



Issues in the  
**FINANCING OF  
FAMILY PLANNING  
SERVICES**  
in Sub-Saharan Africa

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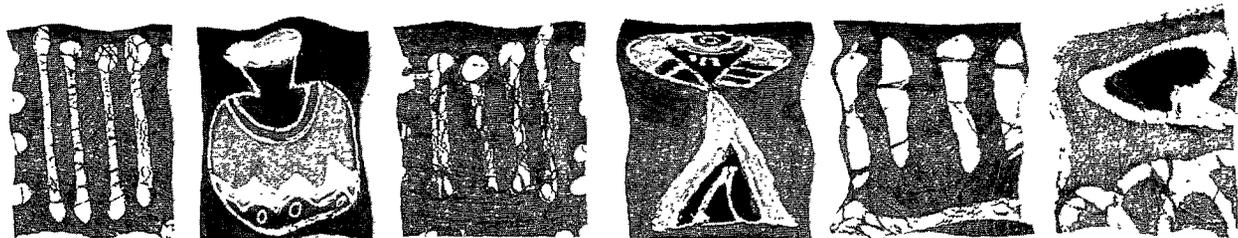
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## Acknowledgments

This report was written by Barbara Janowitz, Diana Measham and Caroline West. It was published by Family Health International, with support from the Office of Sustainable Development, Bureau for Africa, U.S. Agency for International Development (USAID). This report contributes to the work of the Office of Sustainable Development to address issues regarding the financing of health and family planning services.



The authors thank Abraham Bekele, the senior technical advisor of the Office of Sustainable Development, and Phyllis Gestrin, Lenni Kangas, Alex Ross, and Hope Sukin of the Bureau for Africa for their support and participation in the review of the report. The authors also thank other members of the Technical Advisory Committee: Stan Bernstein, Logan Brenzel, Barbara Crane, Bob Emrey, Dan Kress, Bill McGreevey, Robert Miller, Jim Rosen, Naomi Rutenberg, and Ken Yamashita. Special thanks go to Bill Winfrey of the Futures Group International, who reviewed earlier drafts and made substantial contributions.

ISBN: 0-939704-53-6

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Additional copies may be obtained from:  
Publications Coordinator  
Family Health International  
P.O. Box 13950  
Research Triangle Park, NC 27709 USA

## Preface

During the last decade, there has been substantial growth in the proportion of women who use family planning in sub-Saharan Africa. In the mid-1980s, fewer than 5 percent of African women used contraception. Today, almost 20 percent of African women use family planning. While this development is gratifying, there is a great deal more to be done. Too many countries, particularly in Western and Central Africa, still have prevalence rates well below 10 percent. Contraceptive use is far higher in countries outside the region. In the coming years, sub-Saharan Africa should move closer to the rest of the world in offering couples and individuals better access to safe, effective, affordable and acceptable contraceptives.

It will be difficult to find the resources to make free family planning available to every woman and man who wants services. Donor contributions have been stagnant in recent years, and many governments in sub-Saharan Africa, despite their policy pronouncements, are unable to increase their contributions for family planning. Therefore, new approaches must be devised to increase the resources available and to improve access to family planning within limited resources. The 1994 International Conference on Population and Development (ICPD) recommendation for making family planning services part of more comprehensive reproductive health services has been enthusiastically endorsed by African governments. Some have started to make the policy and program changes necessary to implement this approach; others are still to start. The majority, however, have yet to make the budget and funding changes needed. Funds for the comprehensive approach should not be expected only from family planning budgets. Funding elements from other reproductive health sectors must be pooled together, and the opportunity to include family planning education and services within other reproductive health programs must not be ignored.

Policy-makers and program planners must take steps to fill the gap between needs and resources. This report reviews the literature and hopes to assist the reader to appreciate and understand the policy options and actions that can help increase the availability of resources and contribute to better family planning services within overall reproductive health services.

One possibility is to find ways to increase the contributions of users of free or highly subsidized services, particularly from women and men who can afford to pay higher prices. A second possibility is to encourage users of subsidized services who can afford to purchase services in the commercial sector to do so, thus allowing subsidized services to help more people who cannot afford to do so. There is also ample room to increase the efficiency of service provision so that resources may go further and needs may be reduced. Other innovative and imaginative approaches need to be devised.

This document is intended to serve as a guide to policy-makers for developing plans to meet resource needs. The ICPD in Cairo sensitized us to the need to continue to provide family planning and to find ways of better meeting women's reproductive health needs. It is important not to let the momentum from that conference disappear. Detailed plans are needed to assist countries and donors to improve family planning programs.

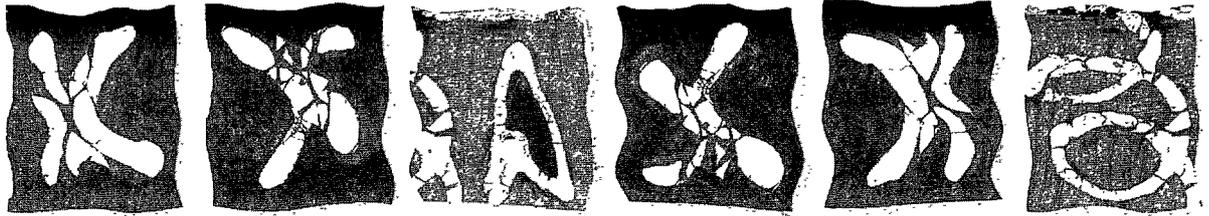
The increasing interest in the decentralization of health services in our region is to be welcomed. But every effort should be made to ensure that this does not result, at the ground level, in diminished funding of preventive programs such as family planning, and in extra favoring of programs that stress curative health services.

It is my personal concern that, now that most African countries have accepted family planning as an important part of overall development programs, as demonstrated by the 1984 Kilimanjaro Declaration and the 1992 Dakar one, international funding for the field is stagnant or diminishing. It is my hope that, as African governments take seriously and implement — as appropriate — the recommendations of this document, both they and the donors will endeavor to increase the resources available for family planning and reproductive health. Increasing contributions to this field has been justified over and over again in many countries, both on humanitarian and economic grounds.

—Fred Sai, MB, BS, FRCPE, MPH  
*President, Ghana Academy of Arts and Sciences*  
Board of Directors, Family Health International

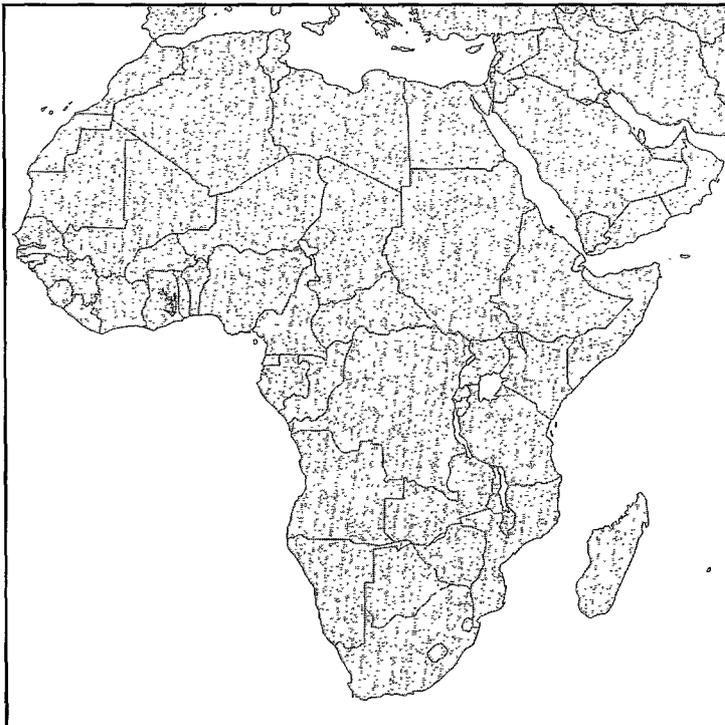
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## Chapter I

# INTRODUCTION



**T**his report addresses major issues related to the financing of family planning services in sub-Saharan Africa by consolidating and analyzing available information, much of which is not published or readily available. It is addressed to policy-makers and program managers in African government and donor agencies active in the health and family planning fields, and aims to identify gaps in the information base that will need to be filled to facilitate policy and program change. A series of policy briefs highlighting key issues is also available (Family Health International (FHI), 1999).

Unmet need for family planning services in sub-Saharan Africa is large and growing. Even if donor and government funding is projected optimistically, countries will be faced with a large and growing gap between needs and

resources. Providing services to meet reproductive health needs beyond contraceptive delivery widens this gap significantly. Eventually, countries will also need to replace donor funds with in-country resources. Failure to take these realities into account encourages the development of service delivery systems that are neither efficient nor sustainable. Even countries with low levels of income and low contraceptive use must begin now to plan for future funding of services.

While donor and African government contributions may increase in the short run, we believe that such funds are limited and that other sources of revenue, as well as ways of providing quality services at lower cost, must be identified. Subsequent chapters of this report explore the potential of the following three options:

1. increasing contributions from users in highly subsidized government and nongovernment programs;
2. encouraging subsidized service users with the ability to pay to obtain methods in the commercial sector; and
3. reducing the costs of services.

Chapter II aims to illustrate the large and growing gap between the need for family planning services in sub-Saharan Africa, and the availability of donor and government funds to meet this need. We begin by presenting available information on current and projected needs for family planning services. Next, we estimate the costs of meeting those needs, both today and in the future. We then present data on current levels of government and donor expenditure on family planning in the region. Much of the information available on these topics — and particularly on future resource requirements and current government expenditure — is extremely rough. Nonetheless, it is possible to state with certainty that there is a need for additional resources, over and above donor and government funds, to finance current and projected needs for services.

Chapter III covers the first of these options: charging or increasing fees to users of public sector and nongovernmental organization (NGO) outlets, so that they pay a higher share of service costs. This strategy should be used with caution, since price increases could discourage those who need services, and particularly the poor, from using them. In theory, means testing systems can protect those who are unable to pay for services. The performance of these systems, with particular reference to the sub-Saharan context, is also evaluated in Chapter III.

**Table 1.1. Public-Private Modes of Financing and Delivering Family Planning Services**

Delivery Mode	Financing Modes	
	<i>Public: general government revenues or publicly mandated insurance</i>	<i>Private: direct, out-of-pocket expenditures and voluntary insurance</i>
Public	Public sector providers supply services directly.	Governments charge for the services they provide, particularly those supplied to the wealthy, in order to target public spending to the poor.
Private, for-profit and not-for-profit	Governments subsidize or contract with nongovernmental organizations or private for-profit providers to supply services.	Individuals pay directly for services, which are often delivered through organized networks of private providers.

Source: Tsui et al., 1997.

Chapter IV discusses the second option: encouraging greater use of the commercial sector. The current scope of commercial sector involvement in family planning service delivery in sub-Saharan Africa is explored and contrasted with other regions of the world. The factors that affect commercial sector development are also discussed. Specific attention is paid to the role of for-profit providers, retailers, social marketing, managed care, and employer-based family planning programs.

Finally, Chapter V examines the third option: reducing the costs of family planning services. A case study of Kenya is used to demonstrate the limited reliability of available cost information and to illustrate the need for more rigorous research on this subject. The chapter also discusses potential strategies for reducing the costs of family planning services, such as mobilizing underutilized capacity, eliminating unnecessary medical barriers, and integrating family planning and other reproductive health services.

## **Overarching Issues: Financing**

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### **The financing context**

Family planning services can be financed from a number of sources, including fees charged to service users, revenues raised through taxation, and contributions from donors. The mix of these funding sources will vary by type of service provider (Table 1.1 shows the relationship between source of funding and place of service provision). Purely commercial outlets generally cover their costs solely through client fees; in such cases, sales of pills in pharmacies or payments for visits to commercial clinics are not subsidized. Social marketing programs, however, also sell their products at commercial outlets. Since donors often provide some of the funding for these programs, they tend to be partially subsidized. Purely commercial family planning activities are very rare in the sub-Saharan region; donors provide at least some funding for

most retail contraceptive services. Ministry of health facilities may be supported through a combination of fees, tax revenues, and donor contributions. Fees generally cover only a small portion of costs, and, in some countries, these services are free. Nongovernmental, not-for-profit facilities may be supported with the same types of financing, though government funding is likely to be more limited or nonexistent.

### **A public finance perspective**

To what extent are governments and donors obligated to fill the gap between needs and resources? There are several arguments that are made for a public role in the financing of family planning services and activities. Broadly, these can be classified as follows: they are merit goods; they carry positive externalities; they can be used to alleviate poverty; and they are public goods. Each of these ideas is summarized below.<sup>1</sup>

First, it is argued that contraceptives should be subsidized because they are merit goods, or goods that society believes each individual should have access to regardless of ability to pay. Merit goods include items that satisfy basic needs, such as food, clothing, and shelter; many also believe that family planning services fall within this area of social obligation. “Contraceptives are very strong candidates for the merit goods characterization because they enable individuals to exercise greater control over their reproductive lives” (Desai, 1997). The merit goods argument is possibly the strongest justification for public provision of contraceptive information and services.

Second, it is argued that governments and donors should help finance goods with large positive externalities. These goods benefit not only the individual using them, but also society as a whole. Condom provision is an example of a family planning service with large positive externalities, since the benefits of condoms accrue both to the

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<sup>1</sup> The interested reader may consult Desai (1997), Tsui et al. (1997), Haaga and Tsui (1995), and UNFPA (1992) for additional discussion of the rationale for government or donor support of family planning programs.

person using them and to others in the community, as a result of reduced incidence of sexually transmitted diseases (STDs). In this case, public subsidies are again justified, because the price charged to individuals for these services will usually result in suboptimal use.

According to Desai (1997), the use of contraceptives for general family planning purposes also produces positive externalities by reducing population growth rates, which in turn reduces the strain on public sector social services — benefiting society as a whole. This argument can be challenged on two grounds: First, as Desai notes, there may be more effective means of reducing the strain on social services than by reducing population growth rates; and second, even if reductions in population growth rates are the best way to reduce the strain on social services, many would argue that population growth is more appropriately and effectively influenced through broad socio-economic development initiatives than through family planning services.

An additional argument for public and donor support of family planning concerns poverty alleviation. According to this argument, donors and governments can work toward equity goals by providing family planning services to those who need them, but who would not normally have access to them due to limited resources. The suggested weakness of this argument is that because the cost of obtaining family planning services constitutes only a small portion of any family's budget, public subsidies do not contribute much to alleviating poverty. It can also be argued that by reducing unwanted fertility, family planning services alleviate poverty at the household level.

There are, however, more effective ways of achieving poverty reduction goals. In addition, as we will discuss later, it is also difficult to target services only to the poor; subsidies invariably “leak” to the non-poor.

Finally, it is argued that governments should finance public goods, or activities that the private sector will either not undertake or will undertake at suboptimal levels because users cannot be charged for them (Tsui et al., 1997). Within family planning activities, contraceptive regulation and testing, as well as the provision of information about family planning, can be defined as public goods. Private providers have little incentive to finance these activities, since associated benefits accrue to all other private providers (Desai, 1997). According to this argument, these activities will be performed at suboptimal levels in the absence of public support. This argument applies

only to the regulatory and educational aspects of family planning, however. Public support for contraceptive service delivery cannot be justified using the public goods argument.

*To what extent are governments and donors obligated to fill the gap between needs and resources?*

## **Overarching Issues: Health Care Context**

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### **Family planning as a component of overall health care**

In sub-Saharan Africa, family planning and other health services are generally provided in the same facilities, by the same staff, using the same overall funding stream. There are many reasons, however, for a singular focus on the family planning component of these services, particularly where finance issues are concerned. In many countries,

family planning is the dominant component of the integrated service package, due in large part to donor funding priorities. In addition, any discussion of financing must keep in mind that the reasons people use family planning services may differ from their reasons for seeking preventive or curative health care. Individuals tend to see immediate benefits from curative care, and are the sole recipients of those benefits. Preventive care is sought to prevent the probability of future illness. Family planning, on the other hand, is sought to prevent the probability of a future pregnancy. These differences in motivation for — and the impact of — using services will influence the extent to which individuals are willing to pay fees, their propensity to seek care from different provider and outlet types, their concerns with service quality, and a range of other relevant factors. Hence, while lessons from the health-care finance literature are referred to throughout this document, our focus remains on family planning.

### **Family planning in the context of health sector reform**

Since family planning services tend to be provided in the context of general health care, changes in the way health care is managed and financed will have an impact on family planning management and financing. Many countries in sub-Saharan Africa have instituted a process of health sector reform; the specific reform agenda varies from country to country. According to Cassels (1995), it may include the following components:

- efforts to improve the performance of public sector health-care providers through changes in the numbers of staff, payment and appraisal systems, and job descriptions;
- decentralization of health management and service provision;

- improving the functioning of national ministries of health through organizational restructuring, changes in the priority-setting process, etc.;
- broadening health financing options through user fees, insurance schemes, etc.;
- introducing managed competition; and
- working with the private sector.

While a number of these issues are discussed in the chapters that follow, a full analysis of the impact of health sector reform on family planning services is beyond the scope of this document. The interested reader is encouraged to consult Cassels (1995), Aitken (1998), and Standing (1997).

### **A reproductive health approach to family planning services**

In recent years there have been calls for a reorientation of family planning services from a focus on fertility control to a focus on the achievement of reproductive health and rights goals. This change in the family planning program paradigm has a range of implications for the way in which services are designed and delivered — as well as the way they are financed.

At a minimum, contraceptive delivery services must be provided in a manner that does not compromise reproductive health and choice. This implies, for example, that the full range of contraceptive methods should be made available; that clients should be given full information and counseling to enable them to make the choice of method most appropriate to them; and that women in need of other reproductive health services should be referred to appropriate personnel or facilities.

Ideally, contraceptive delivery services should be provided as one of a constellation of other services essential for the achievement of reproductive

health and rights, including: safe abortion management; screening for and treatment of STDs, other reproductive tract infections (RTIs), and reproductive cancers; maternity care; infertility management; and a range of other services.<sup>2</sup>

Improving the reproductive health and rights orientation of services — whether minimally, by ensuring that contraceptives are provided in a manner conducive to reproductive health, or ideally, by ensuring that women have access to comprehensive reproductive health care — has profound implications for the costs and financing of services. While this report looks at cost and finance issues related to contraceptive delivery services, we do so with reproductive health goals in mind, drawing to the extent possible on the very limited literature and experience to date in integrating family planning with broader reproductive health services. There is a significant literature on costs and finance issues related to other individual components of reproductive health care, e.g., on STDs and maternity care per se. Reviewing the implications of this literature for reproductive health costs and finance as a whole is beyond the scope of this report.

While we are unable, given constraints of time and resources, to develop a strategic framework for reproductive health finance as a whole, this should be made a priority by the U.S. Agency for International Development (USAID) and other

agencies. There is an urgent need to assess the costs of integrated reproductive health services — including but not limited to contraceptive delivery services — and to identify options for mobilizing the resources required to provide them.

