prevalence and fertility goals for the year 2000 are far from current levels and will require major increases in family planning users over the next decade. Furthermore, the government has a high recurrent cost burden for family planning services because users are heavily dependent on government subsidies and resupply methods.

Sustainability is considered primarily from a resource standpoint: i.e., the diversity of funding sources for the program, the level of the public sector's recurrent cost burden, the degree to which public sector subsidies reach targeted groups, and the extent to which public sector resources are being allocated efficiently. After a background section that gives a historical perspective on family planning in Indonesia and describes current family planning patterns, subsequent sections address different resource allocation issues. The first addresses the government's recurrent

Table I A Statistical Overview of Indonesia

Population ^a	187.6
Per Capita Income ^a	US\$610
Female Persistence to 4th Grade ^b	78%
Distribution of Consumption (Lowest 20%) ^b	8.8%
Infant Mortality Rate ^a	68 per 1,000
Contraceptive Prevalence Rate ^a	47%
Total Fertility Rate ^a	3.0 births per woman
Method Mix (Methods over 10%) ^c	pill, IUD, injectable

SOURCES

- a Population Reference Bureau 1993
- b World Bank 1991
- c Based on calculation of all methods adding to 100% of utilization

cost burden and the program's reliance on government and donor resources. The second addresses equity and the targeting of subsidies in the program and the third focuses on efficiency issues. The final section broadens the discussion to take into account other non-economic dimensions which may be critical to the sustainability of the program and assesses prospects for the future. This analysis draws heavily on past work (World Bank 1990 and Curtin et al 1992) and on cross-tabulations from the 1987 and 1991 household surveys.

Background

Programmatic History. Prior to 1967, the Government of Indonesia took a pronatalist stance toward population policy. Family planning services were provided primarily through non-governmental organizations (NGO) and commercial channels. With the change in government in 1967 came a high-level policy concern about population growth and the subsequent establishment of the BKKBN (The National Family Planning Coordinating Board of Indonesia) in 1970. The BKKBN, as a coordinating agency, works closely with other ministries and, in particular, relies heavily on the Ministry of Health (MOH) to deliver family planning services (the oral contraceptive and condom are the only methods distributed directly by BKKBN staff).

The cornerstone of BKKBN's strategy in the early years was a model of village-based family planning, built around significant community participation and an extensive network of fieldworkers, volunteers and acceptor groups. Initially, the program focused on Java and Bali, expanding to two other sets of islands in 1974 and 1979. The village-based family planning program which ultimately operated in 60,000 villages was designed to compensate for the inadequate reach of the MOH clinic system. One indicator of the inroads made by the village family planning program is that contraceptive prevalence was actually lower in urban than in rural areas in the late 1970s, which is the reverse of what is commonly found in other countries (at the present time, contraceptive prevalence is higher in urban than in rural areas).

Beginning in 1980, the BKKBN initiated an urban family planning program. The BKKBN and foreign donors supported a variety of alternative commercial and private approaches in urban areas because urban households seemed to have a greater willingness to pay for contraceptives and a preference for private over public providers. A socially marketed condom was introduced in the mid 1980s; start-up funds were given for private freestanding and employment-based family planning clinics; and government family planning supplies were distributed free-of-charge by the BKKBN to NGO and employment based clinics. In addition, private midwives and doctors received family planning training and equipment to enable them to provide services in their private practices and ultimately, under a program called Jalur Swasta, they also received free government supplies for their private practice.

In 1988, the Blue Circle social marketing campaign was launched which promoted a new Blue Circle product line (including an oral contraceptive, an injectable, and an IUD) and private doctors, midwives, and pharmacies as sources of family planning services. The Blue Circle products were priced at a level designed to recover the costs of manufacture and distribution and

were not subsidized directly. Donor resources were devoted to the advertising and marketing of the products and services. While the Blue Circle products have made inroads into the commercial market, sales have fallen short of goals.

At the present time, a Gold Circle initiative is being launched which is still evolving (Maher and Delatour 1992). Its objectives are to expand the reach of the commercial market into rural areas and to expand the range of methods and brands available to consumers. This initiative will include a large line of commercial products which will be socially marketed. Unlike the Blue Circle campaign, the Gold Circle initiative may involve ongoing subsidies, possibly implying a high recurrent cost burden.

One of the BKKBN's strategies in recent years has been to move toward KB Mandiri (literally family planning self-sufficiency) in which contraceptors are expected to make as much of a financial contribution to cover their family planning services as they are able. This concept builds on the longstanding Javanese tradition of Gotong Royong which emphasizes the individual's responsibility to act for the social good, contribute according to one's ability and support those in need.

Source Distribution. Notwithstanding the large scale efforts to stimulate greater private sector involvement in family planning, the Indonesian program revolves around the public sector. According to 1991 household survey data, 22 percent of Indonesians relied on a private source for contraception. Of these, 5.7 percent relied on private clinics and hospitals, 1.6 percent relied on pharmacies, 10.1 percent on midwives, and 4.7 percent on physicians (see Table II).

In addition, private sector users are heavily subsidized by the government. A recent retail audit suggested that more than one third of the clients of private sector sources are relying on government commodities (Reynolds 1992). Thus, the current financial burden for contraception rests largely with public sector resources (both from donors and the GOI). In contrast to other countries, Indonesians do not uniformly rely more heavily on private sources for resupply methods compared to clinical methods. The majority of condom users, 40 percent of injectable users, almost 30 percent of female sterilization clients, and 21.3 percent IUD users rely on private sources, while only 10.5 percent of oral contraceptive users use private sources (see Table III).

Fertility Changes and Demand for Family Planning. As already noted, Indonesia has seen substantial decreases in fertility and increases in contraceptive prevalence since the inception of the BKKBN. The total fertility rate was halved between 1971 and 1991 and contraceptive prevalence in Java and Bali doubled between 1976 and 1991 (Curtin et al 1992). Desired family size was 3.2 in 1987, which was significantly lower than in earlier decades but is still above what would be consistent with replacement fertility.

Based on desired family size, the demand for family planning seems very strong within Indonesia (although actual and desired fertility levels are above replacement levels). However, we do not know what the willingness to pay for family planning services is broadly or for

Table II Reliance on Different Types of Private Sources in 1987 and 1991

Private Sources	1987			1991		
	Total	Urban	Rural	Total	Urban	Rural
Hospital	n.a. ^a	n.a.	n.a.	3.5	7.3	1.8
Clinic	n.a. ^a	n.a.	n.a.	2.2	4.2	1.3
Doctor	5.5	12.5	2.6	4.7	11.4	1.6
Midwife	4.4	6.3	3.5	10.1	13.9	8.3
Pharmacy	2.5	6.5	0.7	1.6	4.1	0.4
TOTAL	12.4^b	25.3	6.8	22.1^b	40.9	13.4

SOURCES: Indonesian Demographic and Health Survey 1991 and National Indonesian Contraceptive Prevalence Survey 1987

- a The 1987 survey did not differentiate public from private hospitals and clinics.
- b The total figures for 1987 and 1991 are not comparable because the 1987 figures did not differentiate public from private hospitals and clinics.

Table III Reliance on Private Sources in 1991 by Method and Residential Location

	Urban	Rural	Total
Oral Contraceptive	23.9	5.5	10.5
IUD	44.5	10.9	21.3
Injectable	55.3	29.9	39.0
Condom	63.4	33.8	53.6
Norplant	13.9	3.1	4.3
Female Sterilization	35.7	20.3	28.9
Male Sterilization	19.5	7.5	9.6
TOTAL	40.9	13.4	22.1

SOURCE: Indonesian Demographic and Health Survey 1991

segments of the population. Market studies of consumers of Blue Circle Products show that they draw from across the income spectrum and that in particular, Blue Circle injectable users are even drawing from the lowest income group (Smith 1992). Recent evidence suggests, though, that contraceptors, especially among low-income households may be very sensitive to price

changes (Jensen et al 1993).

It is not clear how much the BKKBN program contributed to the fertility decline since significant increases in female educational attainment occurred over the same period. However, contraceptive prevalence did increase for every educational group during the period after which the BKKBN initiated its programs (World Bank 1990).

Analysis by Gertler and Molyneaux (1993) found that changes in socioeconomic factors played a large role in reducing fertility between 1982 and 1987 and that changes in family planning inputs over the period contributed little to the fertility decline. The authors argue that changes in the demand for children that resulted from increases in educational attainment were translated into increased contraceptive use because the government has made family planning services widely available, thus permitting supply to accommodate demand. To assess the contribution that the BKKBN has made to fertility declines, one would have to examine changes over a longer time period during which supply was growing more dramatically than between 1982 and 1987. At the very least, this analysis suggests that BKKBN's efforts allowed women to realize their fertility preferences.

Method Mix. More than 80 percent of contraceptors rely on oral contraceptives, IUDs and injectables: 30 percent rely on oral contraceptives, 27 percent rely on the IUD and 24 percent rely on injectables (Indonesian DHS 1991). Less than 7 percent rely on sterilization and 6 percent rely on the implant. Analysts have argued that the program revolves too heavily around resupply methods and that sterilization is an underused method by comparison to other countries (World Bank 1990). In addition, evidence from the 1987 household survey suggests that many women who want no more births are using temporary supply methods (Galway 1990). For many reasons, the BKKBN has not been as supportive of sterilization as of other methods, so that women are much less likely to even know about sterilization much less know where to obtain one in comparison to their knowledge of other methods (World Bank 1990).