## Overarching Issues: Regional Diversity

Writing a single document on financing options for family planning in sub-Saharan Africa as a whole is a tall order. The region is made up of 45 markedly different countries. It is easy to find cultural, institutional, and historical parallels among countries within anglophone Africa on the one hand, and francophone Africa on the other, or between East

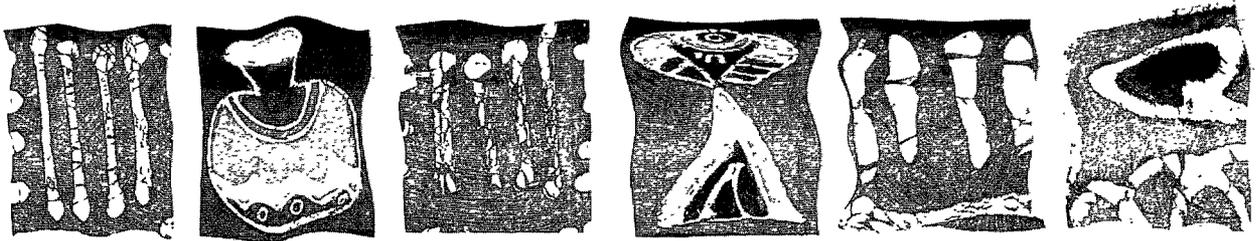
Africa and West Africa. Yet each country differs significantly on many of the levels that will affect its options for resource mobilization, including: current financing and service delivery mechanisms; the history and culture of paying for social services; commercial sector policy and laws; available personnel and infrastructure; coverage of family planning services; culture of family planning use; and income

levels. We examine the implications of these differences wherever the literature permits — which is less often than we would like. Needless to say, the conclusions we draw should be interpreted with due regard for any specific country context.<sup>3</sup>

*Improving the reproductive health and rights orientation of services...has profound implications for the costs and financing of services.*

<sup>2</sup> The *Programme of Action of the International Conference on Population and Development (ICPD)* states that “reproductive health care in the context of primary health care should, *inter alia*, include: family planning counseling, information, education, communication, and services; prenatal care; post-natal care, prevention and appropriate treatment of infertility, abortion services as specified in paragraph 8.25, including management of the consequences of unsafe abortion; treatment of reproductive tract infection, sexually transmitted diseases and other reproductive health conditions; and information, education and counseling, as appropriate, on human sexuality, reproductive health, and responsible parenthood.” [The foregoing is an edited version of the interventions listed in paragraph 7.6 of the *Programme of Action*.]

<sup>3</sup> See the Population Council publication entitled *Clinic-Based Family Planning and Reproductive Health Services in Africa: Findings from Situation Analysis Studies* for a discussion of the diversity of family planning programs in Africa.



## Chapter II

# THE GAP BETWEEN NEEDS AND RESOURCES

**T**his chapter aims to illustrate the large and growing gap between the need for family planning services in sub-Saharan Africa and the availability of donor and government funds to meet this need. We begin by presenting available information on current and projected needs for family planning services. Next, we estimate the costs of meeting these needs, both today and in the future. We present data on current levels of government and donor expenditure on family planning in the region. Much of the information available on these topics — and particularly on future resource requirements and current government expenditure — is extremely rough. Nonetheless, it is possible to state with certainty that there is a need for additional resources, over and above donor and government subsidies, to finance current and projected needs for services.

### **The Costs of Family Planning Services**

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#### **Need for services**

Almost 10 million sub-Saharan African women currently use family planning. About three times this number — or about 29 million women — have an *unmet need* for family planning services. Traditional definitions of unmet need include married women of reproductive age who are fecund and who desire either to cease or delay childbearing, but are not currently using contraception (Curtis and Neitzel, 1996; Rutenberg et al., 1991; Westoff and Bankole, 1995; and Westoff and Ochoa, 1991). Clearly, many unmarried women (widows, divorcees, and younger, unmarried women) also need contraception. As a result, estimates of unmet need as traditionally defined underestimate the true need for family planning.

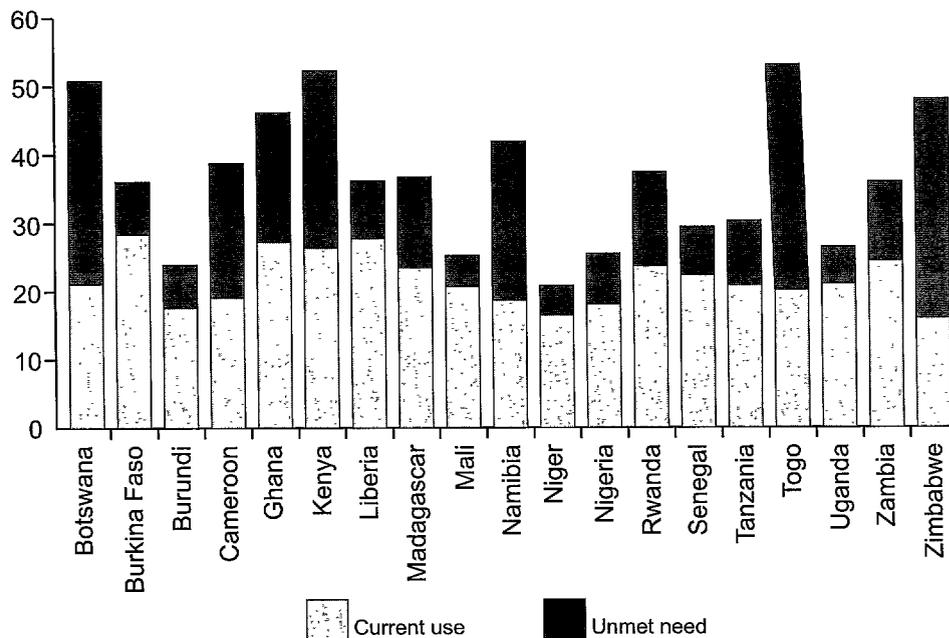
Figure 2.1 illustrates the extent of unmet need and current use of family planning among all women of reproductive age in the region.<sup>1</sup> The sum of current use and unmet need in sub-Saharan nations by Demographic and Health Surveys (DHS) ranges from 21 percent of all women of reproductive age in Niger to 53 percent in Togo. In other words, in Togo, resources must be found to provide family planning services to 53 percent of all women of reproductive age. Currently, 20 percent of women are using contraception, and more than 30 percent of women have an unmet need for services.

On the other hand, a significant proportion of women who are described as having an unmet need still say that they do not intend to use contraception, since they do not believe they need it. This can be for religious or cultural reasons, because of a lack of information, or for a host of other reasons. Family planning programs can alter some but not all of these client-described barriers to use. As

such, conventional measures of unmet need overestimate the true extent to which current contraceptive delivery services fail to keep pace with true need as defined by individuals.

Westoff and Bankole (1995) estimate potential levels of contraceptive prevalence under a range of definitions of unmet need, including meeting all unmet need (conventionally defined) and meeting need as expressed by women themselves. About 15 million women consider themselves to be in need of contraception, and would use services if they were available. The results of these alternative scenarios are presented in Figure 2.2. In Burkina Faso, the potential contraceptive prevalence rate is reduced by half if only those women with an expressed desire for contraceptive services are taken into account. In Kenya, the rate is reduced by only five percentage points, because the expressed need for contraception accounts for a considerable proportion of unmet need.

**Figure 2.1. Current Use of and Unmet Need for Family Planning among All Women Regardless of Marital Status, 1987-1993 (percentage)**



Source: Westoff and Bankole, 1995.

<sup>1</sup> The sum of current use and unmet need for contraception is often referred to as "demand" for contraception. Economists define demand as the willingness and ability to pay for a product or service at various prices — a narrower definition. Individuals may be classified as being "in need" of a service for which they have no demand. For this reason, we have opted not to use the term "demand" to refer to the sum of current use and unmet need for contraception

Regardless of which definition of unmet need is used, it is clear that a high proportion of sub-Saharan Africans wish to use contraception, and cannot.

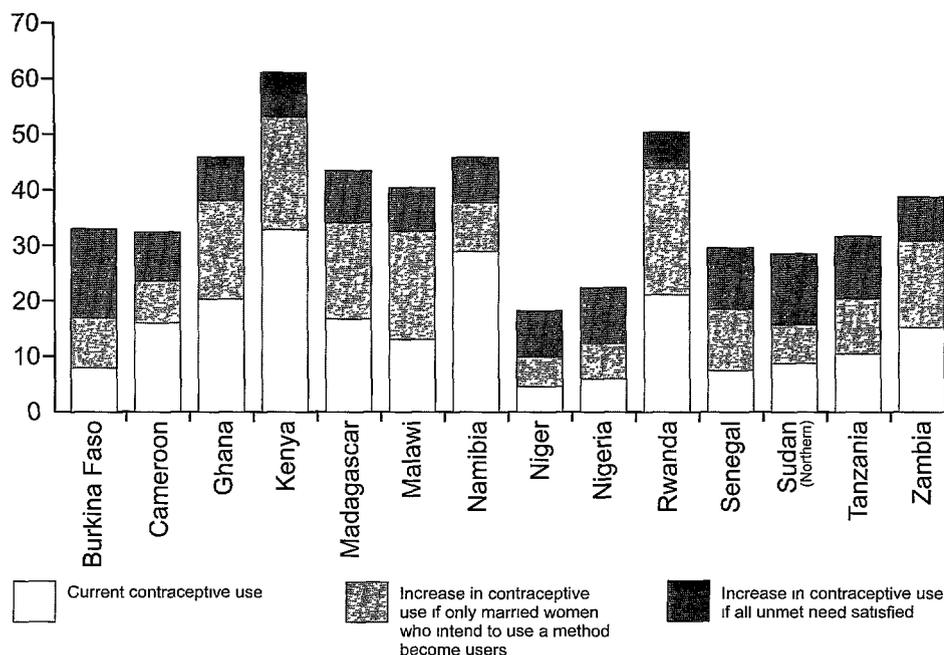
### The costs of meeting unmet needs today

It is possible to estimate the costs of providing services to the limited proportion of women in need who now receive them, as well as to estimate the additional funds that would be needed to provide services to all women who wish to use them. A total of approximately U.S. \$283 million was spent annually in the early 1990s to provide family planning services to just over 9.7 million women in sub-Saharan Africa in 1995 (Conly et al., 1995).<sup>2</sup> This translates to a cost per user of about U.S. \$29. As noted above, about 29 million additional

women wish to delay or limit childbearing but are not using contraception. Assuming constant costs per user, providing services to these women would cost approximately U.S. \$841 million, about three times the amount now spent. Providing services only to those women who say they would use contraception — about half of those defined as having unmet need — would cost approximately U.S. \$420 million. Total expenditure under this scenario would need to increase by 150 percent, just to meet existing needs for services.

For a number of reasons, these estimates of additional, current resource needs should be interpreted with caution. As we will discuss later in this chapter, information on total expenditure, and particularly government expenditure, is very rough. In addition, costs per user are likely to decline as

**Figure 2.2. Estimates of Potential Family Planning Use among Married Women, 1990-1994 (percentage)**



Source: Westoff and Bankole, 1995.

<sup>2</sup> As discussed later in this chapter, there is some evidence that government expenditure is underestimated in Conly et al. (1995).

programs expand due to economies of scale. Nonetheless, these rough estimates make it clear that substantial, additional resources are needed to meet existing needs.

### Projecting unmet needs

Without a significant expansion in the resource and service base, a much higher proportion of women will have unmet needs in the future. Unmet need is likely to grow substantially for two reasons:

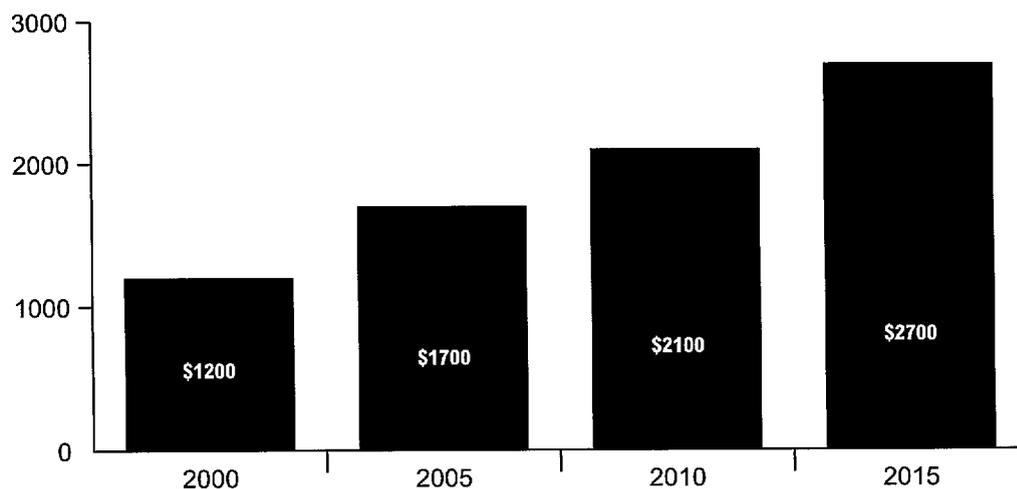
1) Populations are growing, and women of reproductive age make up an increasingly high proportion of these populations; and 2) A growing proportion of women will desire to use contraception. In Kenya, for example, the population of women of reproductive age will increase by 40 percent between 1992 and 2000. The commensurate figure for Nigeria is 35 percent (United Nations, 1994). Providing contraception to all those who want to use it will

imply an enormous increase in the number of contraceptive users. For example, an increase in the contraceptive prevalence rate of 15 percent in Kenya and Nigeria would imply an increase in the number of contraceptive users of 121 percent and 275 percent, respectively (Haaga and Tsui, 1995).

### The costs of meeting future unmet needs

Numerous efforts have been made to estimate the cost of meeting family planning needs in the next century (*Amsterdam Declaration*, 1989; Gillespie et al., 1989; Janowitz et al., 1990; Kocher and Buckner, 1992; Lande and Geller, 1991; McNamara, 1991; and Lewis, 1992). The *Amsterdam Declaration* estimate, which was based on an amalgam of the estimates produced in the late 1980s, placed total family planning resource requirements for the year 2000 at U.S. \$9 billion.

**Figure 2.3. Total Estimated Annual Resource Requirements for Family Planning in Sub-Saharan Africa, 2000-2015 (millions of U.S. dollars)**



Source: UNFPA, 1996b.

The most recent estimates, developed by the United Nations Population Fund (UNFPA), are the best available to date. While past efforts had been based on the cost of achieving the contraceptive prevalence rates required to meet demographic goals, UNFPA based its estimates on the cost of meeting unmet need for contraception, thereby emphasizing individual reproductive intentions and choice rather than fertility reduction targets. UNFPA also estimates need among all women of reproductive age, rather than limiting the analysis to married women, and makes provisions to account for the fact that not all those defined as having unmet need intend to use contraception.<sup>3</sup> As such, total expenditure is likely to be somewhat higher than the estimate we use here.

UNFPA's estimated annual resource requirements for family planning in sub-Saharan Africa are provided in Figure 2.3. Resource requirements will grow from an estimated U.S. \$1.2 billion in 2000 to almost \$3 billion in 2015.

We must emphasize that these resources are required to finance basic family planning services. Significant, additional funding will be needed to provide sub-Saharan African women with broader reproductive health services (see Box 2.1).

## Trends in Donor Funding to Family Planning Programs

### The global picture

According to the 1994 *Global Population Assistance Report* (GPAR), published by UNFPA, global population sector funding grew at a steady pace over the last decade, reaching record high levels in 1994 (UNFPA, 1996a). As illustrated in Figure 2.4, this is true of both the funding made available by donors (primary funding) and funds spent on population activities in country (final expenditures).<sup>4</sup> In real terms, primary funding for population assistance grew by an average of 5

### Box 2.1. The Additional Costs of Providing Basic Reproductive Health Care

UNFPA's resource requirement estimates also consider the costs of providing a broader package of reproductive health care in accordance with the vision promulgated by the International Conference on Population and Development (ICPD) held in Cairo in 1994. Definitions of the content of "reproductive health care" beyond the provision of contraceptive services are variable. The UNFPA definition, based on the definition provided in the ICPD *Programme of Action* (see Chapter I), is very comprehensive, but includes only those aspects of care provided at the primary level.

If the costs of meeting reproductive health needs are added to those for meeting family planning needs, total estimated resource requirements for sub-Saharan Africa in the year 2000 will increase by more than 65 percent over the amount required to finance family planning services alone, to a total of almost U.S. \$2 billion. By the year 2015, total requirements will be almost \$4 billion.

However, it is likely that the UNFPA estimates of resource requirements for reproductive health care underestimate true needs. Due to data limitations, they include only the costs of providing primary level maternity care and HIV prevention. The estimates do not include the costs of providing the other services outlined in the ICPD *Programme of Action*, most notably the diagnosis and treatment of sexually transmitted diseases (STDs) and other reproductive tract infections (RTIs), and the prevention and treatment of other reproductive health conditions, such as cervical cancer. Some of these reproductive health problems will respond favorably to interventions in other areas; e.g., HIV prevention efforts will also help to prevent other STDs. But the bulk of screening and treatment is excluded. Some of these omitted services would increase resource requirements substantially. On the other hand, the estimate for family planning resource requirements already includes some elements of the joint infrastructure for family planning and other reproductive health services. This implies that the marginal cost of adding some reproductive health services may be lower than suggested by the estimates developed for each individual reproductive health program component.

There is an urgent need for further work to refine and standardize definitions of reproductive health care and to assess the costs of integrated provision of reproductive health and family planning services. While the UNFPA estimates are a good starting point, they are not a substitute for conducting assessments at the country level. Until such studies are conducted, our knowledge of the costs of providing a package of family planning and reproductive health services will remain limited.

<sup>3</sup> UNFPA also takes into account the fact that costs per user do not remain constant. Economies of scale will tend to reduce average costs over time, as will efficiency enhancements and the mobilization of underutilized capacity, which is extensive in family planning services in the region (see Chapter V for a discussion of underutilized capacity). On the other hand, urgently needed quality improvements will tend to increase costs per user. Research on the true cost implications of such factors as mobilization of underutilized capacity and efficiency enhancements on the one hand, and quality enhancements on the other, is warranted.

<sup>4</sup> Because of funding/expenditure cycles and reporting variations, these two figures differ by an average of 24 percent in any given year.

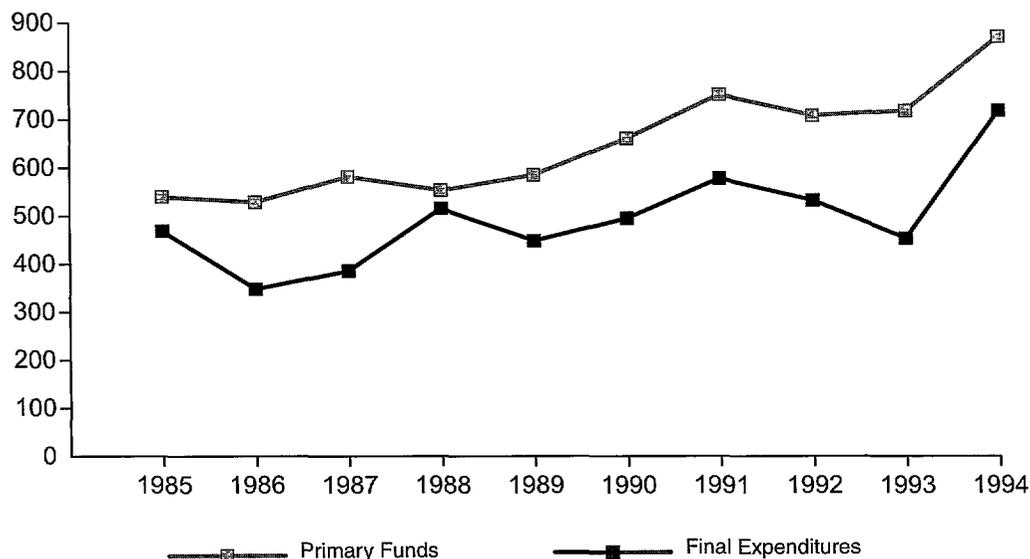
percent per year between 1985 and 1994. Growth between 1993 and 1994, at 24 percent, was significantly above average (final expenditures grew by a record 62 percent during the same period). This is mostly likely due to funding commitments made prior to the International Conference on Population and Development (ICPD).

The ICPD called for governments, international agencies and NGOs to adopt a broader view of population programs beyond family planning services by including a broader range of reproductive health services. The 1995 GPAR, therefore, documents total donor contributions to family planning programs as well as a range of other areas, including basic reproductive health services; maternal, infant, and child health care; and the prevention of STDs, including HIV/AIDS (UNFPA, 1997). While total funding under the new definition increased by 22 percent between 1994 and 1995,

this appears to be due to the addition of new program categories. Indeed, if these new categories are extracted, funding for traditional population sector programs — predominantly family planning services — appears to have declined by about 15 percent between 1994 and 1995.

This information should be interpreted with caution. While it is possible that funding for conventional family planning services has declined somewhat — due perhaps to a redistribution of donor funds toward other elements of reproductive health care — this cannot be known with any certainty. It is unclear how much of the funding to traditional population programs outlined in prior GPAR reports actually supported elements of reproductive health care, even if these were not specified. Nor is it clear whether or not and how donors may have redefined their own funding categories. Most importantly, we have very little reliable data on country-level

**Figure 2.4. Primary Funds and Final Expenditures for Population Assistance, 1985-94 (millions of constant U.S. dollars)**



Source: UNFPA, 1996a.

spending on these different categories of care, implying that global estimates are necessarily rough. Given that the objective of this chapter is to elucidate trends in funding to family planning programs per se, we will draw predominantly on information provided by the GPAR for 1994, the last year that UNFPA focused on traditional population programs. We will supplement this with

information from the 1995 GPAR on trends between 1994 and 1995, with appropriate caveats.

According to the 1994 GPAR, developed-country governments provided almost 70 percent of all population funding between 1985 and 1994; almost half was provided by the United States. U.S. funding increased more between 1993 and

### **Box 2.2. Key Issues in Donor Funding**

#### **Changes in donor funding patterns**

Over the last few years, some major donors and development banks have begun a shift from targeted grants/lending to sectoral grants/lending. This implies that the World Bank, for example, is more likely to lend funds for activities that benefit the health sector as a whole, e.g., infrastructure investments or finance reform, than for activities such as family planning or diarrheal disease control.

Within targeted funding, donors are moving away from vertical funding for family planning toward integrated funding for reproductive health—as illustrated by the most recent edition of the GPAR, discussed above. In India, for example, the World Bank has shifted from a focus on family planning to a “reproductive and child health approach.” A similar approach is being advocated by USAID, though the project cycle has not yet caught up with changes in strategy.

The impact of these dual trends toward sectoral investment and integrated reproductive health investment on the overall level of resources available for family planning is not clear. As discussed, it is difficult to compare family planning specific funding data through 1994 to more recent data that attempts to delineate spending on a broader range of reproductive health service categories. Based on the rough estimates available, however, it does appear that funding for family planning per se may have declined.

#### **The composition of external assistance for family planning**

While we have a fairly clear idea of the total amount of external assistance to family planning activities, we have less information on the way these funds are allocated across such functional categories as service delivery; information, education, and communication (IEC); training; policy; and research and evaluation. The composition of external financing should be assessed from a public finance perspective. There is more public finance justification for donor or public sector support for information dissemination than for other types of family planning activities. Concerns about program sustainability, however, call for donor spending on infrastructure and training to prepare countries to develop and manage their own programs. Within

spending on service delivery, it is important to know if donor funding is focused on the development of innovative activities, which may strengthen the program, or on supporting recurrent costs, which may simply increase a country's dependence on donor funding.

The limited information now available suggests that donor funds are often used to finance recurrent program costs and especially commodities. It is argued that without this type of donor support, countries will develop or revert to programs with limited method choice. No research has proven this outcome, however, and the limited information available suggests a more complex relationship between funding sources and method mix. Thailand, for example, once received USAID commodities, and now does not. Nonetheless, its method mix continues to be one of the most varied of any country program. Other countries, such as Mexico and Brazil, have received U.S. commodities in quantity, but have programs that are heavily focused on a limited number of methods: female sterilization and IUDs in Mexico, and oral contraceptives and female sterilization in Brazil.

#### **The influence of donor funding on African government expenditure**

External assistance may also influence the magnitude and composition of government funding. In many countries, the size and focus of the family planning sector has been influenced primarily by donor interest in this area. Have governments diverted resources they might have used for family planning to other areas (either within or outside the health sector) because of the availability of donor funds for family planning? Will they consider family planning services to be worthy of domestic funding when donor funds are withdrawn? Case studies of USAID “graduate countries” (e.g., Botswana) would help to answer these questions. Similarly, an assessment of family planning financing in South Africa, which did not receive donor contributions until very recently, would be useful. Data on the composition of family planning financing should be collected both before and after donors withdraw (or make substantial changes in their funding levels) to assess the role of donors in influencing the composition of government funding.

**Table 2.1. Source of Family Planning Expenditure, by Region (percentage)**

<i>Region</i>	<i>Donors</i>	<i>World Bank</i>	<i>Government</i>	<i>Consumers</i>
Sub-Saharan Africa	53.9	10.1	22.3	13.7
Sub-Saharan Africa (excluding South Africa)	71.2	13.3	8.7	6.7
East and Southeast Asia	3.5	1.6	88.1	6.8
South Asia	15.6	23.8	55.2	5.4
Latin America and the Caribbean	21.6	2.0	27.8	48.6
North Africa and West Asia	26.7	5.7	36.0	31.6
All Developing Regions	13.9	7.0	65.4	13.7

Source: Conly et al., 1995.

1994 than funding from any other source — rising by U.S. \$96 million. While funding from 12 of the 21 donor countries declined between 1993 and 1994, funding increases among the other donor countries far more than offset these declines. Increases were even more dramatic between 1994 and 1995, due in large part to the inclusion of other reproductive health program categories. U.S. funding, for example, increased by U.S. \$204 million. Almost 85 percent of this funding — or about U.S. \$173 million — was for family planning services. Twelve other donor countries also reported significant increases in funding. The Netherlands, for example, increased its contribution by U.S. \$43 million, but only about 40 percent of this amount — or U.S. \$17 million — was for family planning services; an equivalent amount was allocated to “basic reproductive health services” and prevention of STDs/HIV. Similarly, while the United Kingdom increased its overall contribution by over U.S. \$40 million, less than 20 percent was allocated to family planning services.

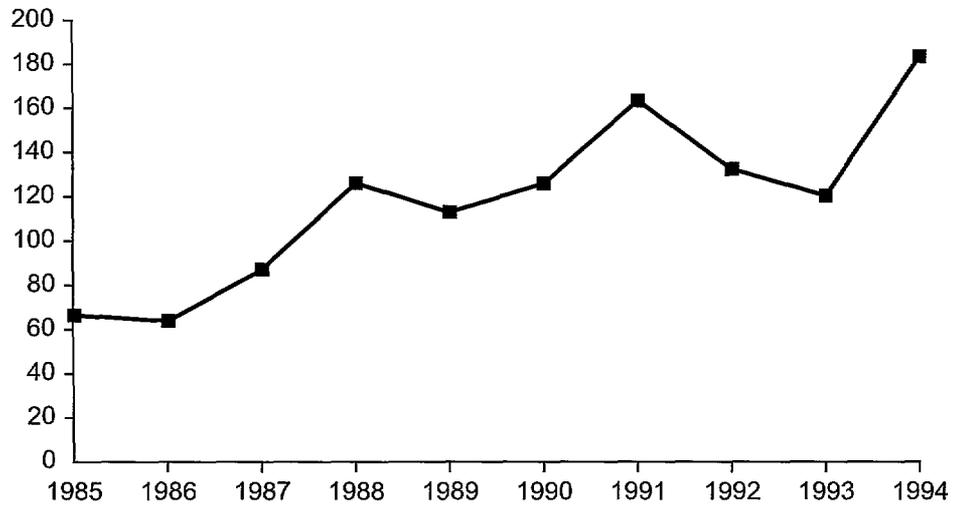
Population funding represented 1.65 percent of total official development assistance in 1994, the highest percentage in ten years. Between 1994 and 1995, the proportion increased to 2.32 percent, due largely, if not completely, to the addition of new funding categories.

Box 2.2 presents additional information on the donor funding patterns that must be considered in any discussion of resource requirements and program sustainability. Changes in donor funding patterns may have an impact on the availability of resources for family planning. The functional composition of donor funding to family planning programs must also be considered, as it is inextricably linked to sustainability concerns. External assistance may also affect African government spending patterns, and may do so in ways that detract from sustainability goals.

### **Trends in donor funding to sub-Saharan Africa**

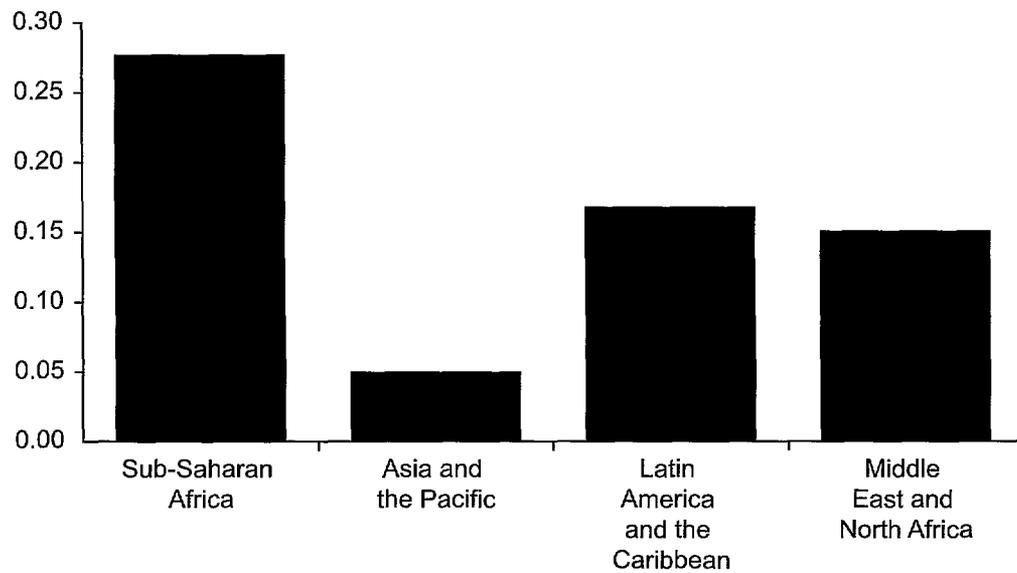
Trends in population funding in sub-Saharan Africa have been even more positive than in the world as a whole. Year-to-year growth in population assistance to the region from 1985 to 1994 is shown in Figure 2.5. The average annual growth rate over the decade was high, at almost 15 percent (constant dollars). Growth between 1993 and 1994 was particularly high, at 52 percent. Sub-Saharan Africa was the only region in which population assistance increased between the quinquennia 1985-89 and 1990-94 (data not shown). In addition, according to 1993 data, the region receives a disproportionate share of international population assistance in per capita terms (see Figure 2.6), at

**Figure 2.5. Final Expenditures for Population Assistance, Sub-Saharan Africa, 1985-94 (millions of constant U.S. dollars)**



Source: UNFPA, 1996a.

**Figure 2.6. Final Expenditures for Population Assistance Per Capita, by Region, 1993 (U.S. dollars)**



Source: UNFPA, 1995.

nearly U.S. \$0.30 per person — almost double the next highest regional level of per capita funding. Sub-Saharan Africa has also had the greatest increases in per capita expenditures over time — the amount doubled between 1984 and 1993 (data not shown).<sup>5</sup>

The proportion of family planning expenditure made up by donor contributions is far higher in sub-Saharan Africa than in any other region (see Table 2.1). Donor funds cover 54 percent of all family planning funding in the region. If South Africa (which accounts for most regional spending, but until recently received no donor funds) is excluded from the estimate, the donor contribution rises to more than 70 percent. By contrast, the donor contribution is only 3.5 percent in East and Southeast Asia, 22 percent in Latin America and the Caribbean, 16 percent in South Asia, and 27 percent in North Africa and West Asia.<sup>6</sup>

The fact that family planning programs in the region are overwhelmingly donor supported implies that governments and consumers contribute very little. If World Bank loans — many of which are provided at concessionary interest rates — are included as part of donor funding, governments and consumers can be estimated to contribute only 15 percent of total funding in sub-Saharan Africa (excluding South Africa) compared to nearly 95 percent in East and Southeast Asia, for example. Patterns of government spending on family planning in the region are discussed in detail later in this chapter.

### Intra-regional donor funding patterns

There are considerable differences in the amounts of absolute and per capita funding received by the countries of the sub-Saharan region. According to the GPAR, 45 sub-Saharan nations received a total of almost U.S. \$182 million in international population assistance in 1994. Amounts received by country ranged from a low of about U.S. \$51,000

**Table 2.2. Government Family Planning Expenditures, by Country**

Country	U.S. \$ (millions)	% of Total Expenditure
Botswana	0.2	8.3
Burkina Faso	1.0	18.9
Central African Republic	0.4	19.0
Chad	<0.1	NA
Côte d'Ivoire	0.1	2.0
Congo	<0.1	NA
Ethiopia	0.3	3.9
Ghana	2.1	18.6
Guinea	1.0	32.3
Guinea-Bissau	0.2	20.0
Kenya	0.8	2.6
Lesotho	<0.1	NA
Liberia	0.1	7.7
Madagascar	0.1	2.5
Malawi	0.2	4.0
Mali	3.7	43.5
Mauritania	<0.1	NA
Mozambique	1.0	24.4
Nigeria	0.7	3.3
Rwanda	1.2	9.2
Senegal	0.2	2.3
South Africa	22.3	64.5
Tanzania	0.6	5.4
Uganda	0.3	3.5
Zaire	0.2	3.8
Zambia	0.1	NA
Zimbabwe	2.5	16.9

Source. Conly et al., 1995.

(Comoros) to a high of almost U.S. \$26 million (Kenya). The regional total for 1995 was about U.S. \$361 million. Amounts received by country ranged from a low of about U.S. \$57,000 (Comoros) to a high of about U.S. \$41 million (Kenya). Again,

<sup>5</sup> Editions of the *Global Population Assistance Report* since 1993 have not provided information on per capita expenditures

<sup>6</sup> The donor contribution would be higher in East and Southeast Asia if China were excluded. Of the other countries in that region, the proportion of expenditures covered by donor funds is highest in the Philippines (55 percent). Worldwide, the proportion of total funding covered by donors exceeds 70 percent in very few countries (Nepal, Guatemala, Peru, El Salvador, and Haiti)

however, it is not clear what proportion of the 1995 amount was allocated to family planning versus other elements of reproductive health care.

## Government Funding of Family Planning Programs in Sub-Saharan Africa

Estimating government expenditure on family planning services is a difficult exercise. Conly et al. (1995) attempted to develop empirical estimates of the approximate magnitude of family planning expenditures — including government expenditure — based on a review of the literature and the responses of key informants (primarily local donor agency representatives) to a questionnaire (see Table 2.2). In addition, more detailed, country-level analyses of government expenditure are now available for three countries of the region: Ghana (Thompson and Janowitz, 1997), Côte d'Ivoire (Stewart and Koffi, 1997), and Kenya (Abel, 1995).<sup>7,8</sup>

The results of these studies and a description of the methodology used in each case are shown in Box 2.5. The estimate derived by Conly et al. (1995) for each country, and the source used to develop the estimate, are provided for comparison. In Ghana, for example, Thompson and Janowitz (1997) estimate that the government spends approximately U.S. \$4 million on family planning. Conly et al. (1995) place government spending closer to U.S. \$2 million. Similarly, in Kenya, Abel (1995) places government spending at about U.S. \$2 million, while the Conly et al. (1995) estimate is

U.S. \$800,000. Finally, in Côte d'Ivoire, Stewart and Koffi (1997) estimate that government expenditure on family planning program *salaries only* is about U.S. \$120,000, while Conly et al. (1995) place *total* government family planning expenditure at approximately \$100,000.

While the estimates from the detailed country analyses are likely to be more reliable than those provided by Conly et al. (1995), both should be interpreted with caution given the paucity of accurate data and degree of estimation required. In

both Ghana and Côte d'Ivoire, central level information on government spending was not available: In Ghana, where health services have been decentralized, information was only available at the level of service delivery sites; in Côte d'Ivoire, access to government spending records was not permitted. (See Table 2.3 for a summary of the estimation metho-

dology used in the absence of expenditure records.) Even when records are available, as in the Kenya case, they often need adjustment before they can be used. Since expenditures on health and family planning services are generally integrated in ministry of health accounts, allocation rules must be developed to determine the way in which shared personnel, facility, equipment, and other costs should be divided among health and family planning programs. UNFPA is now supporting a project to obtain country-level information on funding for and expenditures on family planning and other reproductive health services, which should improve our knowledge in this area.

*...analyses...should be interpreted with caution given the paucity of accurate data...on government spending...*

<sup>7</sup> Both the Ghana and Côte d'Ivoire analyses were developed as part of an effort by Family Health International and the EVALUATION Project of the Carolina Population Center at the University of North Carolina at Chapel Hill to develop a simple, standard, and replicable methodology to estimate expenditures on family planning, including government expenditure.

<sup>8</sup> Detailed, country-level information on family planning and reproductive health care expenditures is currently being collected by the Netherlands Interdisciplinary Demographic Institute (NIDI) for countries worldwide. At the time this report was written, data were too preliminary for our use.

**Table 2.3. Estimates of Government Family Planning Expenditure in Ghana, Kenya and Côte d'Ivoire**

Country	Government Expenditure	Methodology	Source
Ghana	\$3,770,491	Because no data were available from government accounts, government expenditures were assessed using an estimation process that drew on a range of sources. First, provider salaries were estimated based on interviews with donors. Estimates of expenditures on other items were based on the ratio of salary and commodity expenditures to expenditures on other program items found in expenditure analyses conducted for the Planned Parenthood Association of Ghana, and in Bangladesh and Ecuador.	Thompson, Andy, Barbara Janowitz, and Population Programming, Monitoring and Evaluation Division, Ministry of Health, Ghana. 1997. <i>Country Report: Estimating Family Planning Expenditures in Ghana</i> . Research Triangle Park, NC: Family Health International.
	\$2,100,000	Figures obtained from USAID's 1993 Final Report, <i>The Analysis of Government of Ghana/Ministry of Health Expenditures on Family Planning and AIDS</i> .	Conly, Shanty R., Nada Chaya, and Karen Helsing. 1995. <i>Family Planning Expenditure in 79 Countries: A Current Assessment</i> . Washington: Population Action International.
Kenya	\$2,195,125	Recurrent and development expenditures for the National Council for Population and Development and the Ministry of Health (MOH), as reported in official government documents, were added together, using a range of allocation assumptions when not all the reported expenditures could be assumed to be for family planning. For example, it was assumed that a certain portion of the recurrent expenditures of the Division of Family Health (DFH) of the MOH were for family planning services (the DFH is also responsible for maternal and child health (MCH) services). A recent analysis found that 18 percent of MCH service visits were for family planning services. Therefore, it was assumed that 18 percent of DFH expenditures were on family planning.	Abel, Edward and National Council for Population and Development, Kenya. 1995. <i>Family Planning Financial Resource Requirements (1993-2010): Technical Notes and Methodology</i> . Washington: The Futures Group International (RAPID IV).
	\$800,000	Population Action International (PAI) distributed a questionnaire regarding the level of government expenditure on family planning. Where family planning was subsumed within the health budget, respondents were asked to make an informed estimate of the percentage of the health budget allocated to family planning and to explain how the estimate was derived. The Population Council/Nairobi completed the questionnaire.	Conly et al., 1995.
Côte d'Ivoire	\$120,172 <i>(salaries only)</i>	Because government accounts were not available, an estimate of government expenditure on salaries only was derived by combining government information on the salaries of family planning workers with an estimate of the number of family planning visits to government facilities (using the records of AIBEF, the International Planned Parenthood Federation (IPPF) affiliate in Côte d'Ivoire, which supports many government family planning clinics with training, logistics, etc.) and data on staff time per family planning visit (from a survey of facilities).	Stewart, John F. and Kouame Koffi. 1997. <i>Country Report: Estimating Family Planning Expenditures in Côte d'Ivoire, 1994</i> . Draft. Chapel Hill, NC: University of North Carolina and Association Ivoirienne pour le Bien Etre Familial.
	\$100,000 <i>(total expenditure)</i>	PAI distributed a questionnaire regarding the level of government expenditure on family planning. Where family planning was subsumed within the health budget, respondents were asked to make an informed estimate of the percentage of the health budget allocated to family planning and to explain how the estimate was derived. UNFPA/Abidjan and USAID/Abidjan completed the questionnaire.	Conly et al., 1995.