Another explanation for the relatively low reliance on sterilizations may be the high average outlay required of clients for sterilizations. Within the public sector, implant, IUD and sterilization users are more likely to be getting services free relative to oral contraceptive and injectable users which could provide incentives to contraceptors to rely on clinical methods (see Table IV). However, outlays are much higher for those who do pay for sterilizations, making the average price paid much higher relative to the average amount paid on a yearly basis for oral contraceptives and injectables.¹ From the client's perspective, public sector sterilizations cost more than 10 times the yearly cost of pills and almost 7 times the yearly cost of injectables in urban areas, and 9 times the cost of pills and 16 times as much as injectables in rural areas (see

¹ It should be noted that the yearly cost for oral contraceptives may actually be much lower than what has been estimated and presented in Table IV if oral contraceptive users are given more than one pill cycle per visit. For example, if they are given three pill cycles per visit, yearly costs of oral contraceptives would be even much lower still than the prices paid for sterilizations than it appears here.

Table IV Proportion Obtaining Method Free and Average Prices Paid (in Rupiahs) in Rural and Urban Areas in 1991, by Method and Source

Method	Urban				Rural			
	Public		Private		Public		Private	
	% Free	Average	% Free	Average	% Free	Average	% Free	Average
Oral Contraceptive ^a	32.5	3,699	8.9	20,719	37.4	2,815	29.7	7,073
IUD	63.7	1,963	13.8	28,282	73.9	340	36.4	7,038
Injectable ^a	11.0	6,824	5.0	18,075	15.4	1,609	2.1	3,044
Implant	50.4	4,638	49.4	17,937	57.3	1,809	15.9	5,332
Sterilization	31.0	46,849	7.3	165,781	42.8	25,046	47.4	30,983

SOURCE: Indonesian Demographic and Health Survey 1991

Note: These prices are calculated using the product of the proportion of family planning users who paid for services and the average price for those who paid.

a Represents yearly costs to users of oral contraceptives and injectables (assuming 13 pill cycles per year and 4 injections per year) and prices paid by IUD, implant, and sterilization users.

Table IV). To induce a greater shift toward sterilizations, it may be necessary to alter the relative prices of different methods in order to make sterilizations a more desirable option for users. According to the survey data, the IUD appears to be least expensive of all methods. The current price structure in the program may encourage pill and IUD use and discourage sterilizations.

Among clients who pay, private and public prices diverged most for IUD users, likely because of the high service component for insertion and the large number of IUDs in government stocks (see Table V). Public charges for IUD users were 11 percent of private charges in rural areas and 15 percent of private charges in urban areas. The comparable figures for oral contraceptive users were 24 percent in urban areas and 44 percent in rural areas and for injectable users they were 40 and 60 percent respectively. Among IUD, oral contraceptive, and injectable users, public sector subsidies seem to be greatest for IUD users and lowest for injectable users.

Government of Indonesia and Donor Support, and the Recurrent Cost Burden

Historically, the Government of Indonesia has been very supportive of the BKKBN and of family planning in general for the last 25 years. Even during the 1980s, when the decline in the oil price led to major budget reductions in other sectors, the BKKBN's budget was well insulated. In addition to providing the BKKBN with substantial financial resources, the government has also given strong political support to the family planning effort. The president

Table V Prices Paid (in Rupiah) by Oral Contraceptive, IUD and Injectable Users at Public and Private Sources in 1991, by Residential Location and Education

Method/Source	Urban			Rural		
	High Education	Low Education	Total	High Education	Low Education	Total
<u>Oral Contraceptive</u>						
Government	603.1	370.2	421.5	562.2	330.8	345.9
Private	2,310.2	1,051.2	1,749.5	1,393.2	704.5	773.9
<u>IUD</u>						
Government	5,676.8	5,095.4	5,408.3	2,833.4	1,028.1	1,304.3
Private	36,540.1	24,714.7	33,970.1	18.2	6,198.1	11,065.5
				96.0		
<u>Injectable</u>						
Government	2,065.4	1,851.3	1,916.8	1,851.3	1,907.1	1,901.4
Private	4,517.7	4,937.0	4,756.6	3,312.2	3,039.5	3,109.3

SOURCE: Indonesian Demographic and Health Survey 1991

Note: These prices pertain to those who actually paid for the service. The High Education Group contains women with at least some secondary education.

has promoted family planning in speeches and local political leaders are judged in part on the basis of the achievement of family planning goals.

USAID and the World Bank have been the major donors to the BKKBN in terms of the volume of funding. Initially, foreign assistance constituted 59 percent of the BKKBN's expenditures (World Bank 1990). In subsequent Five Year Plans, the donor share was 48, 29, and 45 percent respectively (World Bank 1990). The increase in the donor share of expenditures in the late 1980s was a function of delayed disbursement of a World Bank Loan and an infusion of USAID funds. A phase-down of USAID support had been anticipated but was reversed because of USAID's recent emphasis on providing support to programs in countries with large populations, high levels of unmet need and large numbers of high risk births. It is not clear what the USAID funding level will be after 1998.

While no more recent estimate of the share of funds attributed to donors is available, the large ongoing programs of USAID and the World Bank, the two largest donors indicate that donor support to the BKKBN remains substantial. In addition to significant financial contributions, donors have also provided substantial technical assistance and support.

The BKKBN has benefitted significantly from government and donor resources and support. The issue for the future is whether government and donor resources can keep pace with

the growing financial requirements of the program. The majority of Indonesians use family planning services that are either fully or partially subsidized by the public sector. Given the high proportion of family planning users subsidized by the government, the large numbers of women entering childbearing years (due to the population momentum), the rising contraceptive prevalence rate, and the heavy reliance on resupply methods, the BKKBN's resource needs will grow at an unprecedented rate over the next decade (World Bank 1990).

Table VI Proportions Relying on Private Sources and Proportions Receiving Free Services, by Education and Residential Location, 1991

Source	Urban			Rural		
	High Education	Low Education	Total	High Education	Low Education	Total
Private Source	52.6	30.5	40.9	25.6	11.6	13.4
Public Source	47.4	69.5	59.1	74.4	88.4	86.6
Government Pay	56.0	65.9	62.2	47.0	53.4	52.7
Government Free	44.0	34.1	37.8	53.0	46.6	47.3
Private Free	10.4	7.7	9.3	10.5	19.5	17.3
Private Pay	89.6	92.3	90.7	89.5	80.5	82.7

SOURCE: Indonesian Demographic and Health Survey 1991.

Note: The High Education group contains women with at least some secondary education.

Currently, BKKBN's outlays for contraceptive supplies are close to \$27 million on yearly basis (Curtin et al 1992). Under the present structure, contraceptive users obtaining services from public outlets do not pay user fees under a formal fee schedule. However, evidence from household survey data suggests that the majority of public sector users are making some type of payment for service (see Table VI). Revenues generated from these user fees are not being returned to the BKKBN or the Ministry of Health and therefore do not directly defray the BKKBN's costs. User fees may be defraying the out-of-pocket expenses of volunteers or fieldworkers, or in the case of injectables, they may go toward the purchase of supplies. In addition, some communities have reportedly collected fees to pay for the treatment and transportation of women suffering from the side effects of contraceptives.

If the majority of contraceptors are going to continue obtaining family planning services from public outlets, the major way that the BKKBN could rely less heavily on public funding would be to institute user fees on a formal basis (with some type of means testing) and to use the fees to offset costs. Given the large number of public sector outlets which include

fieldworkers and volunteers and the fact that such a collection system is not currently operating within the Ministry of Health (and is in fact illegal), it may be extremely costly and administratively complex to attempt to recover costs in this way. Moreover, user fees could deter use, especially among low-income households with few or no alternatives. Instituting user fees that have the effect of reducing contraceptive use may not be palatable to the GOI because it would be inconsistent with their goal of achieving lower fertility levels.

Subsidization/Equity Issues

Along a number of different dimensions, the Indonesian program has been successful at making family planning services accessible and affordable to the majority of Indonesians. In general, with the exception of voluntary sterilization, Indonesians are very knowledgeable about contraception and where to obtain family planning services. Family planning services are widely available throughout the country. The majority of Indonesians receive services that are either free or heavily subsidized. However, in spite of the wide reach of the program and the deep subsidies, there are several indicators that some groups may not have full access to services. Moreover, while higher income Indonesians may be receiving proportionately lower subsidies relative to lower income groups, the breadth of the subsidies suggests that many Indonesians are being subsidized who could pay for services themselves.

As already indicated, Indonesian contraceptors are heavily subsidized by the public sector. This includes both users who obtain services from public sources and users who obtain services from commercial and other private sources. In 1991, 75.8 percent of Indonesians obtained services from government sources (see Table II). Of those, 62.2 percent in urban and 52.7 percent of rural users were paying some amount for services (these figures are not reported in the table). Using private charges as a point of comparison, it appears that public sector users who pay are paying less than 40 percent of private charges in urban areas and less than 61 percent in rural areas, indicating very deep subsidies for public sector users, even among those who pay for services (see Table V).