According to the estimates in Conly et al. (1995), government support for family planning in Africa ranges from a low of 2 percent of total expenditure in Côte d'Ivoire to a high of 64.5 percent in South Africa.<sup>9</sup> In more than half of the countries for which this information is available, the government's contribution to total family planning expenditure is less than 10 percent, and in nine of these countries, it is less than 5 percent. Only in four countries does the government's contribution exceed 20 percent of all family planning expenditure. As noted earlier in this chapter, this is far less than the contribution made by most governments in other developing regions.

Future government funding for family planning services in the region could be affected positively by such factors as growing female participation in the political process, though this is slow to change. It could also be affected either positively or negatively by economic growth or political change. Even allowing for the possibility of substantial growth in public sector family planning expenditure, it is unlikely that African governments will be able to fill the gap between available resources and growing needs for services.

## **Conclusion**

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The need for family planning services in sub-Saharan Africa is high and rising. Meeting current need for family planning would require spending more than twice the amount spent today. Future needs and funding requirements will be even greater, since the population of women of reproductive age will increase and a higher proportion of these women will want to use contraception.

While the most recent assessments of donor funding for family planning are quite optimistic, they must be interpreted with caution. In the last decade, donor funding for family planning in sub-Saharan Africa appears to have grown dramatically. Between 1994 and 1995, however, the growth in

the overall resource base for both family planning and reproductive health care appears to be due in large part to increased funding of other elements of reproductive health care. Indeed, funding for family planning per se may have declined.

Funds from donors and The World Bank account for about 85 percent of all family planning expenditure in sub-Saharan Africa (excluding South Africa). This contrasts dramatically with donor contributions to other developing regions, which never exceed 40 percent. Governments in the sub-Saharan African region contribute significantly less toward overall family planning expenditure than those in other regions, and this is unlikely to change. However, it is likely that donors will aim to subsidize lower proportions of overall expenditure over time. At the same time, resource requirements will increase dramatically.

These three forces — probable declines in the proportion of expenditure covered by donors, limited potential for increasing government subsidies, and a rising level of contraceptive use and unmet need — imply an urgent need to identify and mobilize additional, alternative sources of funding for family planning. This will be necessary even to sustain current, inadequate levels of service provision. Meeting high and rising unmet need levels increases the need for additional, domestic resources substantially. While it is not possible to predict the gap between future donor and government subsidy levels and resource requirements with any certainty, even the most optimistic projections suggest that the need for additional resources will be enormous.

Immediate efforts must be made to identify alternative sources of funds for family planning services and/or to decrease the need for funds by improving the cost-effectiveness of services. One resource-mobilizing strategy is to charge fees for services in subsidized programs, as discussed in Chapter III. Chapter IV addresses the potential for

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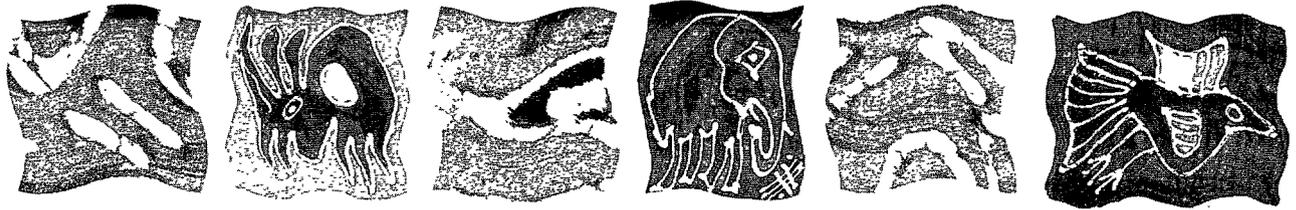
<sup>9</sup> At the time of the Conly et al. study, the South Africa case was an anomaly in the region. There was no donor funding, government funding and consumer payments financed services in their entirety.

mobilizing resources through client payments in the commercial sector, by promoting the growth of this sector. Finally, Chapter V considers ways in which the costs of services can be minimized to increase the impact of existing resources.



## P O L I C Y   A C T I O N S

1. The sub-Saharan region has high levels of unmet need for family planning services, as well as a large gap between need and both actual and potential resources. As a result, this region should continue to receive its proportionate share of donor resources in the short and medium term.
2. In the short term, donors should increase their support to African family planning programs in order to sustain them in the face of increasing demand for services. In order to prevent dependence and to minimize host-country displacement of resources, donors need to work with governments to set clear time frames for phase-out of increased assistance and assist countries to develop their own plans for domestic resource mobilization.
3. The resources needed to implement the broad *Programme of Action* from ICPD in Cairo are not available. Donors must prioritize among the various elements of the *Programme*. Care must be taken to ensure that funding for family planning services is not diminished as implementation of the Cairo agenda moves forward.



# CHARGING FOR FAMILY PLANNING SERVICES

**P**olicy-makers and health finance planners need to consider the potential of fee-for-service family planning programs as a strategy for mobilizing revenue. While raising revenue is but one of many reasons for charging fees for services (see Figure 3.1), it is emphasized here due to our overall focus on potential alternatives to government and donor financing.

The concern with charging or increasing fees for family planning services is that it will discourage service use. This chapter, therefore, addresses both the revenue-raising potential of fees and the conflict between raising revenue and ensuring access to services. Because information on the impact of fees on the use of family planning services is limited, we also refer to the literature on the health sector as a whole.

**Figure 3.1. Rationale for Fee-for-service Family Planning Programs**

**Revenues and Quality of Services**

Increased revenue from user fees can:

- augment financing of recurrent inputs, such as contraceptives, and improve the quality and effectiveness of services;
- free up resources to expand the availability of services; and
- lessen dependence on donor funds.

**Efficiency**

Strategic pricing of services:

- can reduce excessive use of services and bring supply capacity in line with willingness and ability to pay; and
- can direct clients to lower-cost sources (for example, to pharmacies/shops for re-supply methods) while higher-level facilities provide clinical methods and methods to new acceptors.

**Equity**

User fees can improve equity:

- if higher prices are charged to those most able to pay, making it possible to channel family planning subsidies to the poor; and
- if exemptions are implemented for the most destitute.

**Public-Private Collaboration**

User fees for government services:

- foster greater competition between private and public providers and improve the efficiency of both; and
- divert demand to private providers, freeing up government resources to improve care for the poor.

Source. Based on Shaw, 1995.

## How Do Fees Affect the Demand for Family Planning Services?

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### An economic model of contraception and fertility

The economic model of household production dates back to Becker (1981) and has been applied to contraception and fertility (Rosenzweig and Schultz, 1985). According to the model, if the costs of children outweigh their benefits, then couples may choose to contracept to limit the number of children they bear. Similarly, if couples believe that spacing their children will bring them health or other benefits, they may contracept to achieve these benefits. The decision to use contraceptives will depend on the perceived costs of contraceptives relative to the benefits of using contraceptives. Costs will depend on the efficacy of the contraceptive, the cost of obtaining it (its price, as well as the costs of travel time, waiting time, and transport) and the cost of using it (including side effects, cultural or spousal sanctions, etc.) (Thomas and Maluccio, 1995).

Early studies of the impact of prices on contraceptive use had mixed results. Some studies suggested that prices have a minimal impact on demand; others suggested a dramatic impact. This variability is likely to reflect measurement differences as much as true differences in the price elasticity of demand in different settings (see Lewis, 1986; Janowitz and Gould, 1993, for a review of early studies).

In this chapter, we provide a review of more recent studies of the impact of prices on contraceptive use in sub-Saharan Africa. We first provide a framework to classify the studies by the type of methodology used. In this way, the methodological strengths and weaknesses of each study can be kept in mind when its findings are assessed.

### A framework to examine the impact of fees on demand for services

Shaw (1995) categorized studies of health care demand into five types, as follows:

**Type I** studies use facility-based data to compare service use before and after fees are instituted without adjusting for client characteristics or the quality of care, and without using a control group. Studies of this type are likely to measure incorrectly the effect of prices on demand because they neglect the impact of quality improvements made possible by increased revenues (consumers may be willing to pay more for services if fee revenues are used to improve service quality). There also is no consideration of the possibility that consumers will simply find alternative sources of care when confronted with a price increase; instead, it is assumed that declines in service use at any given facility represent declines in overall use.

**Type II** and **Type III** studies are based on multivariate statistical analyses of cross-sectional household data. These studies control for some client characteristics and other variables that affect use. They are generally computer simulations of what individuals would do, rather than studies of what individuals actually do, in response to a price change. **Type II** studies use non-monetary costs to the client (such as distance and time costs) as proxies for prices, either because services are provided free of charge or because information on prices is not available. Shaw (1995) notes that such variables may not adequately reflect how price changes affect demand for services because: (a) service fees tend to represent a far smaller proportion of income than these other costs; and (b) the opportunity cost of time may be so low as to obviate the impact of time costs on service use. **Type III** studies, on the other hand, are based on actual price data. These studies separate the effects of the price of services per se from the effects of distance, time and other costs to the client.

**Type IV** studies also use cross-sectional data, but they improve on study types II and III by building in data on facility characteristics, thereby allowing consideration of the impact of quality on demand. Because these studies are cross-sectional, they do not actually measure behavior change. Nonetheless, they generate an important policy consideration: The impact of fees on demand may hinge on whether or not revenues are used to improve the quality of care.

**Type V** studies are the gold standard for studying the effects of fees on demand. They are based on actual behavior change in response to the institution or an increase in fees for services, as well as quality enhancements, and they include a control group. Although very valuable, these studies are time-consuming and expensive.

### Family planning demand studies in sub-Saharan Africa

A series of studies has been conducted in Africa to assess the impact of costs to clients (fees, travel, and time) and quality on contraceptive use. The results of these studies vis-à-vis the impact on demand of the fee or price component of costs (or a proxy thereof), as well as the impact of quality, are described below.

In Tanzania (Beegle, 1995), no information was available on prices, but information on facility characteristics was available from a Service Availability Module (SAM). Cross-sectional household data were available from the DHS. This study, therefore, is a combination of types II (no information on prices) and IV (information on quality). The price of contraception was proxied using information on distance to the nearest facility. As noted earlier, when no information on price is available — or when the price is zero — distance is often used as a proxy for price, based on the assumption that time and travel costs affect service use in the same manner as monetary prices. The author notes that

this proxy has some drawbacks, since visits to the nearest family planning facility may be “shared” by other services (i.e., individuals may obtain a range of services in addition to family planning when they visit the facility). The study found no consistent relationship between price and demand.

Only two of a number of quality variables used — availability of pills and injectables — were found to have a positive impact on use.

A study carried out in Zimbabwe (Thomas and Maluccio, 1995) may be classified as type IV. Information on household variables was available from the DHS and quality measures were available from the Zimbabwe Situation Analysis. The authors used the price of a package of oral contraceptives as the price variable. Partly because there is no heterogeneity of prices in Zimbabwe (all clinics charge Z\$0.20 per package), the study found no impact of price on demand. In addition, experiments using different specifications for distance to facilities (which captures part of the time cost) indicate that it does not have an impact on use. However, women in areas with a community-based distribution (CBD) program were significantly more likely to be using contraceptives, and this variable may, in part, be capturing the cost of time.

Only two of the quality variables for clinics had a significant impact on use (the number of needles in stock and the number of nurses on site). Quality of CBD workers, as measured by whether or not they had a bicycle or had taken a training course, also had an impact on contraceptive use.

In Ghana (Oliver, 1995), information was available from the Ghana Living Standards Measurement Survey as well as from a survey of the health and family planning facilities nearest to each group of households. This study is therefore classified as type IV. The family planning consultation fee and the price of spermicides were used to construct price variables. The effect of distance to the nearest

health facility offering family planning was also assessed. The price of spermicides was found to have a negative impact on use, but only in private facilities. The consultation fee had no impact on use. The author concluded that prices have very little impact on the probability of contraceptive use. Distance to facilities proved to be a significant constraint to use.

In this study, quality was represented by variables measuring the availability of other maternal and child health (MCH) services, the availability of several methods, and the number of staff available to provide family planning services. The coefficients on the measures “are inconsistent and sometimes perverse...” The author suggests that this result may reflect the lack of variability in quality levels, the inability of the variables to measure appropriately important aspects of quality, or the fact that at low levels of contraceptive prevalence, quality is not an important determinant of use.

The study in Nigeria (Feyisetan and Ainsworth, 1996) may also be classified as type IV since information was available on both the price and quality of services. Data were from a DHS-type survey and a SAM-type facility survey. No relationship was found between contraceptive use and the level of outpatient or registration fees. The price of methods (at pharmacies only) was associated with lower use. Distance to the nearest facility offering family planning services did not affect use.

The quality variables appeared to have limited impact. The authors suggest that the facility survey was unable to capture all aspects of service quality, though a recent Population Council situation analy-

sis (Mensch et al., 1994) also found no statistically significant effect of quality on contraceptive use in Nigeria.

In sum, these four studies suggest that prices have a relatively limited impact on demand for family planning services. In addition, quality appears to have a less significant impact on demand than one might expect.

### Lessons from the health-care literature

There is a growing literature from the health sector on the impact of fees on demand for care.

Unfortunately, even in this more developed body of work, much of the evidence on price elasticity of demand is “mixed, piecemeal, and of questionable validity” (Shaw, 1995). Relevant findings are discussed below.

1. **Individuals may react to fees by finding new sources of care.** In Swaziland, Yoder (1989) found that when prices at Ministry of Health facilities were raised by 300 percent to 400 percent, there was a 32 percent drop in use; however, 30 percent to 40 percent of prior Ministry of Health clients switched to the private sector.
2. **Quality is more important than price.** The results of health-care demand studies support the hypothesis that price plays a limited role in determining use of health care. However, quality may have a stronger impact on health-care use than it does on family planning use. For example, Lavy and Germain (1996) found that fee increases contributed little to the dramatic

*...while fees do have some effect on demand, this effect is limited when quality improvements are made simultaneously.*

decline in health-facility use in Ghana between 1973 and 1987, particularly in comparison to the effects of distance and service quality. This type IV study used a nationally representative survey of the population and a comprehensive survey of facility characteristics. A study in Nigeria (World Bank, 1991) also found that the impact of quality on use was far greater than that of price, and that quality improvements could offset the impact of higher prices.

The role of quality in determining the demand for health care is confirmed by the results of type V studies. Litvack and Bodart (1993) conducted research based on a natural experiment in Cameroon, through which three of five facilities introduced a user fee and quality improvements, and two introduced fees but did not make improvements. They found that while fees do have some effect on demand, this effect is limited when quality improvements are made simultaneously.<sup>1</sup>

A similar study conducted under the Health Financing and Sustainability (HFS) project in Niger (Ellis and Chawla, 1994 in Wouters, 1994) assessed the impact of two types of payment systems, introduced in conjunction with quality improvements (improved drug supply), on revenues and demand. The positive effects of quality improvements again offset the demand-dampening effects of price.

**3. Improving quality can be costly.** Wouters et al. (1993) caution that the cost of implementing necessary quality improvements could outstrip potential fee revenues, given the lack of a service base in many settings. This is particularly true in sub-Saharan Africa. For example, the value of drugs that facilities consumed in one Niger district undergoing quality improvements was 2.5 times higher than the annual Ministry of Health drug budget. The authors suggest that even if the primary purpose of fees

is to raise revenue to improve services — or if quality improvements are necessary to prevent demand from falling in response to prices — initial improvements will require financing beyond fee revenues. If, on the other hand, the purpose of fees is to cover existing costs, making quality improvements may make it impossible to achieve this objective.

**4. Local fee retention can increase revenue collection.** Governments have tended to require that facilities return any fees they collect to the central government for distribution in the manner most likely to enhance the public good. There are, however, benefits to local retention and use of fee revenues, including a greater incentive to collect fees and the potential improvement of service quality on site. In an analysis of Cameroon, Central African Republic, and Swaziland (McInnes, 1993), facilities that retained revenues performed substantially better than facilities that remitted revenues to the treasury. In Cameroon, facilities that retained revenues were able to cover drug costs, as well as increase use of health centers, with the poor benefiting more than the rich. In Swaziland, one of the reasons for the low percentage of costs recovered by public facilities was lack of incentive to collect fees. By comparison, Osuga and Nordberg (1993) found that the introduction of user charges for outpatient services at Ministry of Health facilities in Kenya resulted in a 20 percent to 40 percent decrease in overall health-care use after six months. This occurred despite the fact that 75 percent of the revenues collected were to be retained by facilities — presumably to finance service improvements. However, it is not clear that fee revenues were used to improve quality.

**5. Means testing cannot guarantee that the poor will be protected.** Even if most people are able and willing to pay for services, there is evidence that some people cannot. For example,

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<sup>1</sup> Clinics were not randomly assigned to experimental or control groups. It is possible that the clinics making the changes were in some way different from the ones that did not, and that part of the measured impact has to do with initial clinic characteristics. It is important that facilities be randomly selected into experimental or control groups. (FHI, INOPAL and the POLICY Project carried out a study in Ecuador in which clinics are randomly assigned to different price groups.)

### **Box 3.1. Means Testing in Sub-Saharan Africa**

An extensive review of means testing in developing countries (Levine et al., 1992) found that "success measures are neither widely available nor uniformly applied." One assessment based on staff opinions found that only ten of 28 programs were successful. Only one of these was in sub-Saharan Africa. The conditions required for successful means testing, such as formal wage records, adequate information, and administrative infrastructure, tend not to exist in the region (Willis and Leighton, 1995).

Means testing systems in Africa tend to be decentralized and informal. Reviews have found that only two countries (Zimbabwe and Ethiopia) have official income ceilings for exemptions: one (Lesotho) has specific landholding and livestock ownership criteria; one (Malawi) has landholding criteria only; 12 claim to provide exemptions but do not specify the criteria used; and eight are based on ad hoc local policy (Nolan and Turbat, 1993; Russell and Gilson, 1995 in Leighton and Diop, 1995). On closer examination, many of these criteria appear to be ad hoc, vague, or inequitable. The programs have considerable "leakage" of exemptions to the non-poor, either intentionally or otherwise, and their coverage of the poor is inadequate.

In Lesotho, for example, while 30,000 health workers and their young children are exempt, the poor must be officially certified as "paupers" to receive an exemption; only 200 paupers are certified in the country as a whole (Nolan and Turbat, 1993). In Senegal, local health committees can exempt certain individuals, including "certain kinds of poor people" and various government workers (Vogel, 1988 in Levine et al., 1992). Malawi, on the other hand, has developed an exemption system through which the "core poor," a category being defined through a detailed examination of the landholding structure, receive exemptions; about 19 percent of the population will qualify (Ferster et al., 1991 in Shaw, 1995). In Ethiopia, peasant associations are authorized to determine eligibility based on income, and little leakage occurs (World Bank, 1987 in Levine et al., 1992).

In an extensive review of informal means testing systems in Burkina Faso, Niger, and Senegal, Leighton and Diop (1995) found that the proportion of poor clients receiving exemptions is higher than the proportion of non-poor clients receiving exemptions. This suggests that there is some attempt to identify and give waivers to the poor. Public facilities tended to provide about 25 percent of all exemptions to the poor, and 75 percent to the non-poor (in Senegal, the commensurate figures are 12 percent and 88 percent, respectively).

based on a review of the literature and research in Côte d'Ivoire and Peru, Gertler and van der Gaag (1990) conclude that user fees may cause large reductions in service utilization by individuals in lower income groups. Similarly, Leighton (1991) found that in Senegal, the ultra-poor were far more likely than the moderately poor to reduce their use of primary health care in response to rising prices.

Some form of means testing is needed to identify those who cannot pay and ensure that they have access to care. This can be complicated; in some cases, the expense of designing a system that functions well may negate any benefits that could be derived from imposing fees. The results of recent reviews of means testing in sub-Saharan Africa are summarized in Box 3.1. None of the literature on means testing is specific to family planning. Nonetheless, a general lesson can be learned: If fees for family planning are instituted or increased, effective mechanisms to ensure that the poor will continue to have access to services cannot be taken for granted.

## **Key Issues in Family Planning Pricing**

Based on the lessons learned from the health-care finance and family planning literature, a number of issues must be addressed in considering the potential for fees as a means to raise revenue for family planning.

### **1. To what extent are findings from the health-care literature applicable to family planning?**

It is important to note that consumers may not react the same way to family planning price increases as they do to increases in prices for curative health care. They may be more ready to accept increases in the prices of curative health services without diminishing use if they see immediate benefits and if they are the direct

and sole beneficiaries of those benefits. Consumer reaction to price increases for family planning is likely to be more like that for preventive health care (Desai, 1997). In the case of family planning, however, it is not the probability of a future illness that is being reduced, but that of a birth. The consequences of not taking action to prevent a birth are very different than those of not taking action to prevent future illness; as such, even reactions to price increases for preventive care may be very different than for family planning.

#### 2. Will large increases in fees dissuade use?

While the results reported above generally indicate that price does not have an important impact on demand for family planning services, this may be because contraceptive prices are very low. In Ghana (Oliver, 1995), the higher private sector price was found to have a significant impact on demand. A similar finding was reported for Nigerian pharmacies, where prices are likely to be higher than in public and NGO facilities. These findings also show why price is rarely cited in DHS surveys as a reason for not using or not intending to use contraception (Westoff and Bankole, 1995). If prices are low or nonexistent, then affordability would not be an important deterrent to use. We may conclude that a modest increase in fees from a low level is unlikely to dissuade use; however, large price increases to near-commercial levels might have a more significant impact on demand.<sup>2</sup>

#### 3. Do family planning clients respond to price increases by seeking alternative sources of services?

Shifts of demand to other sources of care may occur when fees are charged for family planning services. Ciszewski and Harvey (1995) point out that an increase in the prices of pills and condoms provided through the social marketing company in Bangladesh led to decreases in sales; however, while the company's market share decreased overall, contraceptive

use rose (Janowitz and Bratt, 1996). The original study had failed to account for source substitution. Most studies of the impact of contraceptive price increases fail to take this phenomenon into account.

- #### 4. Will the impact of prices be different for long-acting and re-supply methods?
- Most of the family planning pricing studies cited above used information on the actual price paid for services. However, earlier work conducted in other regions (for example, Thailand, Indonesia, and Jamaica as reported in Akin and Schwartz (1988), Ashakul (1990), and Jensen et al. (1993)) used a price variable that averaged protection over the period of use. While an individual generally pays for a method at the time of service, some methods last a long time or are permanent. How do women view these prices? Is their reaction to price conditioned by the fact that they may pay more now (for longer-term methods) but will avoid paying later? Will the high up-front costs of long-term methods be a barrier to cost recovery? More research should be conducted to answer these questions.
- #### 5. Do women react differently to price changes than men?
- It is argued that women may be more affected by fees than men, given unequal gender relations and women's lesser say in decisions regarding household resource allocation. However, little research has been conducted on this issue. Some interesting findings have emerged from the Population Council's project in Navrongo, Ghana, but these have not yet been published (Phillips, 1997, personal communication). Phillips does suggest that women's fear of negotiation with their partners may deter them from requesting funds to purchase contraceptives. There is some evidence from the health sector on this issue. For example, a study in Senegal (Leighton, 1991) found that changes in primary health-care utilization in response to rising prices differed by gender, with women more affected than men.

<sup>2</sup> When determining the potential impact of an increase in fees, it is important to note that official prices may underestimate the amount clients currently pay. There is evidence from both the health and family planning sectors that clients often pay more for services than officially stipulated. Even where services are officially provided free of charge, people sometimes are charged for them at the point of service. In Ghana, the price charged for contraceptives was between 200 percent and 638 percent higher than the official price, depending on the method (Kress, 1995). The *Population Council Situation Analysis* in Senegal found similar price variability among facilities.

**6. Will young adults react differently to price changes than older men or women?** There is very little data on the differential impact of fees on different age groups. A recent publication of the FOCUS Project, which reviewed social marketing projects directed at young people, noted that price was a potential barrier to service use among this group. However, none of the projects or research reviewed examined this issue (Israel and Nagano, 1997). Another recent study found that sexually active adolescents in Cameroon were more likely to use condoms they had paid for than those they had received free (Meekers, 1997). However, there was no attempt to determine the role prices play in influencing demand for condoms. If prices have a strong deterrent effect on adolescents' willingness to purchase condoms, free distribution may be preferable even if these condoms are more likely to be wasted.

**7. Will quality improvements mitigate the impact of price increases?** The family planning literature is only now beginning to consider the impact of quality on demand and the potential interaction of quality with price in determining demand. If fee revenues are used to improve service quality, then an increase in fees may have a less significant impact on demand. The studies cited above, however, found that quality had a limited and inconsistent impact on use in the case of family planning services. It may be that the quality variables used in these studies were inadequate.<sup>3</sup>

An alternative interpretation is that quality plays a different role in determining demand for family planning than it does in determining demand for health care. Results from the literature on willingness to pay do support the lack of a strong quality effect in family planning

services. In Burkina Faso, for example, Sow (1994) found that while nearly all households were willing to pay for improvements in health-facility equipment and maintenance and for drugs to treat a range of common ailments, far fewer were willing to pay for contraceptives. Households were willing to pay amounts representing 5 percent to 10 percent of their total expenditures to improve the quality of health care, but less than .05 percent for improvements in the quality of family planning services.<sup>4</sup>

**8. Are time costs a barrier to family planning use and can proxies, such as time, measure the impact of price changes?** The effects of distance and travel time on the use of family planning services are often used as proxies for the impact of prices. As such, it is worth examining how accurate these proxies are. While distance and travel time have been found to have an important impact on the use of curative health care, they do not have a consistent impact on the use of family planning services. This is because distance and travel time have different implications in the case of family planning. For example, the distance and travel time costs associated with obtaining contraceptives may be shared if family planning services are located near other amenities used by the individual (e.g., the market) as was noted by Beegle (1995). In addition, the impact of distance is likely to depend on the type of method a woman chooses. Women who choose long-acting or permanent methods may only need to travel once, whereas those who choose re-supply methods may have to travel often to continue method use. Finally, individuals other than the user (e.g., the husband) can purchase some methods. Because of these issues, inferences about the impact of "price" changes on demand and revenues based on distance and travel time proxies must be made with caution.

<sup>3</sup> In studies that use availability of contraceptives as a measure of quality, the impact of quality on demand may appear to be limited due to endogeneity. In a type IV study of Kenya, for example, Mwabu et al. (1993) focus on drug availability as a quality measure. They point out that lower quality facilities may lack drugs due to supply problems, but higher quality facilities may lack drugs at any given moment precisely because services are in such high demand. In econometric analyses of demand for family planning services, it may be that higher quality outlets lack contraceptives because of high demand, thereby obscuring the role of quality.

<sup>4</sup> In determining the impact of price changes on contraceptive use, it might appear that the most straightforward approach is to ask people how their behavior would change if prices increased; however, it is not clear that responses to these types of questions are reliable. Until results from willingness to pay studies are validated, we must rely on empirical results, derived either from cross-sectional household studies in which inferences are made about behavior or from field-based studies (with or without adequate controls) that assess the impact of actual price changes. POLICY/FHI/INOPAL collaboration in Ecuador is addressing the issue of validity of respondent results on willingness to pay.

### 9. Can means testing ensure equity and access?

There is evidence that the poor — and particularly the very poor — will be more affected by price increases than the wealthier. However, the health-care literature appears to indicate that successful means testing — which should ensure that those who are entitled to exemptions receive them and that those who are not, do not — can only be ensured with great difficulty and

**Table 3.1. Private Health Expenditure as a Percentage of Total Health Expenditure, 1990**

Country	Percentage
Benin	22
Burkina Faso	15
Burundi	25
Cameroon	43
Chad	16
Côte d'Ivoire	27
Ethiopia * (1987)	64
Ghana * -	56
Kenya	38
Madagascar	50
Mali *	61
Mozambique	25
Nigeria	45
Rwanda	31
Senegal * (1989)	51
South Africa *	48
Tanzania * (1991)	62
Uganda	53
Zaire *	80
Sub-Saharan Africa	43

\* The author replaced World Bank Development Report estimates with Data for Decision Making estimates, for reasons of accuracy. All figures are for 1990, unless noted otherwise.

Source: Derived by Hanson and Berman, 1994, from estimates prepared for the World Bank Development Report, 1993.

at very high cost. It is possible that efforts to ensure equity will be so costly that they will obviate potential fee revenues altogether.

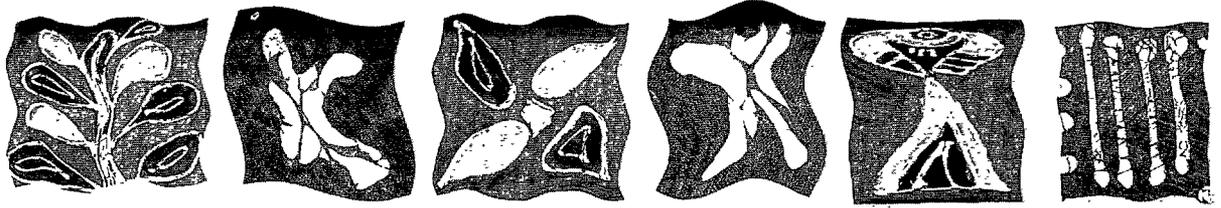
**10. How much revenue can fees be expected to generate?** Recent data suggest that private financing, mostly by individuals, comprises about 43 percent of total health expenditure in sub-Saharan Africa — a far more significant proportion than is generally assumed (see Table 3.1, Hanson and Berman, 1994). However, for the reasons discussed above, potential family planning fee revenues are likely to be less substantial. Family planning programs need to consider this possibility carefully in determining how much they can rely on fees as a revenue source. This is particularly true if quality enhancements — which will require a significant proportion of revenue — are key to ensuring that prices do not deter use. If the objective of fees is to improve program sustainability by finding sources of domestic revenue to substitute for donor funding, quality enhancements may not be possible or may need to be limited in scope.

**11. Potential fee revenues are limited by the high cost of implementing collection systems and by inadequacies in these systems.** The costs of establishing, administering and operating fee collection systems may be high. In addition, gross inefficiencies in collection systems limit the potential of private financing. Deficiencies in these systems, which are difficult and costly to overcome, should be taken into account when the potential of fees is assessed. The structure and poor administration of exemption systems — which often fail to protect the poor while providing substantial numbers of non-poor individuals with fee waivers — also limit potential fee revenues.



## POLICY ACTIONS

1. Government and NGO programs should consider introducing limited fees for family planning services. Without some level of cost recovery, programs will be unable to expand services to meet high and growing levels of demand for services, make urgently needed quality improvements, or expand their service base to include elements of the ICPD *Programme of Action*. Indeed, the inadequate, existing service base will be increasingly under threat unless some cost recovery is instituted.
2. Means testing cannot be relied upon as a strategy to ensure that the poor and other vulnerable groups have access to services in a fee-charging system. Available evidence suggests that means testing, as currently implemented, is extremely costly and fails to protect many who need protection, while providing exemptions for those who are able to pay. The imperfect, short-term solution may be to charge fees at a very low level, and to use simple targeting strategies that do not require means testing, such as targeting by geographic area, facility type, etc. This implies accepting both limited cost recovery and mistargeted exemptions as inevitable until more is known about ways to institute effective means testing in the circumstances that prevail in the region, at reasonable cost. At that time, higher fee levels, and more effective, specific means testing systems, can be instituted.
3. At least some fee revenues should be retained by the service delivery outlets that collect them and, to the extent possible, used to improve service quality. This will enhance revenue collection and may mitigate the demand-dampening effects of fees. Quality improvements are also important in their own right.
4. Given the concern that high fees may deter contraceptive use and given the poor performance of means testing, greater attention should be given to encouraging the growth of the commercial sector and cutting costs in subsidized programs. These strategies are discussed in the following two chapters. Programs should center their resource mobilization efforts on strategies such as encouraging public sector users with the ability to pay to use commercial sector services, and creating an environment conducive to commercial sector growth.



## Chapter IV

# EXPANDING THE COMMERCIAL SECTOR

**I**n theory, the need for government and donor financing of family planning services could be reduced if more individuals obtained services in the commercial sector. The commercial sector includes predominantly for-profit sources of contraceptives and related services such as retailers, private providers and facilities, employers, and private health insurance. It does not include other private sector providers, such as non-profit, government- or donor-financed NGOs (mission facilities, IPPF affiliates). Neither does it include most social marketing programs, which tend to be highly subsidized by governments and donors.

To what extent is the commercial sector a participant in family planning service delivery and financing in

sub-Saharan Africa today? Is it reasonable to assume that the role of the commercial sector will expand significantly in the African context?

To explore these questions, we begin by presenting recent data on the scope of commercial sector family planning service provision in the region. This is followed by a review of the constraints to expanding the commercial sector, including specific constraints to expanding the role of employer-based services, social marketing, health insurance, providers in private practice, and retailers. We also outline options to overcome these constraints, drawing as much as possible on policy and program experience.

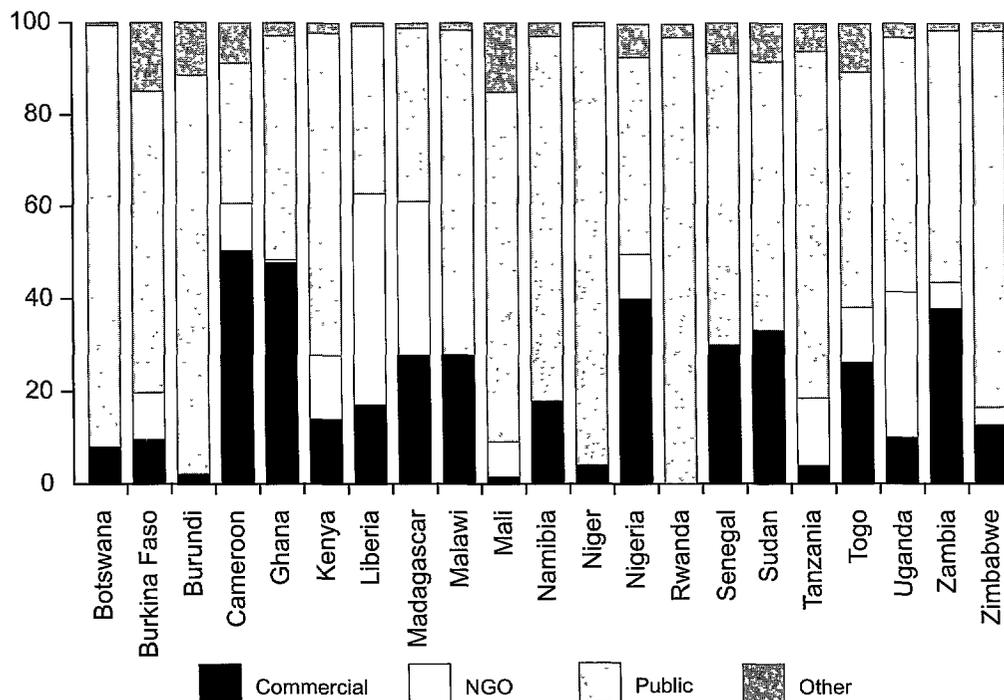
## What Role Does the Commercial Sector Currently Play in Family Planning in Sub-Saharan Africa?

It is difficult to gauge the size and nature of the commercial sector using available data.<sup>1</sup> Based on extensive re-categorization of DHS data for the region, Winfrey et al. (1996) were able to show that sub-Saharan Africa has the least developed commercial sector worldwide, with market share ranging from less than 2 percent in Mali and Rwanda to about 50 percent in Cameroon. (See Figure 4.1 for data on the market share of public, NGO, and commercial providers in the region.) Even within those categories defined here as commercial, there is often some kind of public subsidy; the “pharmacy” share of the market, for example, is often dominated by social marketing products, which are often heavily subsidized.

Twelve of the 21 sub-Saharan Africa countries with DHS surveys have commercial market shares below 20 percent; again, however, much of this limited activity is comprised of subsidized social marketing. In Latin America, by contrast, only one country (El Salvador) has a commercial market share of less than 20 percent and far less of this commercial activity is comprised of subsidized social marketing.

The limited role of the commercial sector in sub-Saharan Africa becomes even clearer when one assesses what Winfrey et al. (1996) term market size, defined as the percentage of married women served by the commercial sector. Commercial market size is the product of the contraceptive prevalence rate and the share of the market made up by the commercial sector, calculated as follows:

**Figure 4.1. Family Planning Market Share (percentage)**



Source: Winfrey et al., 1996.

<sup>1</sup> DHS surveys classify sources of family planning provision as “government,” “private” (either pharmacies or “other private,” which includes commercial providers and NGOs) or “other” (including both informal sources, such as family and friends, and general shops). The commercial sector is scattered among these categories. It includes the pharmacy category; the commercial providers in the other private category; and the markets, shops, and other commercial sector sources found in the DHS “other” category.

commercial market size =  $CU/W \times Com/CU$ ,  
 where:

- CU = number of women in the population using contraception
- W = number of women in the population
- Com = number of users who obtain their method in the commercial sector

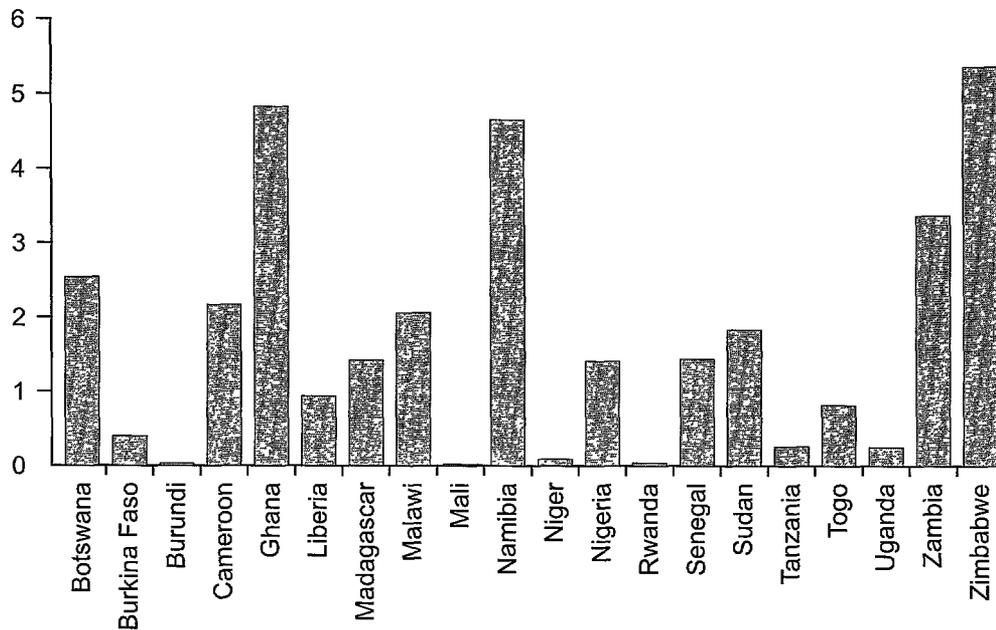
Commercial market size is below 5 percent in all but one (Zimbabwe) of the 21 sub-Saharan African DHS countries (see Figure 4.2). In nine countries, it is below 1 percent. Given the low levels of contraceptive prevalence in many sub-Saharan African countries, commercial market size tends to be limited even in those countries with a large commercial market share. In Cameroon, for example, commercial market share is 50.4 percent, but market size is only 2.2 percent.