Moreover, the 22.1 percent of the population receiving services from private sources is also being heavily subsidized by the government. More than a third of private sector clients use government products because of the leakage of public supplies from public stocks or because of the official BKKBN distribution of public products to private outlets such as NGO and employment-based clinics. In addition, 9.3 percent of urban private sector users and 17.3 percent of rural private sector users get services free from private sources.

Users who obtain services from NGO and factory-based clinics are indirectly subsidized because these clinics are stocked with supplies from the government or because the clinics receive government or donor funding and do not recover all of their costs through user fees. Estimates from Kenney (1989) suggest that Indonesian NGOs and employment-based clinics recover only a small share of costs through user fees.

Using residential location and educational attainment (higher educated women are defined as those with at least some secondary education and less educated women are defined as those who completed only primary school or less) as proxies for socioeconomic status, we find that women of higher socioeconomic status were much more likely than their lower status counterparts to receive services from private sources. However, within each source, they are only slightly more likely to pay for services and when they pay, they pay amounts that are similar to those paid by women of lower socioeconomic status. Thus, it appears that there may be some sorting among family planning clients into private and public services according to income (or willingness/ability to pay), but whether and how much clients pay at a given source is not very sensitive to income.

Urban women were three times as likely as rural women to rely on a private source for service (see Table VI). More highly educated women in urban areas were 1.72 times as likely as lower educated women to obtain private services while those in rural areas were 2.21 times as likely to rely on private sources (see Table VI). This suggests that lower income women (i.e. those in rural areas and those with lower education levels) are likely to be receiving greater subsidies relative to higher income women since they are more likely to be relying on public outlets for services.

There appears to be much greater differentiation in source of services along socioeconomic lines than in the likelihood of paying, controlling for source (see Table VI). Urban contraceptive users were 1.18 times as likely as rural women to pay for services from government sources. More highly educated women were 1.14 to 1.18 times as likely as their less educated counterparts to pay for services from the government (slightly lower differentials were observed for contraceptive users relying on private sources). With the exception of injectable users in rural areas, highly educated women were paying more than less educated women for pills, injectables and IUDs, in both rural and urban areas (see Table V), although some of these differences are not large--i.e., for IUD users in urban areas. For every method in the private sector with the exception of the injectable in urban areas, better educated women pay more than less educated women in both rural and urban areas.

Thus, it appears that better educated women receive lower public subsidies than less educated women. However, there are several indicators that low-income women do not have as greater exposure to family planning as higher income women and that cost and access problems deter a significant number of women from using contraception. In particular, a World Bank assessment concluded that there were gaps in services for poor and rural women and that there was greater need for broader access to free sterilization. As indicated earlier, women do seem to be paying significantly more, on average for sterilizations than for other methods which may be deterring low-income women from obtaining sterilizations.

Women with less education were less likely to have seen a family planning message on radio or television or to know about contraception relative to their better educated counterparts (World Bank 1990). In addition, women with no education had the highest propensity among

all groups to have an unmet need for family planning (defined here as wanting no more children but not using family planning). Of all women who did not want to become pregnant but were not using family planning, 30 percent indicated that they did not use services because of concerns regarding cost and access which translates into 2.8 million additional potential users (World Bank 1990).

In general, Indonesians enjoy broad access to affordable family planning services. At least 86 percent of contraceptors are subsidized by government resources and subsidies seem to be greater for rural and less educated women than for their urban, better educated counterparts. However, several indicators suggest that price and lack of access may be a deterrent for some households and that lower income groups may have less knowledge of and greater unmet need for family planning services. Thus, some groups may have inadequate access to services under the program as it is currently configured.

Efficiency of BKKBN's Resource Allocation

No comprehensive study has been conducted to examine the efficiency with which the BKKBN allocates its resources. Overall, the Indonesian program has a low cost per user by international standards (World Bank 1990). However, there are several indications of inefficiencies. These include:

- Public support for a social marketing program which is undermined by public policies regarding control over contraceptive stocks--public funds have been devoted to number of commercial sector activities, such as the Blue Circle Campaign at the same time that there is substantial leakage of contraceptive products from the government's logistics system which compete with the socially marketed product and thus may reduce the success of the social marketing effort;
- The seeming mismatch of the method and source distribution where a significant number of users may be getting services from a source that is costly from a supply perspective; i.e. 25.8 percent of oral contraceptive users are resupplied with pills from government hospitals and health centers while only 2.4 percent are resupplied from pharmacies;
- The high proportion of women who wish to limit their births but who are using temporary supply methods which are more costly over the long run (Galway 1990); and
- Potential overstaffing at some levels within the BKKBN for example, at the headquarters (World Bank 1992);

It is likely that the BKKBN has never been particularly resource constrained. However, should resources become more scarce over the next decade, which seems inevitable given the unprecedented numbers of women entering childbearing years, the BKKBN may need to examine more closely its resource allocation decisions. One study (Chernichovsky et al 1991) examined how the number of contraceptive users per fieldworker related to the size of the catchment area and the activities and characteristics of fieldworkers in a subset of provinces. While this study was innovative in its methodology and its creative use of service statistics, it does not appear to provide a basis for redirecting BKKBN resources because of serious flaws in the data. Additional analyses along these lines, in tandem with efficiency and cost studies of other aspects of BKKBN's resource decisions are needed to assess the rationality of its current allocation of resources. Given that the program may not be operating at full efficiency, there may be scope within the program to achieve the same outcomes while relying on fewer resources.

Conclusion

The Indonesian program has been highly successful in attaining large increases in contraceptive prevalence over the past two decades. These achievements have occurred in spite of the nation's low per capita income and its heavily rural and Islamic population. The GOI has demonstrated a strong commitment to supporting the BKKBN even when declines in oil prices decreased government revenues. Moreover, family planning achievements have outstripped improvements in other health areas such as maternal and infant mortality.

However, this analysis has pointed to several dimensions along which the Indonesian program may be vulnerable. The first involves its very heavy reliance on government and donor resources as the mainstay of financing for family planning services. This large scale subsidization may be difficult to sustain over the next decade as the population momentum pushes an increasing number of women into the childbearing years. The breadth of these subsidies indicate that many women receive subsidies who do not require them, and thus that there is some room to reduce the degree of subsidization without adversely affecting contraceptive use.

The public sector's ability to meet impending resource requirements is likely to depend on a number of factors including: how the Indonesian economy fares, and in particular, what happens to oil prices; whether the method mix shifts away from resupply methods and becomes more cost-effective; whether Indonesia can continue to attract significant donor funding; and whether the program can reduce inefficiencies in its allocation of resources.

In addition, should the government more directly address the access issues that were highlighted here, even greater outlays may be required. For example, this could involve greater subsidies to low-income sterilization users and innovative programs targeted at reaching the poorest segments of the population who do not seem to be adequately served at the present. Moreover, additional program outlays might be required if attempts are made to raise service

quality.

What are the prospects for shifting more of the resource requirements onto other sectors such as having clients or employers bear more of the costs? At this point it is hard to gauge the potential for cost recovery within the public sector. The Gold Circle initiative, which is in its infancy could involve some cost recovery, although that does not seem to be its principal or even subsidiary goal. The diversity and complexity of the service delivery system may make user fees very costly to administer.

The other major way that the public sector's resource requirements could be reduced would be to shift more users to the private sector. This has been the stated goal over the last five years, to mixed results. Table II gives the relative size of the private and public sectors based on survey data from 1987 and 1991. Survey data seem to indicate that there is an increase from 12.5 to 22.5 percent in the private sector share, apparently reflecting tremendous growth in the private sector between 1987 and 1991. This comparison is misleading, however, because the majority of the increase is actually a reflection of differences in the source questions in the two survey years. In fact, focusing exclusively on pharmacies, private midwives, and physicians, the only groups for which comparisons can be made over time, the private sector share grew only from 12.5 to 16.4 (see Table II).² Thus, while the private sector did absorb an increasing share of contraceptors between 1987 and 1991, the shift is not as dramatic as has been reported and has occurred during a time of heavy investment and promotion of the private sector. It's not clear that private sector can continue to grow at that same rate in the future.

Moreover, as has been discussed earlier, many of the private sector users are heavily subsidized through their reliance on public sector supplies. Thus, increasing reliance on private sources may not do much to reduce the government's recurrent cost burden so long as private sector users continue to depend heavily on public supplies. In order for a thriving commercial market to develop that is not heavily subsidized and which actually reduces the recurrent cost burden on the government, the government may have to exercise better control over the contraceptive supplies flowing through the government's logistics system. In addition, the inability of the Blue Circle social marketing campaign to attain its sales goals suggests that it may be more difficult to induce users to shift to private sources than previously anticipated. In light of Indonesia's low per capita income and population concentration in rural areas, a substantial share of users may not switch to private sources as long as relatively inexpensive public sector services are widely available. The irony is that some of the same factors that may have been key to the BKKBN's success--the widespread availability of heavily subsidized family planning services which was enabled by large scale government and donor investments--mean

² Surprisingly, the midwife role seems to have expanded greatly while reliance on pharmacies and private physicians shrunk in relative terms. The number of trained midwives has been expanding, but the increased reliance on midwives could also be related to the Blue Circle Campaign which, while it drew attention to physicians, pharmacies and midwives as sources of family planning services may have made more households aware that midwives provided family planning services than had been aware in the past.

that the program is now more vulnerable to forces outside the program.