Again, the contrast with other regions is dramatic. Almost half of all DHS countries in Asia and North Africa have a commercial market size greater than 10 percent (nearly 25 percent in Egypt). In Latin America, only three countries have a commercial market size below 10 percent, and in five countries, more than 20 percent of married women obtain contraceptives from the commercial sector.

### What has happened to commercial market share and size over time?

Trend information on commercial market share and size is available for Ghana, Kenya, Senegal and Zimbabwe, where two DHS surveys have been conducted. This information must be interpreted with caution, however, given possible changes in source definitions over time.<sup>2</sup> The data seem to

**Figure 4.2. Commercial Market Size (percentage)**



Source: Winfrey et al., 1996.

<sup>2</sup> While Curtis and Neitzel (1996) state that direct comparison of method source information between the DHS-I and DHS-II surveys is possible, Winfrey et al (1996) found that the codes used to distinguish the commercial sector differed between the two surveys. The questionnaires used in the second round were more specific, making some comparisons questionable.

show that commercial market size grew in all four countries from 1986 through 1989 to 1992 through 1994, though market share increased only in Ghana and Zimbabwe (see Figures 4.3 and 4.4). In Kenya, market share decreased very slightly, while in Senegal it decreased from almost 44 percent to 30 percent. It must be noted that while market size appeared to grow in all cases, nowhere does it exceed 6 percent; in Senegal, it remains below 2 percent.

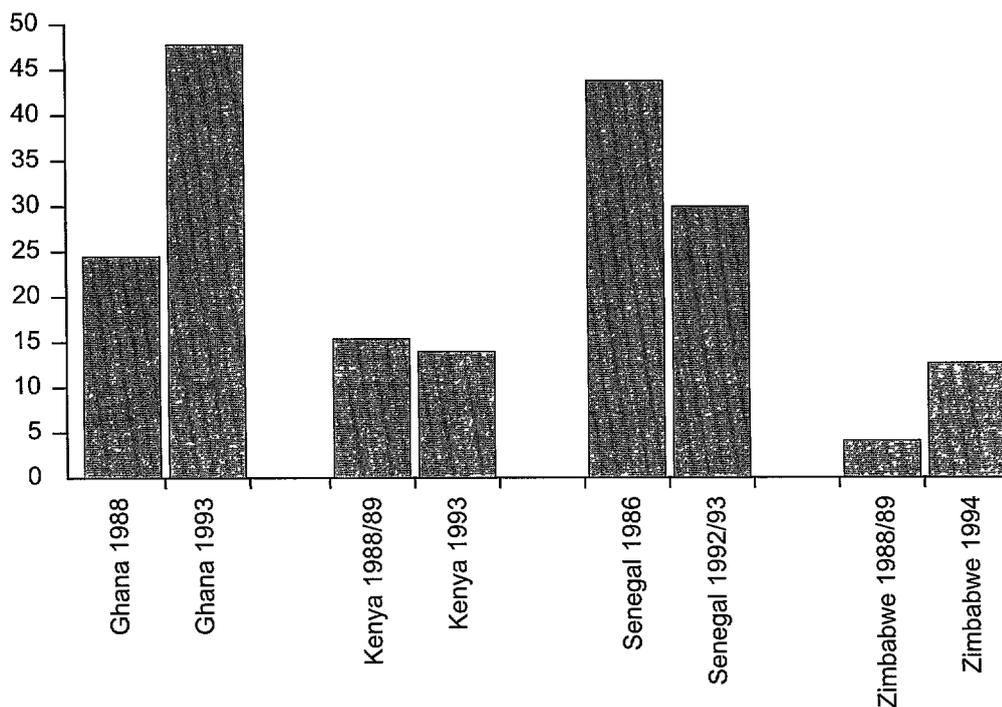
The reasons for these conflicting trends is related to trends in contraceptive prevalence. Because commercial market size is defined as  $CU/W \times Com/CU$ , it can increase if either the contraceptive prevalence rate or the share of the commercial sector increase. Thus, commercial market size may increase even if commercial market share declines,

as long as the growth in the contraceptive prevalence rate exceeds any decline in commercial market share.

### Dominance of the public sector

It is clear that the public sector remains the dominant source of family planning services in sub-Saharan Africa (see Figure 4.1). In 16 of the 21 sub-Saharan African countries where DHS surveys have been conducted, more than 50 percent of contraceptive users obtained their method from a government source (Winfrey et al., 1996). In Botswana, Niger and Rwanda, more than 90 percent of clients use public sector sources. The public sector plays a much more significant role in contraceptive provision in this region than in other parts of the developing world. The contrast with

**Figure 4.3. Trends in Commercial Market Share (percentage)**



Sources: Rutenberg et al., 1991; Winfrey et al., 1996 and Winfrey, 1997.

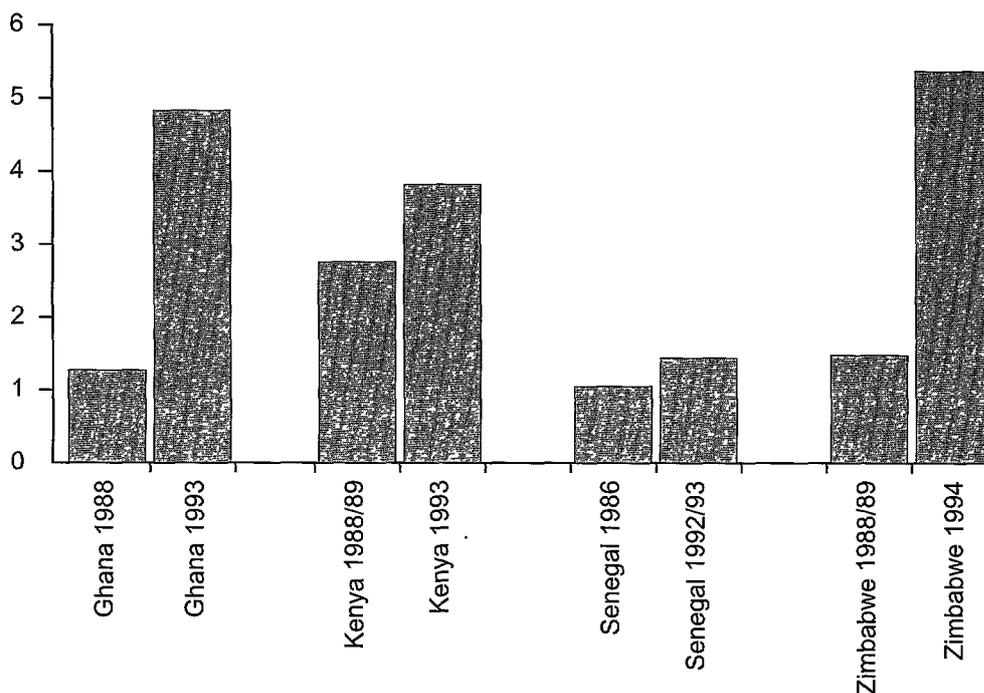
Latin America, where the government is dominant in only one country (Mexico at 62 percent), is particularly stark.

### Source patterns for clinical versus re-supply methods

Analysis of the role of the purely commercial sector in providing particular methods has not been undertaken; however, it is possible to observe source patterns using the more limited, mixed DHS source definitions, which also include noncommercial private providers (Curtis and Neitzel, 1996). In most of the world, source patterns do tend to vary by method; clinical methods are usually obtained from fixed government facilities or other private

providers (including both commercial and non-commercial personnel and facilities), while re-supply methods are more likely to be obtained from pharmacies. This is the case in all countries surveyed with the exception of several in sub-Saharan Africa. In almost half of sub-Saharan African countries surveyed, less than 10 percent of re-supply methods are provided by pharmacies (see Figure 4.5). Only in Cameroon does the pharmacy share of the market for re-supply methods exceed 50 percent. In several Latin American countries, as well as in Egypt and Jordan, pharmacy shares of the market for re-supply methods exceed 50 percent. There appears to be ample room for encouraging a greater role for pharmacies in the provision of re-supply methods in sub-Saharan Africa.

**Figure 4.4. Trends in Commercial Market Size (percentage)**



Sources: Rutenberg et al., 1991; Winfrey et al., 1996 and Winfrey, 1997.

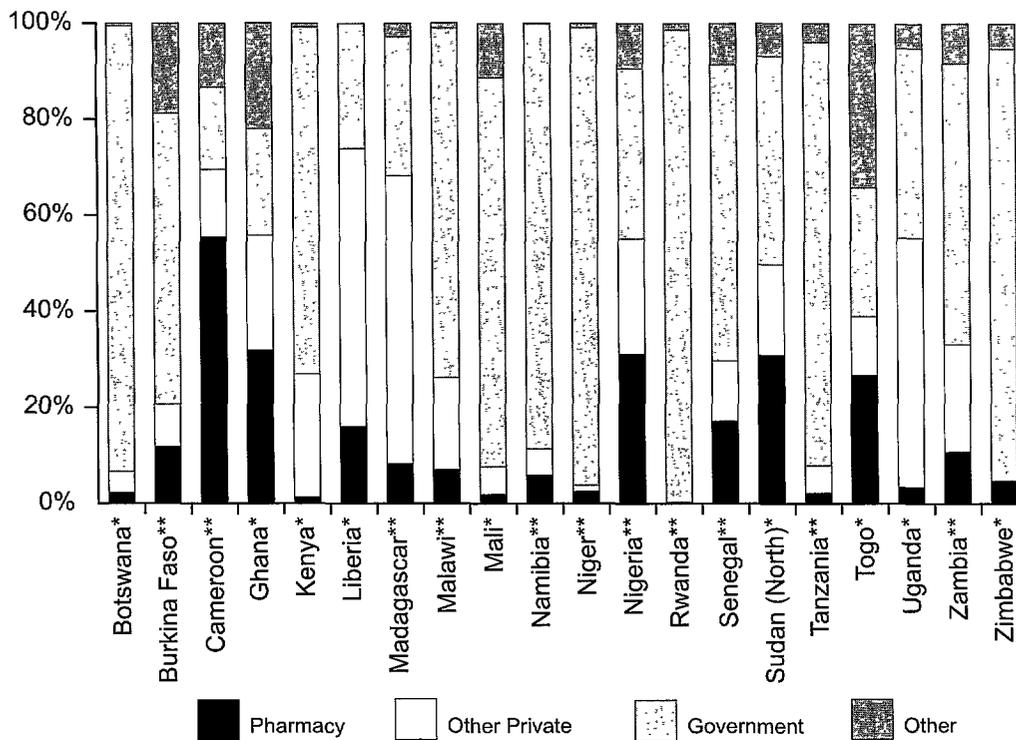
## Can subsidized service users afford to pay for commercially priced services?

Figure 4.6 (adapted from Shaw (1995)), shows how household characteristics, quality, accessibility, and prices may affect the choice of source of supply (and method). The affordability of services — which is affected by both their price and users' income and assets — has an important impact on users' choice of source of supply.<sup>3</sup> Households with higher incomes and more assets are more likely to use the commercial sector, and those with lower incomes and fewer assets are more likely to use lower cost, public and NGO service outlets. However, there is likely to be some overlap in the income/assets levels of clients using different sources, implying that some clients who use the public or NGO sectors could afford to use the commercial sector.

The way in which two household characteristics — availability of piped water and husband's profession — affect source patterns in sub-Saharan Africa is illustrated in Tables 4.1 and 4.2. These variables are used here as proxies for assets and income. While they are not perfect proxies (the availability of piped water, for example, may simply be an indicator of urban residence) they can give some idea of the extent to which there is room to improve the impact of scarce public funds.<sup>4</sup>

As discussed above, one can hypothesize that wealthier individuals — or, in this case, those with piped water or whose husbands have white-collar jobs — are more likely to use commercial sector sources. It is also likely that at least some of those who use subsidized services could afford to use the commercial sector.

**Figure 4.5. Modern Re-supply Methods Market Share (percentage)**



Sources:

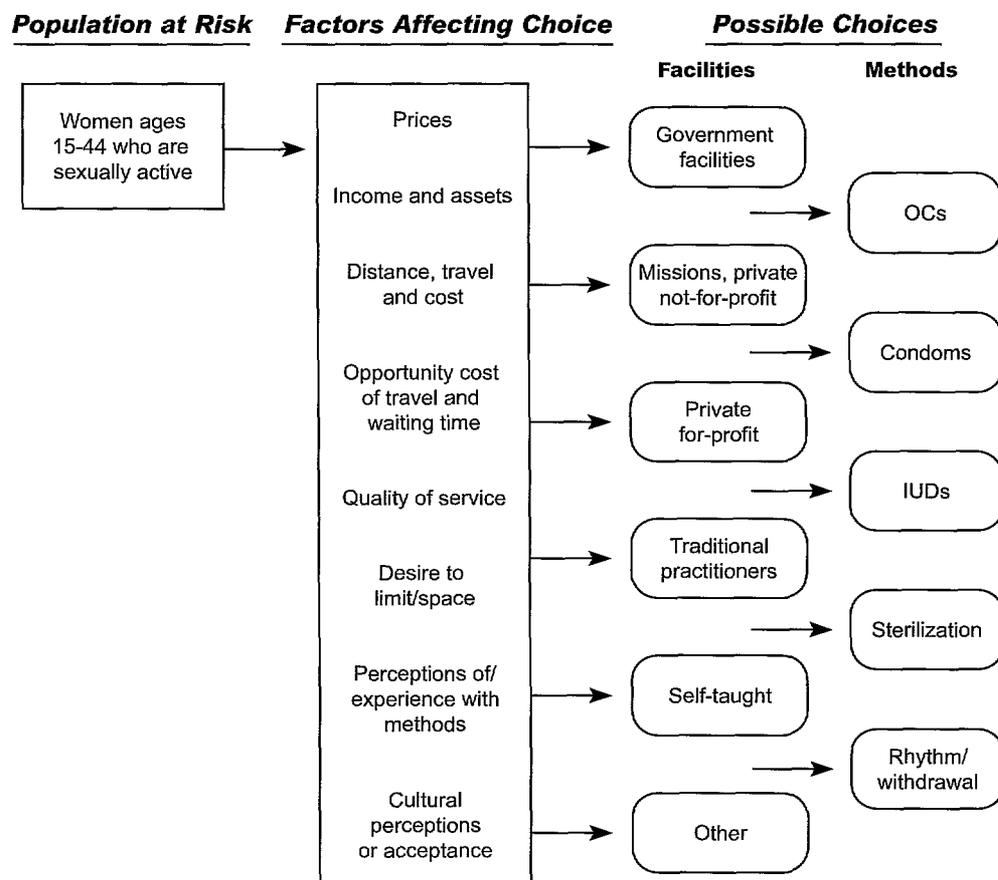
\* Ayad et al., 1994.

\*\* Curtis and Neitzel, 1996.

<sup>3</sup> The World Bank is producing tabulations of source of general health care by wealth quintile, using DHS data. This work will further inform discussions regarding the use of limited public subsidies.

<sup>4</sup> Comparing source patterns to some type of wealth index, based on a wider range of variables, can provide more reliable information on the extent to which the public subsidy accrues to higher income groups (see, for example, Khalifa (1995) for an analysis of the impact of wealth on source choice in Egypt).

**Figure 4.6. The Process of Choosing Family Planning Methods and Facilities**



Source: Adapted from Shaw, 1995.

Table 4.1 illustrates the percentage of women with piped water in their homes according to their source of contraceptives. The percentage of all women with piped water is illustrated for comparison. In most countries, the proportion of women with piped water is highest among those using the commercial sector. In two countries, Nigeria and Togo, the reverse seems to be the case.

Table 4.2 illustrates the percentage of women whose husbands work in white-collar professions according to source of contraceptive services. The percentage of the general population of women married to white-collar workers is illustrated for

comparison. In most countries, the percentage of women married to white-collar workers is highest among users of the commercial sector. This again suggests that in most countries, commercial sector users are more economically secure than those who use the public sector. However, in three countries, Ghana, Malawi and Zambia, the opposite seems to be the case.

While it is clear that in most countries commercial sector users are wealthier than users of government services, not all public sector clients are poor. In fact, if one can assume that the indicators in Tables 4.1 and 4.2 are adequate proxies for wealth

**Table 4.1. Percent of Women with Piped Water, by Source of Contraceptives and in the General Population**

Country	General Population	Source of Contraception		
		Public	NGO	Commercial
Botswana (1988)	11.9	18.6	*	*
Burkina Faso (1993)	5.9	30.2	48.2	*
Burundi (1987)	0.8	20.0	*	*
Cameroon (1991)	7.5	18.4	20.0	29.7
Ghana (1993)	13.3	23.4	*	28.4
Kenya (1993)	16.4	22.4	34.9	44.2
Liberia (1986)	10.3	27.4	34.4	53.4
Madagascar (1992)	6.4	19.5	23.2	39.5
Malawi (1992)	2.0	9.2	*	13.1
Mali (1987)	2.6	19.9	*	*
Namibia (1992)	38.8	73.1	*	94.6
Niger (1992)	4.0	23.8	*	*
Nigeria (1990)	5.2	15.2	*	11.0
Rwanda (1992)	0.6	1.6	*	*
Senegal (1992/93)	64.3	62.2	*	76.2
Sudan (1989/90)	39.5	81.6	*	86.9
Tanzania (1991/92)	10.3	35.7	7.3	*
Togo (1988)	3.1	17.9	22.2	5.0
Uganda (1988/89)	0.8	2.5	13.4	7.0
Zambia (1992)	24.6	59.3	*	85.2
Zimbabwe (1994)	27.8	32.5	*	70.4

\* Countries where the NGO or commercial sectors represent less than 10 percent of market share, or where the number of cases was too small for analysis, are excluded.

Source: Winfrey, 1997.

or income, there is some indication that in all countries, some of the government subsidy for family planning accrues to individuals who could afford to pay for commercially priced services. In Ghana, for example, 23 percent of public sector contraceptive users have piped water, compared to only 13 percent of the general population. Similarly, while only 17 percent of all women in Malawi are married to white-collar workers, this is true of more than 30 percent of public sector contraceptive users.

To determine the overlap in income according to source, information is needed, not only on mean values, but also on the range of incomes. For example, what percentage of public sector users have income levels that overlap with income levels of commercial sector users? The greater the overlap, the more likely it is that some public sector users can afford to obtain services in the commercial sector.

**Table 4.2. Percent of Women Whose Husbands Are in White-Collar Professions, by Source of Contraceptives and in the General Population**

Country	General Population	Contraceptive Users		
		Public	NGO	Commercial
Botswana (1988)	17.5	20.5	*	*
Burkina Faso (1993)	10.2	31.8	53.1	*
Burundi (1987)	5.8	28.6	*	*
Cameroon (1991)	23.9	40.6	36.6	61.2
Ghana (1993)	21.5	33.5	*	29.7
Kenya (1993)	24.9	31.4	28.2	43.1
Madagascar (1992)	11.6	35.6	35.7	42.0
Malawi (1992)	18.1	31.3	*	29.4
Mali (1987)	16.7	59.9	*	*
Niger	10.0	31.5	*	*
Namibia (1992)	19.5	24.6	*	40.9
Nigeria (1990)	22.4	50.2	*	52.9
Rwanda (1992)	6.6	13.5	*	*
Senegal (1992/93)	50.0	56.5	*	73.4
Sudan (1989/90)	31.2	42.8	*	56.1
Tanzania (1991/92)	9.1	27.1	11.2	*
Uganda (1988/89)	17.7	41.4	45.4	48.4
Zambia (1992)	18.0	42.9	*	39.0
Zimbabwe (1994)	20.4	23.0	*	38.4

\* Countries where the NGO or commercial sectors represent less than 10 percent of market share, or where the number of cases was too small for analysis, are excluded.