While this analysis has focused on resource issues, other factors which have been cited as critical to the program's ongoing success are also likely to heavily influence family planning levels in the future. The first issue involves the likelihood that the Indonesian program will enjoy the same level of political support in the future as they have in the past. At this point in time, no successor to longtime President Soeharto has been designated and thus it is uncertain whether the next president will have the same strong commitment to family planning or commensurate political clout. The second issue concerns the prospects that the next generation of leaders in the BKKBN will be as dynamic and innovative as in the earlier years. In the next decade, new individuals should be taking key positions within the BKKBN which could alter the tenor of the organization. Another important factor will be future levels of economic development which will likely figure strongly in shaping desired family size and ability and willingness to pay for family planning in the future. These factors, which are difficult to gauge, may play as large a role as the resource issues that were raised in influencing the long-term sustainability of the program.

Nonetheless, there are several steps that the BKKBN could take to move toward a more sustainable program. These include:

- Reducing public subsidies that are received by contraceptors who do not require them and targeting services at underserved groups;
- Reducing inefficiency and waste in the allocation of resources;
- Shifting users who wish to limit or wait many years for the next birth from resupply methods to more cost-effective long-term methods which may involve providing greater support for sterilization services;
- Introducing cost recovery into the public sector which defrays program costs, is means-tested and does not undermine prevalence; and
- Reducing the flow of public contraceptives into the private market.

To accomplish these objectives, the BKKBN may need to undertake targeted research or pilot studies to help guide decisions. For example, little information is available on the extent of inefficiencies in BKKBN's current resource configuration. In addition, while a substantial amount of "unmet demand" for contraception has been documented in household surveys, it is not known how readily this could be translated into actual use nor how costly it would be. Likewise, access problems have been identified for several subgroups of Indonesians, particularly among rural and lower-income women, but it is not clear what would be required to reduce these barriers. Finally, little is known about the extent of the potential tradeoff between the reduction

of public subsidies for family planning and contraceptive prevalence which would help inform the development of means-tested cost recovery schemes. Research in these and related areas is needed to help the BKKBN make key decisions regarding the allocation of its resources, the targeting of its subsidies, and the reduction of unmet need and access problems. Progress along these lines could make the Indonesian family program more sustainable and increase contraceptive prevalence at the same time.

CASE STUDY 3: COLOMBIA

The Colombian family planning program is relevant to the subject of sustainability for three reasons. First, and most basic, is the dramatic decline in the total fertility rate from around 6.6 births per woman in the early 1960s to about 2.8 births per woman today. Table I provides summary statistics for Colombia that reflect impressive gains made in recent years. Second, the principal factor explaining this decline is the role of a strong, sustained and dynamic family planning program dating from the middle 1960s. Finally, Colombia's program exhibits an example of an inter-sectoral collaborative effort among the public, private voluntary, and commercial sectors. In fact, the private sector as a whole is the predominant provider of choice for contracepting women and couples, regardless of method or point of service delivery.

The Colombian family planning effort has been led by three organizations: the Colombian Association of Medical Schools known as ASCOFAME, whose family planning projects were started in 1966; the Ministry of Health, which began its services in the late 1960s and then expanded these through a vast network of clinics and hospitals in 1973; and PROFAMILIA, or the Colombian Association for Family Welfare, which opened its first clinic in 1965. Each of these organizations has shown that it has a particular role to play in the delivery of family planning services. PROFAMILIA, in particular, has excelled in expanding its coverage while simultaneously implementing concerted efforts to become financially self-sufficient. Given its importance in the Colombian family planning program, and the lessons that can be learned from its progress toward sustainability, we devote much of this case study to PROFAMILIA.

History and Background

Two and a half decades ago Colombia's total fertility rate was 6.6 children per woman of reproductive age, with a population growth rate that was one of the highest in the world at nearly 4 percent. It is estimated that if this growth rate had continued, Colombia's population

Table I A Statistical Overview of Colombia

Population ^a	34.9 million
Per Capita Income ^a	US\$1,280
Female Persistence to 4th Grade ^b	75%
Distribution of Consumption (Lowest 20%) ^b	4%
Infant Mortality Rate ^a	34 per 1,000
Contraceptive Prevalence Rate ^a	66%
Total Fertility Rate ^a	2.8 births per woman
Method Mix (Methods over 10%) ^c	FVSC, pill, IUD

SOURCES

- a Population Reference Bureau 1993
- b World Bank 1991
- c Based on calculation of all methods adding to 100% of utilization

would have jumped from the 18 million it was then, to in excess of 55 million by the year 2000. That alarming scenario, however, never developed. The total fertility rate declined to around 2.9 births per woman. Correspondingly, there was a decrease in the population growth rate to 1.9 percent in 1991.

Most studies assert that the principal factor behind the dramatic decline in the total fertility rate is the rise in contraceptive use within marriage. In 1986, the Demographic and Health Survey found that about two-thirds of all married women of reproductive age use contraception, compared to approximately 20 percent in the 1960s. By 1976 this figure had risen to almost 50 percent.

Despite the impressive gains, sizeable (and predictable) differentials in contraceptive use have persisted within the population. Data from the 1986 DHS reveal that prevalence is higher in the urban areas with 70.2 percent of women in union, as compared to the rural areas with a little under 55 percent. Similarly, prevalence levels are positively associated with level of education rising from approximately 50 percent for women in union with no education to 81.4 percent for women with education higher than secondary school level.

The mix of contraceptive methods has been evolving through the years as services have expanded, reproductive patterns have been transformed, and the population characteristics have changed. In 1978, oral contraceptives represented the dominant method with 36.8 percent of total contraceptive use. 17.5 percent used female voluntary sterilization, while IUD use came in third with 16.8 percent. Currently, female sterilization is the most commonly used method (32.7 percent), with pill use accounting for 21.2 percent, IUDs accounting for 18.6 percent and "other" including rhythm, vaginal methods, etc., at 18.3 percent (Rofman 1992).

Of even more interest from the point of view of program sustainability is the source mix in Colombia, which reflects strong participation of both private voluntary and commercial providers. Overall, 16.3 percent of contraceptive users relied on Ministry of Health services in 1986. 10.8 percent of users obtained services from a private doctor or private hospital; another 33.3 percent depended on a pharmacy. And 38.7 percent of contraceptive users obtained services from PROFAMILIA clinics or community-based distribution agents (Amadeo et al 1991).

A strong relationship exists between the source and methods used. Table II presents data from the 1986 DHS for a range of methods including the pill, IUDs, injectables, vaginal methods and female sterilization. For all methods, the private sector, including both the voluntary non-profit and commercial providers, is overwhelmingly the choice of Colombian women. PROFAMILIA plays a critical role in female sterilization and IUD insertion, while the for-profit sector dominates in hormonal and barrier methods. The public sector plays an important role only in the provision of IUDs, with a marginal contribution in female sterilization, injectables, and oral contraceptives.

Because of the obvious contribution that PROFAMILIA makes in providing effective

Table II Contraceptive Source Mix, 1986 (in percent)

Source	Pill	IUD	Inj.	Vaginal	FVSC
Government Hospital/ Center	9.7	35.5	8.3	0	11.9
PROFAMILIA	8.9	45.2	3.1	5.8	71.7
Private Doctor/ Clinic/Hospital	0.6	14.0	10.4	0	11.5
Pharmacy	75.3	0.6	73.4	88.9	0.2

NOTE: "Other" and "Don't Know" categories excluded. SOURCE: DHS 1986.

modern contraception to a significant share of Colombian women, it is worth taking a look at its organizational evolution, and factors that have favored both its expansion and its progress toward sustainability.

The Evolution of PROFAMILIA's Program

As is typical of many private voluntary organizations, PROFAMILIA's origins lie in the efforts of one visionary and highly motivated leader, Dr. Fernando Tamayo. Recognizing that Colombian couples desired to control the number and spacing of their children, Tamayo's major goal in establishing PROFAMILIA was to ensure family planning service provision for all Colombians, whether rich or poor. Initially begun with one clinic in urban Bogota, PROFAMILIA today has expanded to 48 clinics in both urban and rural areas of the country.

PROFAMILIA's range of activities has diversified over the years. In the beginning, service provision was limited to IUDs, pills, and family planning promotional activities. In 1971, a CBD program spread over the rural areas was started, a first for any country in Latin America. In 1973, PROFAMILIA introduced the social marketing program selling internationally donated commodities to pharmacies. Currently, PROFAMILIA's program offers a wide range of services including clinical, surgical and community services. In addition, it provides training, carries out research, engages in health and family planning promotion efforts and offers counseling services to both adolescents and users.

PROFAMILIA's contribution to providing family planning services is well documented. More than 60 percent of Colombian couples who use modern methods of birth control rely on PROFAMILIA for their contraceptive and family planning needs. It is estimated that since its

Table III Number of Acceptors (in thousands)

	Total Acceptors	IUD	Pill	Total Sterilization	Other Program Methods
1983 MOH	109.8	50.5	36.2	14.5	8.6
1983 PROFAMILIA	637.1	49.9	414.3	51.3	121.6
1989 PROFAMILIA	707.7	113.5	424.6	71.5	98.2

SOURCE: Ross et al, 1992.

inception PROFAMILIA has assisted in preventing about 5 million unwanted pregnancies. Table III shows the number of acceptors for 1983 and 1989 for MOH and PROFAMILIA services. In the six years between 1983 and 1989, acceptors in the PROFAMILIA program increased substantially for all methods except the "other program methods." Comparisons for 1983 with the MOH service delivery network (the most recent year for which complete data are available) show that, with the exception of IUD insertion, PROFAMILIA dominated in attainment of new acceptors.

PROFAMILIA's outstanding efforts at extending and expanding family planning services have won it wide recognition including the UN's Population Award in 1988. The reasons for the organization's success may be conveniently grouped into three categories: external policy and program environment, financial/efficiency, and managerial/institutional factors. It is to the detailed discussion of these factors that we now turn.

- **External Policy and Program Environment:** In the early years after PROFAMILIA's founding, the external environment was not conducive to organizational sustainability. First, Colombia was then a poor country, overwhelmingly Catholic and with a poorly developed public and private health services network. Second, there was a great deal of opposition to the overt delivery of family planning services, particularly from the Church, but also from the left-wing opposition political parties.

For services such as male and female sterilization, parts of the medical hierarchy in Colombia also voiced their opposition on the grounds that these procedures were unsafe for clients. Due to imperfect information there was also a certain amount of apprehension on the part of potential users about the health effects of contraception, particularly sterilization. In the face of these handicaps, the PROFAMILIA's early efforts revolved around establishing its legitimacy in the field and building bridges with the political and medical elites.

Some favorable external conditions did assist PROFAMILIA in its task. The single most

important favorable factor was the latent demand for family planning services. Large numbers of married women, particularly in the urban areas, desired contraceptive services and were quick to avail of them once their supply was assured. PROFAMILIA's continuing survival also benefited from the easy availability of international donor funding. The organization could concentrate on meeting existing demand as well as creating additional demand through health and family planning promotional activities without worrying about the costs of doing so.

Once convinced of the necessity for family planning services, important political leaders were ready to provide support for the organization's efforts. Indeed, in 1966 itself, the then president of Colombia was the first Latin American leader to sign the United Nations declaration on population. The years since have shown clear evidence of the unique nature of the public-private partnership implicit in the Colombian family planning program.

- Financing and Efficiency: Financial factors have played a key role in PROFAMILIA's organizational sustainability over the years. PROFAMILIA relies for its funding on a number of sources, including the national government and foreign donors. However, the extent of reliance on external resources has been declining in recent years, concomitant with the expansion in revenues from other sources. One estimate of the organization's revenues and expenditures based on data from 1986 show that almost 50 percent of PROFAMILIA's total costs are recovered from client payments which, by any measure, is exceptional for an organization in the field of family planning. Thus, the total of 1,267 million CYPs generated by PROFAMILIA in 1986 cost a total of 1,252.8 million pesos (US\$ 6.43 million). Of this amount, approximately 640 million pesos (US\$ 3.32 million) or 50 percent were recovered through charging for contraceptive and allied services (Amadeo et al 1991).

In fact, PROFAMILIA has always made a concerted effort to generate fees from users, and has an organizational philosophy that those receiving its services should be required to pay for them. For IUD insertions, the average charge in 1991 was US\$8.00, while for male and female sterilizations the charges were \$7.00. In both cases, the MOH charges for identical services are either minuscule or nonexistent. Yet as in the case of sterilizations, PROFAMILIA commands 70 percent of the market; only 20 percent of users rely on the MOH system. The evidence shows that it is the greater quality of PROFAMILIA's services that attract acceptors to its clinics as compared to the government's facilities (Roper 1987, Amadeo et al 1991). Yet there may be scope for further increases in the price of PROFAMILIA's services to finance service expansion. Apparently, it is access more than price that constitutes a barrier to utilization of PROFAMILIA's services, and modest price increases could finance improved access and thus enhance equity too (Amadeo et al 1991).

PROFAMILIA maintains a commitment to serving those who cannot pay. Providers use a sliding scale of charges for their poorer clientele. Anecdotal evidence suggests that the scale is administered based on self reporting by clients, as well as judgments of a clients income by providers and clinic staff. PROFAMILIA also uses a services-based cross-subsidization scheme. For instance, in addition to standard family planning services, the organization now provides

medical-surgical services such as infertility tests, pap smears, pregnancy tests, gynecology, urology, diagnosis and treatment of STDs, clinical laboratory services, outpatient surgical services and the like. Profits from these services are then applied to the costs of family planning services. One study states that of the 50 percent of cost recovery effected by the organization, about 60 percent comes from diversified services such as those outlined above, 25 percent from the social marketing program which is also considered a highly successful effort, and 15 percent from other sources (Vernon et al 1988). It may also be noted that through experience, PROFAMILIA has learned to effect price increases when necessary, through incremental steps in the course of the financial year, instead of at one stroke at the beginning of each fiscal year. This has helped it to mitigate the effects of these increases on utilization (Roper 1987).

An exhaustive study by The World Bank in 1991 provides evidence of the relative efficiency of PROFAMILIA's three programs: CBD, the clinical program involving supply of IUDs, and female voluntary sterilization. The study concluded that both the CBD and clinical programs were most cost effective, and that the sterilization program was the least cost effective. Reasons for the latter conclusion lie mostly in the fact that sterilizations are relatively much more costly, have the highest subsidy element, and are undergone by women at a higher mean age than those accepting the other program methods (Amadeo et al 1991).

Table IV Deployment of Personnel

Organization	Total	Physicians	Paramed	Field Workers	Admin-istrators	Other	MWRA per staff
MOH 1986	11,667	1,336	5,240	5,017	74	4	386
PROFAMILIA 1987	3,765	95	175	3,495	N/A	4	1,232

SOURCE: Ross et al, 1992.

A comparison between PROFAMILIA and the MOH system regarding the number of personnel and their utilization reveals that PROFAMILIA's deployment of staff is far more efficient (Ross et al 1992). Thus, although PROFAMILIA's staff constitute only one-third the number of total MOH staff, they provide services to almost four times the number of women in union. Yet, one recent study states that there is even more scope for internal efficiency improvements in the clinical program by reducing the ratio of doctors to nurses, for example (Amadeo et al 1991).

- Managerial Factors: We now turn to a discussion of the managerial factors that have

played a role in the sustainability of PROFAMILIA's family planning program. Of prime importance is the program structure, which has evolved to suit programmatic needs.

The basic structure, while simple and small, is organized around a hierarchy with the president at the top assisted by a board of directors. In addition, an executive director manages the organization on a day to day basis. Each divisional chief and the heads of PROFAMILIA's 48 clinics report directly to the executive director, while certain special offices such as audit and grants report only to the president. These clear lines of authority have meant minimum duplication of effort and overlapping jurisdictions, assisting in constant communication, and more effective and responsive decision making.

New divisions were created as and when the program added new activities to its portfolio: in 1971, the initiation of the CBD program led to the creation of the CBD division; a similar division was set up for the Social Marketing Program in 1973. Additional support divisions have been established for resource development, evaluation and personnel functions.

Together with an organizational structure suited to its goals, PROFAMILIA relies on an extensive system of incentives to motivate its staff. This incentive system is one of the keys critical to its success as a sustainable organization. In terms of material incentives, PROFAMILIA pays its staff salaries that are far higher than those for equivalent positions in the public sector. It also provides staff benefits such as grants and/or loans for educational expenses. Next, all attempts are made to fill vacancies from within the organization, so that staff are provided avenues for promotion and advancement.

Added to the material incentives are nonmaterial incentives that also serve to promote the organization's goals. Nonmaterial incentives flow from the recruitment and training procedures themselves. First, most employees are recruited based on recommendations from current employees, so that great care is taken to select personnel who will fit in with the prevailing ethos. Second, all employees serve a probationary period at the conclusion of which they are deemed permanent staff. Heavy emphasis is also accorded to training of new and continuing staff. However, this training for most positions is an informal affair that proceeds through "hands on" instruction on the job. Only certain categories of medical personnel receive more formal training, but even in these cases, administrative aspects are imparted through actual practice. Finally, supervision is given an important role not merely for its management control functions, but also for its role in propagating and reinforcing organizational values. For example, CBD supervisors spend a great deal of time constantly in the field. In fact, every nine months they visit each clinic and stay for up to a week, providing not only a check on staff functioning but also guidance and advice in solving current problems. Executive staff also spend a few days at a time at each clinic for much the same reasons.

Finally, PROFAMILIA encourages a spirit of competition among its staff and units. In a very real sense, the organization is in competition with the extensive MOH system, since it provides similar services in the same areas. This implies that service quality and a satisfied

clientele are essential for success and PROFAMILIA staff are aware of this and endeavor to maintain a competitive edge. But competition is also encouraged within the organization among the different clinics and units through publication of quarterly reports and service statistics. Each year prizes are awarded for the best performance and the resulting competition serves to ensure delivery of high quality services.