Source: Winfrey, 1997.

An expanded DHS module on income and expenditures would facilitate analyses of ability to pay for family planning. Moreover, it would provide data to help determine what percentage of the public subsidy accrues to those with the ability to pay, and the potential for shifting public sector users to commercial sources through market segmentation.

### Market segmentation as a strategy to increase the size of the commercial sector

Market segmentation strategies are used by businesses to divide their customers into distinct groups based on different factors, such as income, and to target their products accordingly. A variation of this approach is used to market public health goods, including family planning. In family planning, market segmentation is used to divide the family

planning market into groups based on choice of method and provider and to match clients with sources based on need and ability to pay. Effective market segmentation strategies can make it possible for the public sector to focus its resources on those most in need while promoting the growth of commercial sector services for those who are able to pay.

Family planning market segmentation studies provide the information needed to formulate and develop strategies to promote the commercial sector. While such studies have not yet been conducted in sub-Saharan Africa, they have been conducted in Indonesia (Winfrey and Heaton, 1997), the Philippines (Alano et al., 1998), Turkey (Cakir and Sine, 1997), Egypt (Berg et al., 1995) and other countries. These studies often find significant room for a transfer of users from the public to the commercial sector. In the Philippines, for example, while high- and middle-income women are more likely to use the private sector, more than 40 percent continue to use the public sector (Alano et al., 1998). How effective these studies are in catalyzing transfers in clients from subsidized to non-subsidized programs needs to be evaluated. The potential of market segmentation for the sub-Saharan region should also be explored.

*Effective market segmentation strategies can make it possible for the public sector to focus its resources on those most in need while promoting the growth of commercial sector services for those who are able to pay.*

## **Commercial Sector Development: Constraints and Policy Options**

A wide range of factors influence the size of the commercial sector for family planning. Some of these factors can only be influenced by longer-term socio-economic change. For example, in low-income countries, average per capita income is strongly

correlated with commercial market share (Winfrey et al., 1997). More urbanized countries also have larger commercial sectors, most likely because urban centers provide the demand levels necessary to make family planning a profitable enterprise (Winfrey et al., 1997).

Other factors that govern commercial market share are more amenable to

policy intervention (see Box 4.1). However, intervention to spur commercial sector growth by reducing these constraints is likely to have much more impact in some countries than in others, based on socio-economic and other contextual factors. A matrix of opportunity should be developed to direct resource allocation in this area.

### **Box 4.1. Constraints to Commercial Sector Growth**

- Lack of information on the commercial sector market
- Competition with low- or no-cost government programs
- Restrictive regulatory and tax environment

## Lack of information on the commercial market

There is perhaps no greater barrier to donor and government efforts to promote the commercial sector for family planning than lack of detailed, country-specific information on its size and configuration and the constraints to its development. To some extent, the characteristics of the commercial sector in any given country are the consequence of historical and socio-economic antecedents and recent market and nonmarket forces, including government policy toward the commercial sector (Berman and Rannan-Eliya, 1993; Curtis and Neitzel, 1996). In addition, the policy variables over which governments or donors may have some degree of influence vary across countries. Policies to affect source patterns must, therefore, be based on detailed, country-specific analyses.

Country-specific assessments of the commercial sector have already been conducted by the Promoting Financial Investments and Transfers (PROFIT) project in Kenya, Nigeria, and Zimbabwe, as a first step in an effort to encourage commercial sector involvement in family planning in those countries (PROFIT, 1992; PROFIT, 1993; Adamchak, 1996). The assessments — which vary considerably in scope and level of analysis — summarize demographic data and profile relevant areas of the family planning, economic, social, and political environment; examine the potential for innovative investments, private providers, and employer-provided family planning; and describe potential interventions.

The HFS project also conducted private sector (commercial and NGO) assessments covering health care as a whole in Senegal, Tanzania, and other settings (Knowles et al., 1994; Munishi et al., 1995). Some of these assessments examined the actual and potential role of the private sector in

advancing the public health agenda, including its role in family planning and reproductive health service delivery (generally limited to maternal health care). These analyses need to be undertaken in significantly more depth to be of practical use, but they represent an important first step. Even when family planning and reproductive health care are not specifically addressed, or are addressed in a cursory manner, many of the legal, regulatory, and financial factors that impede the development of private sector health care as a whole are relevant to family planning and reproductive health care.

## Government and donor programs providing contraceptives at low or no cost make it difficult for the commercial sector to compete

The scale of donor and government intervention in the family planning market over the past 50 years has led to significant distortion. This is particularly true in many sub-Saharan African countries, where a very limited proportion of women obtain their methods from commercial sources (Desai, 1997). The provision of contraceptives at zero or highly subsidized prices is the main type of distortion.<sup>5</sup>

The commercial sector will have a greater role where the ratio of public to private prices is higher (Berman and Rannan-Eliya, 1993). There is a very strong negative correlation between the percentage of public sector clients who receive free services and commercial market share, particularly in low-income countries (Winfrey et al., 1997). The commercial share of service provision will be limited by the extent to which donors support the development of subsidized NGO and public sector family planning programs.<sup>6</sup>

In Senegal, for example, the commercial share of the contraceptive market fell from about 50 percent to 25 percent as the number of

<sup>5</sup> Other distortions discussed by Desai (1997) include public sector outreach and information efforts, which are more likely to direct clients to public sector sources than to the commercial sector, and legal and regulatory barriers to commercial sector growth, which are discussed elsewhere in this chapter.

<sup>6</sup> It should be noted that Winfrey, et al. (1997) find little correlation between the strength of the government's program and commercial sector size, except in high-income countries, where a negative correlation is found. They suggest that the relationship between government program strength and commercial sector size is clouded by the fact that only some of the factors used to compile the program strength score are important to commercial sector development.

donor-provided contraceptives increased during the late 1980s (Osmanski et al., 1991 in Knowles et al., 1994).<sup>7</sup> In Kenya, the availability and low cost of public sector family planning services has been identified as one of the most significant impediments to private sector growth (PROFIT, 1993). Between 1984 and 1989, the private sector grew by less than 1 percent, compared to public sector growth of more than 14 percent.

Numerous examples from other parts of the developing world show that efforts to expand the public and NGO sectors have a negative impact on the commercial sector. For example, one study found that the introduction of free services in the state of Piaui, Brazil, resulted in a decrease in the share of the commercial sector, while use of oral contraceptives (the main program method) remained unchanged (World Bank, 1993). Commercial sector users simply switched to the public sector to obtain services at a lower price. Similarly, in Honduras, the introduction of a social marketing program did not increase the use of oral contraceptives but did reduce the share of the commercial sector (Janowitz et al., 1992). In Bangladesh, the share of the social marketing company (which was subsidized but did charge for contraceptives) was reduced when the government expanded its force of outreach workers who provide contraceptives free of charge to women in their homes (Ciszewski and Harvey, 1995; Janowitz and Bratt, 1996).

User fees are a much-overlooked method of influencing the development of commercial sector services (Berman and Rannan-Eliya, 1993). One of the most significant steps governments can take to improve commercial sector prospects is to stop providing free or subsidized family planning services to those who can afford to pay. However, as discussed in Chapter III, it is not easy to use means testing to determine who can and cannot afford to pay for family planning.

## Regulatory and tax environment

A wide array of regulations, taxes, and import duties discourage the commercial sector from providing family planning services by making it a burdensome or unprofitable venture. In Kenya, the Ministry of Health and the USAID-funded Health Care Financing Project identified strict licensing requirements for business start-up, ownership, and operation, as well as high taxes on medical equipment and pharmaceuticals, as key constraints to commercial sector expansion (PROFIT, 1993).

The public sector can do a great deal to improve the regulatory and tax environment in favor of commercial sector service provision by eliminating or reducing regulatory and tax barriers. The experience of Tanzania is illustrative: Half of all private facilities now operating in the capital city, Dar es Salaam, were established after the laws regarding private practice were liberalized in 1991 (Munishi et al., 1995).

The public sector can go a step further by setting out to create a positive environment for commercial sector development. Strategies include facilitating the purchase of imported equipment and supplies through the use of preferential import quotas, providing access to rationed foreign currency, and granting exemptions from import duties (Berman and Rannan-Eliya, 1993). In Sudan, for example, the government placed oral contraceptives on the essential drug list, reducing import barriers and improving supply (Cross, 1993).

## The Role of Employer-based Services

Employer-based family planning programs have the potential to shift users from the public to the private sector (Fort, 1990). However, the small size of the formal employment sector, the limited number of women in this sector, and the small number of formal sector companies large enough to

<sup>7</sup> As shown in Figures 4.3 and 4.4, market size may increase when market share decreases. Thus, in some countries, the commercial sector has grown – in size though not in share – in spite of the growth in donor-provided contraceptives.

consider providing on-site services limits the potential of this option for the region. In addition, formal sector employees are least likely to be using subsidized services, further limiting the potential of this option for inducing a shift from subsidized to commercial sources. Employer-based services also have the potential to increase the number of contraceptive users — not just to provide an alternative source to current users.

One of the most significant barriers to the development of employer-based services is lack of employer knowledge of the benefits of doing so. Family planning can be a profitable enterprise for employers if the benefits of providing services (e.g., reduced maternity leave and related productivity losses) outweigh the costs of establishing and running services. It may also be profitable if it enables employers to attract and retain a more qualified work force, or if it enhances the company's image, thereby boosting sales. Companies are more likely to see on-site services as a worthwhile endeavor if they adopt this broader economic perspective. If they focus narrowly on benefits (reduced maternity leave and related productivity gains), they are less likely to be interested, since they will only benefit if services generate new demand for family planning. Otherwise, they are simply paying for services their employees would otherwise have received elsewhere — often at zero or no cost — and there will be no benefits. This highlights a fundamental conflict between some donor and employer objectives for employer-based services: The objective of donors may be to shift contraceptive use from the public sector, while employers will find little incentive to provide services if employees are already using contraceptives they obtain elsewhere.

Even when convinced that providing family planning services to their employees is profitable, employers may not be interested due to their perception that family planning is a government responsibility, the cultural/political sensitivities around family

#### **Box 4.2. Interventions to Promote Employer-based Services**

##### **1. Conducting cost-benefit analyses**

The TIPPS project developed a methodology for conducting cost-benefit analyses of employer-based services. Experience has shown that the complexity and expense of this approach are probably not justified by its results, since, as noted above, employers are only partly motivated by a narrow economic perspective. There are no data to determine the extent to which the analyses motivated the provision of on-site services. In addition, Epstein (1996) reviews no examples of TIPPS efforts in Africa.

The Enterprise and PROFIT projects have also conducted cost-benefit analyses for employers, some of which have resulted in program development. In Nigeria, for example, three major oil companies trained staff to become providers, and other companies now distribute information to employees (PROFIT, 1992). It should be noted that in the Nigeria case, employees have been hesitant to use employer-based services due to privacy concerns.

##### **2. Providing direct technical and financial subsidies to employers**

Providing direct subsidies to employers, in the form of funding or technical assistance, has tended to have a relatively rapid impact on the development of employer-based services. The Enterprise Project's work with Zimbabwean employers is typical of this type of approach. However, no information is available on the extent to which services are sustained once donor support is withdrawn. There is also limited information on the extent to which efforts have been replicated. A recent PROFIT assessment of Zimbabwe determined that more than 200 employers were providing some on-site family planning services (Adamchak, 1996), suggesting some replication in that country.

##### **3. Working through business and professional associations**

In theory, working through business and professional associations should facilitate communication and collaboration with employers, and may make it possible to capitalize on economies of scale (Epstein, 1996). Experience indicates that these associations can help enormously with information dissemination. Their impact on stimulating service delivery among their members is less clear. Strong donor support, which can take the form of start-up funds and/or technical assistance, is essential to this approach. No examples from sub-Saharan Africa are documented by Epstein (1996). The main lesson learned from experiences in other regions is that partners in such ventures should be strong, committed organizations with power among employer members and existing administrative infrastructure. More experiments with this approach are needed to determine its impact in practice.

planning, or other factors. Employers also face a range of financial, organizational and technical constraints to providing family planning services.

A number of major projects, most of them funded by USAID, have aimed to help overcome some of these barriers to employer-based services. These include PROFIT, the Enterprise Project, and the Technical Information on Population for the Private Sector (TIPPS) Project. A recent review of these projects (Epstein, 1996) identified a range of interventions to promote employer-based services. The interventions are summarized in Box 4.2.

### **Lessons learned from a decade of employer-based service projects**

Epstein (1996) concludes that “the experience does not provide enough evidence to draw conclusions about which approaches are most effective...” Long-term follow-up data are not available to provide information on sustainability or project replication. Nonetheless, a number of lessons have been learned. For example, strategies must take into account the fact that employer motivations to provide services vary enormously and are not limited to narrow economic interests. Employers with a prior commitment to employee health and welfare are most likely to be interested, since the added costs they incur will be lower. The commitment of high- and mid-level managers is also key. Perhaps most important is the fact that programs are experimental, need continuing flexibility, and are unlikely to achieve significant results within typical project time frames.

Epstein suggests that USAID recognize that truly scientific comparisons among approaches will be impossible since there is no single standard against which to measure results and the objectives of individual projects are, to some extent, unique. She recommends that USAID wait to make a major investment in evaluating different approaches until they are well under way and proven from an

operational standpoint. As discussed above, however, employer-based programs have limited potential to expand commercial sector provision of family planning in the region, due to the small size of the formal sector, the limited number of women in this sector, the small number of formal sector companies large enough to consider providing such services, and the fact that formal sector employees are already most likely to be using commercial sources.

### **The Role of Managed Care**

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In managed care arrangements (e.g., health insurance or health maintenance organizations (HMOs)), a third party pays providers for services supplied to individuals in exchange for premiums paid by the individuals — or, more often, the individuals' employers (Janowitz and Gould, 1993). While expanded managed care coverage will have an impact on the number of users who turn to the commercial sector, the potential of this approach in sub-Saharan Africa should not be overestimated. The group most likely to be covered, salaried, formal sector employees, is very small; and women, who are most likely to use these services, comprise a limited proportion of formal sector employees. Salaried, formal sector employees are also most likely to use commercial sector services already.

On the other hand, a significant number of salaried, formal sector employees do not have managed care coverage. In Zimbabwe, for example, only 13.7 percent of formal sector employees are covered by medical aid, implying that 1.3 million are not yet covered (Adamchak, 1996). In addition, existing managed care arrangements tend not to cover family planning services.

TIPPS, the Enterprise Project, and PROFIT have worked with insurance companies and HMOs in a number of countries to convince them to add family planning to their benefits package. The projects have also worked to assess the feasibility of

expanding coverage per se. In Kenya, for example, PROFIT collaborated on an assessment of private insurance options (Enright et al., 1994). These efforts are reviewed in Box 4.3.

Based on an evaluation of these and other projects, Epstein (1996) concludes that efforts to expand managed care coverage or to integrate family planning into existing managed care arrangements tend to be relatively high risk and to have few short-term benefits. Insurance companies with purely commercial interests — which are the norm — tend to be conservative, risk-averse, and not primarily socially motivated. Unlike employers, insurance companies and HMOs do not derive savings from reduced employee turnover, productivity gains, etc. Like employers, insurance companies and HMOs can benefit from covering or providing family planning through the savings derived from a reduced number of pregnancies, deliveries, and children among their beneficiaries. However, since most insurance packages do not cover maternity benefits, these potential savings are limited. In addition, the salaried formal sector employees most likely to have insurance coverage are already likely to be contraceptive users. The potential benefits to insurers are, therefore, even lower than those to employers. Including family planning among insurance benefits is unlikely to be profitable; there is little or no incentive for insurers to do so without substantial subsidies.

Epstein concludes that further investigation of the potential role of managed care arrangements in financing and providing family planning services is an area where USAID experimentation could make a major contribution. However, given the limited potential for insurance coverage overall in sub-Saharan Africa, and the clear disincentives insurers face to getting involved in family planning, it could be argued that scarce resources to explore commercial sector options should be directed elsewhere.

#### **Box 4.3. Managed Care**

##### **1. Commercial and Industrial Medical Aid Society, Zimbabwe**

In Zimbabwe, the TIPPS project conducted a cost-benefit analysis for the Commercial and Industrial Medical Aid Society (CIMAS), the country's largest health insurance company (Epstein, 1996). The analysis indicated that CIMAS coverage of family planning would shift users to the commercial sector, but at significant cost to the organization. Nonetheless, family planning was added to the benefits package. It should be noted that CIMAS faces different incentives than standard insurance providers. As a non-profit organization, it is less influenced by the bottom line. In addition, other unique circumstances influenced the decision to add family planning to the benefits package. First, the head of the organization was very supportive of the initiative; and second, CIMAS was trying to curry favor with the government, which sets its rates, and to attract new clients from a lower-income market.

##### **2. HMO style service delivery, Nigeria**

Based on its assessment of potential activities in Nigeria, PROFIT proposed the development of HMO-style service delivery of health and family planning services with a Nigerian Merchant Bank and members of the Nigerian Merchant Bankers Association, which reach 8,000 employees (PROFIT, 1992). The HMO would also be marketed to other industries. Since USAID is no longer active in Nigeria, it is unlikely that these efforts proved successful.

##### **3. African Air Rescue, Kenya**

In Kenya, PROFIT explored two prospects for including family planning in the benefits package offered by African Air Rescue (AAR) Health Services, a pre-paid health insurance scheme (Enright et al., 1994; Epstein, 1996). The first involved marketing family planning and other primary care services to a large employer whose current employee health-care costs were escalating; the company was encouraged to hire AAR to provide pre-paid services to employees and community members through the existing facility. The company declined the offer due to limited evidence of short-term cost savings and concerns that its image would suffer if it stopped playing a direct, visible role in providing employee health services.

## The Role of Private Health-Care Providers

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Health-care providers are influenced by many of the general constraints outlined above, as well as a number of additional constraints. Factors that affect the participation of private providers include:

- limited pool of personnel
- restrictions on private practice
- limited interest among providers
- limited profit potential
- lack of training
- limited access to capital
- limited marketing ability

### Limited pool of personnel

The supply of health-care providers available to provide family planning services may have an impact on the development of a commercial sector for such services. In some settings, the overall pool of available personnel is a constraint; the commercial sector must compete with the public and NGO sectors for a pool of providers often diminished by migration to other countries (Berman and Rannan-Eliya, 1993).

Cutbacks in public recruitment necessitated by economic crisis or prompted by a deliberate privatization policy can result in an expansion of

the commercial sector, even in environments that are not otherwise conducive to commercial sector development, e.g., Mali (Brunet-Jailly, 1992 in Berman and Rannan-Eliya, 1993).

### Restrictions on private practice

In some countries, available providers are prohibited from engaging in private practice or can only do so to a very limited extent. A critical step towards the development of effective commercial sector provision of family planning services is to permit personnel to engage in private practice.

Where private practice is permitted, providers need to be made aware of this option. Most nurses surveyed by PROFIT in Zimbabwe, for example, were not aware of their right to engage in private practice (Adamchak, 1996). In addition, the nurses believed that they were only allowed to practice under the supervision of a physician; a legislative review concluded that there was, in fact, no such requirement. Lack of knowledge or understanding of the complicated legal procedures involved in

setting up a private practice is also an impediment.