Conclusion

The above discussion has sought to highlight the principal factors behind a private voluntary organization's successful efforts in providing sustainable family planning services, and its role within a larger program. Many of these factors cannot be replicated elsewhere in their entirety since they are unique to the Colombian situation. For instance, Rofman (1992) points to the importance of the already existing low demand for children that acted as a springboard to PROFAMILIA's efforts. However, the important point to note, is that the organization has responded to and benefited from the environment in which it has found itself. This is perhaps the key principle underlying strategic planning in any program or organization. This accomplishment is all the more remarkable since PROFAMILIA has resisted establishing a planning division, believing that periodic meetings of executive heads and constant communication with clinic directors are the keys to responsive and effective decision making. That a major segment of the market for family planning services believes that PROFAMILIA provides quality services which are worth paying for is perhaps conclusive evidence that this strategy has succeeded.

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DRAFT FOR MISSION REVIEW

**Sustainability of Family Planning
Programs and Organizations:
Meeting Tomorrow's Challenges
Annotated Bibliography**

**Prepared by the OPTIONS Project
for USAID/Rabat**

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NOTE: *This is only a select list of the now growing literature on sustainability and makes no claim to being comprehensive. Publications that provide an excellent overview of the main issues in sustainability of family planning and health programs are marked in bold type.*

Akin, John, Nancy Birdsall, and David de Ferranti. 1987. *Financing health services in developing countries: An agenda for reform.* Washington, D.C. The World Bank. Policy Study.

[This seminal document suggests alternatives to fully publicly funded health programs that have been more the norm than the exception in the Third World. These public subsidies have created three interrelated problems: insufficient spending on cost-effective health care, internal inefficiencies arising from underfunding of nonsalaried recurrent costs and poor quality services, and inequity in the distribution of care because of the overwhelming bias towards expenditures on tertiary care levels benefiting primarily the rich. The study proposes four policy reforms: instituting user fees, providing third party health coverage through insurance and other risk coverage, greater deployment of nongovernment resources such as the voluntary and commercial sectors, and decentralization of existing public health services so as to promote efficiency in fee collection and service delivery.]

Akin, John, Charles Griffin, David Guilkey, and Barry Popkin. 1985. *The demand for primary health services in the Third World.* Totowa, NJ. Rowman and Allanheld.

[Based on primary data from the Bicol region of the Philippines, this work by four leading researchers in the field of health care financing examines the role of prices, quality, incomes, and substitutes in the utilization of primary health care services such as curative care, immunizations and well baby care, and prenatal care and deliveries. It finds that there is no dearth of medical resources in the countryside, and that private and traditional practitioners continue to be used extensively, even when free governmental services are available. Second, prices seemed to play a small role in the decision to utilize services and choice of practitioner. Finally, income as a determinant of utilization also played a minor role, if any. Education and residence appeared to be more important determinants. This suggests that policies based on lowering the total price of primary care may not have an important effect on increasing the utilization of these services.]

Akin, John, and J. Schwartz. 1988. "The effect of economic factors on contraceptive choice in Jamaica and Thailand: A comparison of mixed multinomial logit results." *Economic Development and Cultural Change*, 36(3): 503-28. April.

[This important study based on a data set from Jamaica and Thailand finds, as expected, that the choice of most contraceptive methods is negatively related to price. However, the magnitude of this effect of price is small, implying that if prices were to be raised over the observed ranges

in these two countries, the effect on utilization of family planning methods would be negligible. Thus, cost recovery efforts through price increases would not lead to a drop in demand. For other methods such as condoms and injectables, price elasticity of demand is higher, meaning that price increases would impact adversely on method use. The effects of an increase in revenues through a price rise for these methods will likely be more than offset by the resulting reductions in the levels of utilization.]

Ashakul, Teera. 1989. "Analysis of Contraceptive Method Choice and Optimum Contraceptive Pricing Structures." *Thailand Development Research Institute Newsletter*, 4(3): 10-13.

[This article based on data from the Third Contraceptive Prevalence Survey in 1984, analyzes the role of contraceptive prices in determining the demand for family planning services. The estimated elasticities show that by raising the effective prices of contraceptives, net public sector expenditures on family planning can be reduced from baht 54 million to baht 40 million per month without affecting overall contraceptive prevalence. The resulting savings could then be utilized to increase coverage in other areas or to provide additional health services. Expecting an increase in effective protection through price restructuring alone, however, is not borne out by the data implying that a further increase in prevalence can only come about through changes in women's desired family size.]

Ashford, Lori S. and Jeanne M. Haws. 1992. "Family Planning Program Sustainability: Threat or Opportunity?" *Studies in Family Planning*, 23 (1): 63-65.

[This commentary argues against the view that self-sufficiency in family planning programs emphasizes income generation to the detriment of service quality and availability. While the article acknowledges that there are trade-offs between the financial and social objectives in family planning programs, it concludes that program sustainability should be seen as an opportunity for managers to gain more control over the future, to expand and improve services, to respond to clients' needs as opposed to those of donors, and to cut costs and increase efficiency.]

Bennett, Sara. 1992. Promoting the Private Sector: A Review of Developing Country Trends. *Health Policy and Planning*, 7(2): 97-110.

[Bennett addresses two questions in her article on the private sector in health care in developing countries. The first relates to the ways in which the private sector can contribute to national health goals, and the second looks for lessons that the public sector can learn from the operation of the private sector. She concludes that there is no doubt that the private sector plays an important role in the provision of health care in these countries, whether by accident or by design. The author's main recommendation therefore, is that *both* sectors should be seen as an integral part of a solution to the problem of adequate

health care, and that national policy makers need to ensure a proper role for each of the two sectors.]

Bossert, Thomas J. 1990. "Can They Get Along Without Us? Sustainability of Donor-Supported Health Projects in Central America and Africa." *Social Science and Medicine*, 30(9): 1015-1023.

[This article presents a synthesis of the findings of five country studies on the sustainability of U.S. government-funded health projects in Central America and Africa. The author reviews health projects within a comparative framework to determine which project activities had continued after donor funding ceased. He finds that health projects in Africa are less firmly sustained than those in Central America. He then goes on to evaluate contextual factors and project characteristics that impacted on the sustainability of the projects.]

Bulatao, Rodolfo. 1985. *Expenditures on population programs in developing regions: Current levels and future requirements*. Washington, D.C. The World Bank. Staff Working Paper no. 679.

[Prepared as a background paper to the World Development Report's 1984 special issue on population, this paper examines data on program expenditures for 46 countries so as to estimate regional expenditures by donors, host country governments, and households on family planning activities. Next, it uses these estimates to project future resource requirements up to the year 2000. It finds that public expenditures would have to grow at a constant 5 percent per year in order to meet The World Bank's standard population projections. To meet even more rapid declines in fertility this constant rate would have to increase to 7 percent. Although the author uses a number of alternative assumptions of use effectiveness, private costs, etc. he finds that the results do not vary a great deal from the base projections.]

Buzzard, Shirley. 1987. *Development assistance and health programs: Issues of sustainability*. Washington, D.C. U.S. Agency for International Development. Program Evaluation Discussion Paper no. 23.

[This report reviews the literature available within USAID and other large donors with the aim of enumerating the factors that either contribute to, or impede, the sustainability of donor financed health programs. The author identifies five such factors: financing, community participation in planning and implementation, host country policies, appropriate program design, and program management. Of these, the first is by far the most critical, but each of the others plays a significant role too. Included in the financing section of the paper is a brief but illuminating discussion of different financing mechanisms such as user fees, community financing, participation of the private sector, and prepayment schemes.]

Cochrane, Susan, Jeffrey Hammer, Barbara Janowitz, Genevieve Kenney, and John Bratt. 1990. *The economics of family planning*. Draft. August 15.

[Although only available in draft form at the present time, this wide ranging review of the economics of family planning programs examines four interrelated issues: (i) projected level of demand for contraceptives (ii) the cost of meeting this demand (iii) measures to increase service efficiency and (iv) funding mechanisms available, including cost recovery. The major conclusion that the authors' arrive at is that there is a significant dearth of contemporary knowledge about these issues in respect of family planning. Further, estimating costs is problematic since there are a multiplicity of actors, programs and overlapping funding sources. The modeling of the determinants of contraceptive use has come a long way since the early simple regression models, but not enough data have been analyzed so far to draw concrete lessons for the rest of the world. Regarding family planning financing, the authors argue that there are clear economic rationales for government support of family planning. However, this support is likely to be forthcoming mostly in Asia. Donor support itself is unlikely to increase, though improvements through tighter focusing of assistance are quite possible. Private sector provision, particularly among the upper income countries, remains a vital if less explored policy option, while the introduction of user fees can help defray program costs without unduly affecting utilization.]

Creese, Andrew. 1991. User charges for health care: A review of recent experience. *Health Policy and Planning* 6(4): 309-19.

[This paper reviews recent experiences with increases in user fees and their effect on the utilization of health care. While cost recovery objectives seem to have been achieved, at least at the modest levels originally aimed at, utilization among the poor has suffered. The author concludes that fee systems require adequate safeguards so as to protect the poor and those unwilling to pay the costs of care.]

Cross, Harry, Virginia Poole, Ruth Levine, and Richard Cornelius. 1991. *Contraceptive source and the for-profit private sector in Third World family planning: Evidence and implications from trends in private sector use in the 1980s*. Washington, D.C. Presented at the 1991 Annual Meetings of the Population Association of America.

[This paper analyzes data from the Demographic and Health Surveys to reveal the role played by the private commercial sector in family planning programs worldwide. The authors stated goal is to discover if the private sector has the potential to take up the slack in the financing and provision of family planning services. They find that the sector is already a major player in many countries. In some cases though, the private sector actually lost ground in the 1980s, which is contrary to the expectation that rising incomes result in higher private sector shares of the contraceptive market. Based on these findings the

authors develop a set of policy recommendations that will assist governments in involving the private commercial sector as a partner in service delivery.]

Curtin, Leslie, Charles N. Johnson, Andrew B. Kantner, and Alex Papilaya. 1992. *Indonesia's National Family Planning Program: Ingredients of Success*. Washington, DC: Population Technical Assistance Project, Occasional Paper No. 6, December 11.

[This paper aims to take 'a broader more comprehensive look at the [Indonesia] national family planning effort -- its development, its achievements and demographic impact, as well as the role that A.I.D. has played.' It identifies sustained political commitment, population policy development, creative leadership, adequate financing, and a cohesive village structure as the key factors responsible for the program's success.]

De Ferranti, David. 1985. *Paying for health services in developing countries: An overview*. Washington, D.C. The World Bank. Staff Working Paper no. 721.

[Long considered a classic in the field of financing of health services, this seminal paper presents the theoretical principles underlying charging for health care. Based on these principles, the paper develops the arguments for governments' role in health care financing and provision. It concludes that both efficiency and equity are enhanced when government concentrates on the supply and financing of services with the greatest social benefits such as immunizations, prenatal care, family planning, and vector control, and leaves the provision of curative care to the private sector. The paper also includes a helpful review of health financing experience in selected developing countries, although much of the data are now outdated.]

Deolalikar, Anil, and Prem Vashishtha. 1992. *The utilization of government and private health services in India*. Washington, D.C. The Futures Group. The OPTIONS II Project.

[In this research paper, the authors draw on data from a national data set in India to analyze utilization patterns in the health care sector. They find that the private sector, especially its commercial section, provides the bulk of basic health services to rural as well as urban residents. Based on these findings the authors call for a more vigorous policy on the part of the central government to involve the private sector in the national health program.]

Feyisetan, Bamikale, and Martha Ainsworth. 1993. *The impact of the availability, price, and quality of services on the demand for contraception in Nigeria*. Washington, D.C. The World Bank.

[This paper represents an excellent analysis of the role that factors such as service characteristics and clients' socioeconomic background play in determining the use of contraceptives. Based on data from the Nigerian DHS of 1990 and its associated Service Availability Module, the study finds, not surprisingly, that education plays a critical role in determining ever use of contraception. But broader availability of the pill and injectables in rural areas will likely result in greater use of contraception. Both the price of the contraceptive and the distance of the facility offering the contraceptive were found to be negatively related to use.]

Foreit, Karen and Linda Lacey. 1991. *Towards an Analytical Framework for Sustainability of Family Planning and Health Services in Bangladesh*. Washington, DC: The Futures Group. Report prepared for the OPTIONS II Project.

[This report identifies a sequence of strategic planning activities aimed at creating a sustainable family planning program in Bangladesh. Activities discussed include strengthening coordination efforts among donors, with governments, identifying possible levers to mobilize greater national resources to population programs (including general revenues, in-kind contributions, volunteers' time, and user fees), focusing on decentralized efforts in expanding family planning services, and coordinating research efforts and other support activities to serve all components of the OPH portfolio.]

Gertler, Paul, and Jacques van der Gaag. 1990. *The willingness to pay for medical care: Evidence from two developing countries*. Baltimore, MD. The Johns Hopkins University Press.

[This is another important contribution to the growing user fee debate in developing countries. The authors analyze data from the Ivory Coast and Peru to estimate the price elasticities of demand for curative care. They find that, as expected, these elasticities differ for the various income groups in the two countries. From a policy perspective they contend that introduction of user fees in health care without adequate safeguards for the poorest of the poor will likely deny them access to the services they need. Thus, policy planners must maintain subsidies to these poorer groups at the same time as they introduce user fees for other income groups in the health system.]

Gillespie, Duff, Harry Cross, J Crowley and Scott Radloff. 1988. *Financing the delivery of contraceptives: The challenge of the next twenty years*. Washington, D.C. Presented at the National Academy of Sciences Demographic and Programmatic Consequences of Contraceptive Innovations Committee on Population Meeting. October 6-7.

[This paper makes a contribution to the financing debate by focusing on estimating the costs of providing family planning services over the next two decades. It also provides details of

the projected method mix, commodity costs and service delivery costs, and outlines recommendations for coping with the expected challenges such as stimulating new sources of investment, concentrating on leveraged activities, and improving both program efficiency and contraceptive technology.]

Gilson, Lucy. 1988. *Government health care charges: Is equity being abandoned?* London, UK. London School of Hygiene and Tropical Medicine. EPC Publication no. 15. Spring.

[This study focuses primarily on the equity aspects of user fees in health care. It presents the theories for both sides of the debate, and the empirical findings from several recent studies. Two appendices are most helpful since they list in summary form details from many of these, along with their key findings.]

Griffin, Charles. 1987. *User charges for health care in principle and practice.* Washington, D.C. The World Bank.

[In this comprehensive paper, the author lays out the principal arguments for and against user fees in health care. He shows how such systems can contribute to both efficiency and equity, in addition to resource mobilization. He concludes with a survey of recent country experience in this regard.]

Griffin, Charles. 1992. *Health care in Asia: A comparative study of cost and financing.* Washington, D.C. The World Bank.

[This is an excellent study of current health conditions in the Asian region and the systems of health financing extant there. The author covers public expenditures for health care, as well as nongovernment resources. Both spending levels and allocation decisions have played a part in successful national programs. The author thus calls for better targeting of resources towards the poor and increased allocations to public health programs.]

Haws, Jeanne, Lynn Bakamjian, Tim Williams, and Karen Johnson Lassner. 1992. "Impact of Sustainability Policies on Sterilization Services in Latin America." *Studies in Family Planning*, 23(2): 85-96.

[This article details the findings of a study conducted by the Association for Voluntary Surgical Contraception to examine the impact of decreases in funding on access to sterilization services at 20 nongovernmental family planning clinics in Mexico, the Dominican Republic, and Brazil. The article concludes that funding phase-outs need to be planned carefully and in conjunction with grantees; grantees need to assess the costs of the procedure realistically, and assign fees

accordingly; management needs to seek alternative funding sources in lieu of, or in addition to, increasing fees; and caseloads can be increased and costs recovered by diversifying services.]

Huber, Sallie Craig. 1993. *A Review of Lessons Learned in Successful International Family Planning Programs*. Washington, DC: Centre for Development and Population Activities (CEDPA). January.

[This article examines lessons learned in the more than three decades of worldwide experience with family planning programs to identify critical components of successful programs. The author identifies political commitment and strategic planning, access to a range of methods through a variety of service delivery frameworks, private public sector partnerships, a well functioning logistics system, training, IEC, and research and evaluation as the keys to success. The section on the merits and demerits of different service delivery mechanisms provides an excellent discussion, particularly with respect to CBD and social marketing approaches.]

Huber, Sallie Craig and Philip D. Harvey. 1989. "Family Planning Programmes in Ten Developing Countries: Cost Effectiveness by Mode of Service Delivery." *Journal of Biosocial Science*, 21: 267-277.

[This article assesses the cost effectiveness of various modes of family planning service delivery based on the cost per couple-year of protection (CYP) using 1984 data for 63 projects in ten countries. It finds that the lowest average costs were incurred by programs with the highest volume of services delivered (social marketing and sterilization projects), the highest costs were incurred by full service clinics and community-based distribution projects, and costs of combined clinic/community-based distribution services fell in between these two extremes.]

Janowitz, Barbara S., John H. Bratt, and Daniel B. Fried. 1990. *Investing in the Future: A Report on the Cost of Family Planning in the Year 2000*. Research Triangle Park, NC: Family Health International. April.

[This report estimates the costs of public and PVO programs that provide family planning services and the costs of related population services needed to reach the medium level population projection of the United Nations in the year 2000 in Asia (excluding China), Latin America, Sub-Saharan Africa and the Near East. The projections indicate that the largest percentage increases in cost will be in Sub-Saharan Africa and the Near East, regions where contraceptive use will likely increase the most, while the largest absolute increase in costs will be in Asia, the region with the largest number of people and the largest predicted increase in population.]

Jarrett, Stephen, and Samuel Oforu-Amaah. 1992. "Strengthening health services for MCH in Africa: The first four years of the 'Bamako Initiative'." *Health Policy and Planning*, 7(2): 164-176.

[Evaluates the early experience of the Bamako Initiative, the movement that seeks to increase local and district level financing and provision of primary health care, with technical support from the MOH level. The authors identify community participation in financing and management as the most critical element in improving quality and ensuring sustainability of services. Problem areas include ensuring access for the very poor, rational use of drugs, ability of governments to maintain support while facing declining economies, and the role of women in community action.]

Jensen, Eric, Neeraj Kak, Kusnadi Satjawinata, Dewa Nyoman Wirawan, Nelly Nangoy, and Suproyoko. 1993. *Contraceptive pricing and prevalence: Family planning self-sufficiency in Indonesia*. Cincinnati, OH. Presented at the Population Association of America Annual Meetings.

[This is another worthwhile addition to the user fee debate now raging across most of the developing world. Analyzing data from Indonesia, the authors' find that while overall price elasticities of demand for public sector contraceptives are low, this does not hold true for poorer households within the sample. These households are much more likely to cut back on consumption when prices of commodities are raised. Secondly, elasticities for contraceptives supplied through the private sector at far higher prices are also much higher than those for the public sector. Thus, if prices for pill or voluntary sterilization in Bali or injectables in North Sulawesi through the private sector were to be increased by 50 percent, demand would likely decrease by 15 percent. The authors' recommend that cost recovery efforts explicitly exclude the poor through a system similar to that of the "blue card" Thailand, whose holders are exempt from most payments for family planning.]

Kenney, Genevieve M. 1989. *The Economics of Private Sector Family Planning Service Provision in Indonesia*. Washington, DC: The Urban Institute. November.

[This paper is an analysis of the current role played by the private sector in Indonesia, the types of clientele it caters to, the cost and quality of its services, and its potential for growth in the coming years.]

Kocher, James E. and Bates C. Buckner. 1989. *Estimates of Global Resources Required to Meet Population Goals by the Year 2010*. Report prepared for the United Nations Population Fund. Research Triangle Park, NC: Research Triangle Institute. November 1 (revised).

[This report presents the findings of a UNFPA-commissioned study aimed at producing a

preliminary global estimate of financial resources required to meet population goals over the next twenty years. Cost estimates for contraceptive use, safe motherhood, education, and other population activities are presented, and the conclusion discusses policy implications and directions for future research.]

Lande, R., and J. Geller. 1991. "Paying for family planning." *Population Reports. Series J*, no. 39. Baltimore, MD. The Johns Hopkins University, Population Information Program. November.

[This constitutes the best single resource on the financing of family planning activities. It has an extensive bibliography with 244 references and discusses all aspects of the issue including the donor role, retail sales, third party coverage, public-private collaboration, cost recovery, and efficiency. The discussion is backed up in each case by a number of country cases and actual experience in the field.]

Lewis, Maureen A. 1986. "Do Contraceptive Prices Affect Demand?" *Studies in Family Planning*, 17(3): 126-135.

[This article examines the advisability of and need for extensive subsidization of family planning services based on studies that have compared free and fee-for-service family planning programs. The article also explores the importance of price in determining family planning demand through studies of demand shifts in response to changes in contraceptive prices. The findings suggest that moderate fees can be imposed for family planning services without affecting demand; however, full cost recovery may pose a deterrent to low- and moderate-income couples.]

Lewis, Maureen, and Genevieve Kenney. 1988. *The Private Sector and Family Planning in Developing Countries*. Washington, D.C. The Urban Institute.

[When it appeared this was the first comprehensive study of the private sector in family planning programs in developing countries. It provides evidence of the extent of private sector provision of services (including nongovernment organizations) and the variety of providers. It also examines how governments can stimulate private sector activity through a number of different policy initiatives and calls for further research in such areas as the cost effectiveness of the sector, and the determinants of private sector use.]

Lewis, Maureen A. 1992. *Cost and Cost-Sharing in Family Planning Programmes: Review of the Evidence and Implications for the Future*. Presented at the Expert Group Meeting on Family Planning, Health, and Family Well-Being, Bangalore, India, 26-30 October.

[Given recent trends of rising total demand for family planning services and projected decline in real international resources, this paper, prepared for the background meetings preparatory to the UN Population Conference in Cairo in 1994, examines likely demand, the costs of meeting that demand, and the options available for financing these expenditures. The paper concludes that data requirements on unmet need and costs of service delivery deserve greater attention, and that governments must husband resources through minimizing subsidies, targeting resources, contracting out, and promoting use of the private sector.]

Mauldin, W. Parker and Steven W. Sinding. 1992. *Review of Existing Family Planning Programmes: Lessons Learned*. Report prepared by the Population Division of the Department of Economic and Social Development, United Nations Secretariat, in consultation with the United Nations Population Fund, for the International Conference on Population and Development, 1994. Expert Group Meeting on Family Planning, Health and Family Well-being, Bangalore, India, 26-30 October.

[This report presents a panoramic view of the population and family planning situation in different regions of the world, illustrated by country-specific examples. It concludes with a detailed list of the aspects of family planning programs considered critical for success. This list covers a wide range of topics including: leadership and policy, administration of programs, contraceptive availability, service delivery, social marketing, NGO involvement, and financing considerations.]

Nortman, Dorothy, Jorge Halvas, and Aurora Rabago. 1986. "A cost-benefit analysis of the Mexican Social Security Administration's Family Planning Program." *Studies in Family Planning*, 17(1): 1-6.

[A cost-benefit analysis of the Mexican Social Security System (IMSS) was undertaken to test the hypothesis that IMSS's family planning services yield a net saving to IMSS by reducing the load on its maternal and infant care service. It concludes that for every peso spent on family planning services the agency saved nine.]

Rimon, Jose G., III, Mark Sherman, and Benjamin V. Lozare. 1992. *The Devolution of the Philippine Population Program: Findings and Recommendations*. Washington, DC: The Futures Group. December.

[This document examines the implications of the recently introduced Philippines Local Government Code (LGC) for the devolution of health and family planning programs. The paper makes several recommendations for this process, including defining institutional roles more clearly and using non project assistance, and it concludes that the opportunities provided by

devolution far outweigh the associated risks.]

Rosenzweig, Mark, and Kenneth Wolpin. 1986. "Evaluating the effects of optimally distributed public programs: Child health and family planning interventions." *American Economic Review*, 76(3): 470-82.

[Since considerable public resources have flowed into subsidies for family planning and child health programs in developing countries in recent years, this article attempts to set up appropriate estimation strategies for evaluating the effects of such programs. The authors formulate and test an optimizing model determining the allocation of subsidies for health and family planning across diverse households. Based on data from 20 randomly selected barrios in the Philippines, the authors conclude that subsidization of family planning is likely to be Pareto efficient when there are health externalities extant, as in low income households, since these subsidies may actually substitute for direct expenditures on health investment. In the case of both family planning and health subsidies, fertility control subsidies minimize the subsidy burden for donors, and are likely to be at a maximum where total subsidy expenditures per child are the greatest.]

Ross, John A. and Stephen L. Isaacs. 1988. "Costs, Payments, and Incentives in Family Planning Programs: A Review for Developing Countries." *Studies in Family Planning*, 19(5): 270-283.

[Based on responses to a questionnaire from 65 developing countries, this paper attempts to catalogue the variety of cost recovery measures, as well as incentive payments made to acceptors and motivators. The authors find that there is great diversity in practice but also inconsistency in applications *within* countries, leaving much scope for improvement. They conclude with a discussion of the ethical aspects of incentive schemes and recommendations for effective financial policies.]

Stover, John. 1993. *The contribution of contraceptive social marketing programs to the sustainability of family planning services*. Cincinnati, OH. Presented at the Population Association of America Annual Meetings. April.

[Against the background of the continuing resource crunch in the international family planning movement, this paper examines three aspects of contraceptive social marketing programs as they relate to financial sustainability. The first looks at the costs of CSM programs, the second at the relationship between the price and demand for contraceptives, and the final aspect relates to the contribution that CSM could make towards meeting existing and future demand. The author finds that existing costs of CSM programs are only a fraction of public sector costs, and that with complete self-sufficiency the fraction would be even smaller. However, CSM programs cannot be a full substitute for public sector programs since they inevitably involve at least some amount

of cost recovery. But by serving that segment of the market that is able and willing to pay, these programs can make an important contribution to the sustainability of the overall program.]

Vogel, Ronald J. 1988. *Cost Recovery in the Health Care Sector: Selected Country Studies in West Africa*. Washington, DC: The World Bank. World Bank Technical Paper Number 82.

[This study examines the health financing experience in Senegal, Mali, Côte d'Ivoire and Ghana. In all four countries the examination focuses principally on cost-recovery, resource allocation issues, and the status of health insurance and other risk sharing mechanisms. Recommendations range from encouraging programs to incorporate some elements of financial autonomy, to improvements in the quality of services and ensuring a gradual transition towards cost-recovery.]

Waddington, C.J. and K.A. Enyimayew. 1989. "A Price to Pay: The Impact of User Charges in Ashanti-Akim District, Ghana." *International Journal of Health Planning and Management*, 4: 17-47.

[This paper examines the impact of user charges on utilization of health services in the Ashanti-Akim district of Ghana, since their introduction in 1985. User charges have been successful in effecting some amount of cost recovery, and in maintaining utilization in urban areas. However, in the rural areas demand actually fell off as a result of the imposition of fees. There has also been a more than nominal shift in utilization towards private sector health services, which might pose problems since the sector is not subject to effective regulation and might suffer from poor quality of services. User fee collections also have not been used to reduce inequalities in health service distribution, as might have been expected.]

Yoder, Richard. 1989. "Are People Willing and Able to Pay for Health Services?" *Social Science and Medicine*, 29(1): 35-42.

[This paper analyzes the effect of increases in the user fee levels for public health services in Swaziland in 1984 on overall utilization, utilization of preventive versus curative care, and consumption patterns of the rich versus the poor. Both the initial study as well as the subsequent round of data collection revealed that demand declined substantially as a result of the fee increases. To some extent this reduction reflected a shift over to church mission services, but the evidence also showed that a dominant portion simply shifted out of the modern sector, perhaps to traditional care.]