Even where there is a favorable environment for private practice, numerous restrictions on providers can limit the extent to which family planning services are included as part of the care package they provide. In Zimbabwe, for example, the government requires that all physicians interested in providing

family planning services pass a forensic exam or provide evidence of familiarity with regulations on safe custody and dispensing (Adamchak, 1996).

*A critical step towards the development of effective commercial sector provision of family planning services is to permit [medical or health] personnel to engage in private practice.*

In addition, physicians who do not practice within five kilometers of a pharmacy are not allowed to prescribe oral contraceptives. Restrictions on the types of services particular categories of personnel can provide also inhibit the commercial sector role in family planning. In Zimbabwe, nurses are not allowed to prescribe or provide most drugs (Adamchak, 1996). As discussed in Chapter V, there is a growing body of evidence that indicates that non-physician staff with appropriate training and supervision can safely perform numerous family planning procedures often reserved for physicians (Cottingham and Mehta, 1993).

### **Limited interest among providers**

Even where the environment for commercial family planning services is favorable, provider interest may be limited. Evidence on the extent to which commercial providers are interested in engaging in family planning service delivery is mixed, and varies from country to country. In Senegal, a survey found that providers lacked interest in providing low-cost, preventive services, including family planning (Knowles et al., 1994). In Kenya, however, 46 of 69 providers surveyed by the Family Planning Private Sector Programme expressed strong interest in providing or expanding family planning services (PROFIT, 1993). In Zimbabwe, almost all physicians interviewed already provide a range of family planning services to their private patients (Adamchak, 1996).

### **Limited profit potential**

The size of the family planning market determines the profits a provider can expect to make by providing services. This is particularly true when the absolute profits from each unit of the product are small, as is the case with contraceptives (Desai, 1997). Because the market for family planning is so small in many sub-Saharan African countries, it is generally not a profitable enterprise in and of itself.

As noted by Desai (1997), contraceptive services are rarely, if ever, the only good or service provided by a commercial provider. The profits generated by contraceptives will comprise only a limited proportion of a provider's total earnings; this accounts for much of the lack of dynamism in the commercial sector for family planning.

### **Lack of training in family planning service delivery**

Where they are interested in providing family planning services, providers often lack the requisite training. Physicians in Zimbabwe identified lack of training in family planning as one of the most significant barriers to service provision (Adamchak, 1996). One-third expressed an interest in additional overall training in family planning service delivery; far greater numbers were interested in training in Norplant and voluntary surgical contraception.

Efforts to promote provider interest and give them the training they require to engage in commercial family planning activities can have an impact. Governments have a key role to play in influencing the content of curricula (promoting the inclusion of family planning topics) and providing targeted training and re-training subsidies.

A number of targeted efforts to promote private provision of family planning through training have been undertaken. In Kenya, for example, family planning training initiatives have involved more than 2,000 private physicians. The extent to which this effort has increased the physicians' share of the family planning market is not known. In Ghana, the Enterprise Project worked with the Ghana Registered Midwives Association to help position midwives as family planning service providers through management training, provision of start-up funds, and efforts to reduce their dependence on technical support from physicians. Midwives have become respected and well-known providers of

family planning services; by 1991, 240 were providing services and had increased their profits by an average of 15 percent, encouraging other midwives to do the same (Fort and Hart, 1991).

### **Limited access to capital**

Service providers need capital to buy or expand facilities, equipment, and supplies to provide family planning services. The Ministry of Health of Kenya and the USAID-funded Health Care Financing Project identified lack of capital for providers as a key constraint to commercial sector expansion and called for targeted subsidies (PROFIT, 1993). Lack of funding for specialized equipment and supplies was also found to be a significant impediment to private practice among midwives in Zimbabwe (Adamchak, 1996).

Governments often have considerable control over the supply of capital needed by doctors and other health personnel to set up or expand their practices to provide family planning services. Possible interventions include credit schemes to assist with start-up costs.

### **Limited ability or incentive to market services**

Providers often lack the ability or incentive to market their practices or new services to potential clients. Desai (1997) notes that given the limited profitability of the contraceptive delivery component of the service package, it is unlikely that private providers will conduct independent advertising of these services. This is compounded by the personal and sometimes controversial nature of the service. Even when providers are willing and able to advertise, they are sometimes prohibited from doing so.

One potentially profitable avenue for private practice is to market provider services to employers on a contract or fee basis. A limited number of

projects have aimed to strengthen providers' ability to market their services to employers (Epstein, 1996). Experience to date seems to indicate that this is an expensive and labor-intensive approach. There are no long-term data to indicate whether or not provider-employer relationships are sustained once donor support is withdrawn.

### **The Role of Retailers**

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Retailers are also influenced by many of the general constraints outlined above, as well as a number of additional constraints. Factors that limit retail contraceptive sales include:

- restrictive regulatory environment
- lack of training
- lack of incentive to advertise
- inadequate space for counseling activities

In many countries, retailers operate in a regulatory environment that inhibits them from fulfilling their full potential role in family planning. In Nigeria, for example, pharmacists are not permitted to provide injectable contraceptives, though they do provide other types of injections, and market tradeswomen are not permitted to sell oral contraceptives (PROFIT, 1992).

In Zimbabwe, lack of up-to-date information prevents pharmacists from starting women on oral contraceptives, though they are permitted to do so (Adamchak, 1996). University of Zimbabwe pharmacists received only three or four days of training on contraceptives, and were trained an average of seven years ago. In addition, the informational checklist they have for their own use and to provide to clients has not been updated or redistributed since 1982. Pharmacists expressed great interest in additional training in contraceptive technology.

**Table 4.3. Ongoing Social Marketing Programs in Sub-Saharan Africa**

Country*	Donor Support	Products Provided				
		Condoms	OCs	Vaginal Foaming Tablets	Injectables	IUDs
Burkina Faso	PSI	✓				
Cameroon	PSI	✓				
Chad	PSI	✓				
Ghana	SOMARC	✓	✓	✓	✓	✓
Guinea	PSI	✓	✓		✓	
Kenya	PSI	✓				
Mali	SOMARC	✓	✓			
Namibia	PSI	✓				
Rwanda	PSI	✓				
Senegal	SOMARC	✓				
Tanzania	PSI	✓				
Togo	SOMARC	✓				
Uganda	SOMARC	✓	✓		✓	
Zimbabwe	SOMARC	✓	✓			✓

\* Excludes PSI's regional initiative in four West African countries. Separately contracted activities in Burkina Faso and Cameroon are included.

Source: Information on PSI provided by PSI. Information on SOMARC reported in Stover and Heaton, 1997

Given the limited profitability of the contraceptive component of most retailers' sales inventory, they may be unlikely to engage in independent advertising of contraceptives (Desai, 1997). Producers, not retailers, will generally undertake product-specific advertising.

Lack of a private area for counseling patients can inhibit pharmacist participation in family planning service delivery, as in Zimbabwe (Adamchak, 1996).

## **Contraceptive Social Marketing**

Contraceptive social marketing (CSM) — i.e., the sale of contraceptives at subsidized prices at retail outlets — is the most important component of retail sales in developing countries, including those in sub-Saharan Africa. The approach involves the application of commercial marketing techniques to contraceptive sales, with the objective of increasing the availability and affordability of contraceptives

to low- and moderate-income consumers. Although programs sell their products through commercial outlets, they cannot be considered as purely commercial because they generally receive some funding and in-kind contributions of contraceptive commodities from donors.

An approach that is becoming common is one in which for-profit distributors reach formal agreements with governments and donors to maintain prices at levels affordable to the middle and lower-middle class in order to encourage them to switch from the more highly subsidized public sector to social marketing products. In return, donors provide funds to companies for marketing their products with the expectation that these efforts will eventually be funded by the companies.

Several CSM programs have been active in sub-Saharan Africa; these generally received support either from the Social Marketing for Change

(SOMARC) Project or Population Services International (PSI), which were funded by USAID. Table 4.3 provides a list of countries in sub-Saharan Africa in which there are such programs. All of these programs sell condoms and a few also sell other methods. Ghana's program sells five methods, the most of any sub-Saharan African country. The dominance of condoms in CSM programs is related to an emphasis on AIDS prevention and to restrictions on the sale of hormonal methods at commercial outlets.

Some social marketing programs have shown substantial growth. For example, in three of the largest social marketing programs which have received support from SOMARC, (Ghana, Mali, Uganda) sales growth has been strong. However, in some countries (Togo, Niger, Zimbabwe), sales have remained low or fallen (Stover and Heaton, 1997).

Two important issues related to the introduction of CSM are: a) whether it decreases program costs; and b) whether it reduces the reliance of country programs on donor funding. The costs of CSM programs implemented through the SOMARC project have been evaluated (Stover and Heaton, 1997). The authors conclude that the average costs per couple year of protection (CYP) of social marketing projects implemented by SOMARC are substantially lower than those of other modes of service delivery. However, these costs are defined as the total USAID costs and do not include any costs covered by other sources (clients, governments, etc). Thus, the study measures only those costs borne by SOMARC and its funder, USAID, rather than total program costs. Over time, as the commercial sector and governments in developing countries take over some of the tasks originally paid by SOMARC, they will require less funding from SOMARC, and donor funding per CYP will decline. Thus, while the distribution of costs between donor and in-country sources may shift, total costs might not change. However, it is certainly important that lower donor contributions per CYP will be required.

In general, CSM programs are expected to decrease reliance on African government and donor funds by inducing users to switch from more to less highly subsidized services. One study in Honduras, however, found that the introduction of a social marketing program which provided oral contraceptives (OCs) did not accomplish these goals. The market share of commercial brands fell, and the costs of providing OCs to users previously paying the full cost of OCs was now partially borne by donors. However, given that the share of the commercial sector is far smaller in sub-Saharan African countries than in other regions, source switching from commercial to social marketing brands may be of little significance. While the market share of the CBD program also fell, which was a positive result, any cost savings of OC provision by the CBD program were likely to be minimal as the number of distributors in that program actually increased (Janowitz et al., 1992). An earlier study showed that about half of the purchasers of the OCs sold in the CSM program had previously used other brands of OCs, with about half of those previous users from the commercial sector (Bailey et al., 1989).

Similar analyses have not been conducted in sub-Saharan African countries. However, before we can say that substitution of social marketing for other service delivery modes saves donor and public funding, such analyses should be undertaken. More qualitative assessments suggest that the change from subsidized to sustainable programs is a slow and not always successful process (Handyside et al, 1996; Kincaid et al, 1997).

## **Conclusions**

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A vast array of activities has been undertaken to stimulate commercial sector provision and financing of services; the activities profiled in the literature are limited to a few countries (notably Kenya and Zimbabwe) and were generally developed based on detailed assessments of the

particular characteristics of each country's commercial sector. Given the heterogeneity of this sector among countries, lessons learned in one setting cannot necessarily be applied elsewhere. Even within countries, lessons learned often have limited applicability. The nature and outcomes of any given employer-based program, for example, relate to the unique nature of that employer. Similarly, interventions to facilitate the commercial sector participation of any given cadre of health personnel must be developed based on the very particular barriers these providers face.

Nonetheless, it is important to evaluate which approaches work best in order to provide guidance to donors and countries as to how best to use limited resources to encourage commercial sector growth. Projects undertaken to date have tended to have weak evaluation components (Cross, 1993). Efforts must be made to ensure that the evaluation components of commercial sector projects assess their ability to provide family planning services; their ability to increase the size of the commercial sector by transferring users of subsidized services; and their sustainability, replicability, and cost-effectiveness.

In addition, the following points should be considered in determining whether and how to invest further resources in the development of the commercial sector:

**1. Is it reasonable to expect a thriving commercial market for family planning to develop without substantial economic development?** Research indicates that variations in the size of the commercial sector reflect basic differences in countries which are not amenable to policy change in the short term. Thus, the potential to increase the commercial sector may be very limited in scope. The limited success of projects that have sought to increase commercial sector provision of family planning must be judged against this background.

**2. Is it possible for donors to support simultaneously the growth of commercial and noncommercial sources of family planning?**

There is evidence that the growth of subsidized services has impeded the growth of the commercial sector. While the commercial sector might have shown healthier growth in the absence of support for subsidized services, the result would likely have been slower growth of family planning services overall. There is a fundamental conflict between donor efforts to stimulate service provision through subsidization of government and NGO services and the goal of fostering domestic resource mobilization. Donors will not be able to fill the growing gap between needs and resources; in-country resources will need to fill the gap. Careful attention needs to be paid to the role that donors play in encouraging the growth of the public sector and NGOs, since their services may be difficult to sustain in the long run, while in the short run they impede the growth of the commercial sector.

**3. Do governments use resources that are freed by the transfer of users to the commercial sector to expand or improve public sector services?**

It is often taken for granted that the resources freed by a reduction in the number of public sector clients will be used to extend services to needier groups. If this is not the case, then it is difficult to justify investment in efforts to expand commercial sector services. Research should be conducted to identify both the quantity of public sector resources freed by commercial sector mobilization, and how the public sector uses these resources.

**4. What should be the mix of support for particular versus more general interventions?**

To a large extent, commercial sector projects undertaken to date have focused on the promotion of employer-based services and the potential of managed care arrangements. Given

that there are limited incentives for employers to provide family planning services and for managed care to add family planning as a benefit, these efforts may not be very successful in shifting users to the commercial sector. The potential of these approaches is also limited by the small size of the eligible population (salaried, formal sector workers). Moreover, if donors are to support any one particular strategy to foster commercial sector growth, it should be for social marketing, as it has a far greater potential to reach a large segment of the market. It may also be that more general interventions —such as changes in regulatory and tax policy — should receive greater attention.

5. **Where should resources for commercial sector growth be targeted?** In some countries, commercial sector growth is stymied by factors that are not amenable to short-term intervention. An effort should be made to identify those countries where intervention will have the most effect, based on thorough analysis of related socio-economic and other key contextual issues. On this basis, a matrix of opportunity can be developed to guide the allocation of available resources. In addition, at least in the short term, the growth of services in the commercial sector may require subsidization through social marketing programs. A large unsubsidized commercial sector may need to await greater economic development in much of sub-Saharan Africa.
6. **Does the introduction of social marketing save donor and public funding?** Research should be conducted to determine if the introduction of social marketing induces users to switch from more highly subsidized sources and whether it reduces costs.

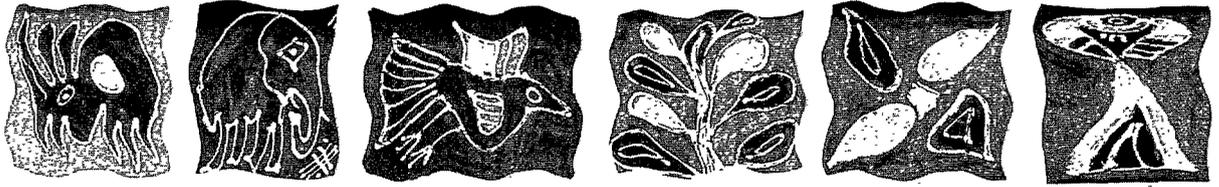


## P O L I C Y   A C T I O N S

1. Many clients who use free or low-cost public services can afford to pay (or pay more) for services. Mechanisms should be developed to shift such individuals to commercial sector sources. Governments should develop explicit policy statements describing their target clientele (i.e., market segmentation).

Urban markets are likely to offer the greatest potential for commercial sector growth. As a result, policy-makers should first devote attention to segmenting the urban market and promoting urban-based commercial sector development.

2. Greater support for social marketing programs may be one of the best ways to promote the development of commercial market sales even though these are subsidized. Analysis of the impact of social marketing programs should be undertaken and results used to plan for additional investment.
3. Governments should create incentives for commercial sector growth, particularly in urban areas — e.g., by reducing associated taxes, liberalizing regulations, and reducing or eliminating other barriers to market entry — while taking care to ensure service safety and quality, as well as vigorous and fair competition.
4. Employers have limited incentives to provide family planning services. Insurance companies and other managed care arrangements have even less incentive to cover family planning services. Further investment in these approaches should be undertaken cautiously; it is likely that the limited resources available for commercial sector promotion could be used to far greater effect in other areas.



## Chapter V

# COSTS OF SERVICES

**W**hile the previous chapters considered ways of mobilizing resources to meet family planning finance needs, this chapter considers ways of reducing funding requirements through the use of cost-saving strategies. Costs may be reduced in several ways:

- lower cost methods and distribution systems can be identified, with due regard for choice and access;
- excess capacity in delivery systems can be tapped;
- costly regulations and unnecessary procedures can be eliminated or minimized; and
- family planning services can be integrated with broader reproductive health services.

### **The Costs of Methods and Distribution Systems: A Case Study of Kenya**

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Before we can identify lower cost methods and distribution systems, it is necessary to assess current costs. We begin, therefore, by examining the current costs of methods and delivery systems, using a case study of Kenya. This case study illustrates that our knowledge of family planning costs is mixed and limited. This impedes efforts to identify and implement cost-minimizing strategies.

### **Estimates of family planning costs in Kenya**

Many cost studies have been conducted in Africa, but their results are difficult to compare because of wide country variation in programs and economic

**Table 5.1. Conversion Factors for CYPs**

<i>Method</i>	<i>CYPs</i>
OCs	15 packets per CYP
Condoms	150 condoms per CYP
IUD	3.5 CYPs per IUD
Injectables	4.0 doses per CYP
Norplant	3.5 CYPs per implant
Tubal Ligation	12.5 CYPs per procedure

conditions. We are focusing on only one country, Kenya, thereby eliminating some of the reasons for the variability in cost estimates.

We examined nine studies of the cost of Kenyan family planning programs that have been conducted in the past few years. We began by using data from the five recent studies that provided method-specific visit cost estimates to construct estimates of method-specific costs per CYP. We make comparisons using cost per CYP, rather than cost per visit measures, because CYPs take into consideration the amount of time that a woman is protected against the risk of pregnancy by the method she receives. Method costs can best be compared using this standardized output measure. Although it has been criticized, the CYP measure remains the best means available of comparing costs and output associated with method provision.<sup>1</sup> Each contraceptive method is assumed to have a number of CYPs associated with its distribution or use, corresponding to the average number of years of contraceptive protection that it provides. For example, because the average woman will use an IUD for 3.5 years and is assumed to be fully protected from pregnancy for this period, 3.5 CYPs are assigned to the IUD. Likewise, since a woman requires four injections to receive a year's contraceptive protection using injectables, one injection is allotted 0.25 CYPs.

The cost per CYP is calculated by dividing the costs of providing and continuing to use a method (including all necessary visits and services) by the number of CYPs associated with that method. Standard conversion factors are shown in Table 5.1. In order to determine the costs of all visits, we made some assumptions about the programs' distribution policies for OCs and condoms specific to visits.<sup>2</sup>

Table 5.2 presents our results. In four of the five studies, costs per CYP are lowest for IUDs and second lowest for sterilization. In the fifth study, sterilization had the lowest costs per CYP. Costs per CYP are much higher for the other methods.

We then compared the costs of alternative distribution methods, using the Family Planning Association of Kenya (FPAK) program as an example. In that study, clinic-based delivery has lower costs per CYP than do CBD programs (U.S. \$10.09 versus U.S. \$16.30 (Chee 1996), data not shown). However, CBD programs provide only re-supply methods, and re-supply methods have a higher cost per CYP.

### The role of methodological differences

There are large differences in the cost per CYP estimates reported in Table 5.2. The use of different methodologies probably accounts for much of this variation. Table 5.3 describes the methodologies used in each of the studies included in Table 5.2, as well as four other studies that provided non-method specific cost information. These additional studies were included here since they provide a useful point of methodological comparison. Unfortunately, many of these studies fail to provide a clear description of the research methods they employed. Some provide reasonable detail about the methods used to derive cost estimates, while others provide very little such information, making it difficult to interpret or

<sup>1</sup> The CYP measure has been criticized on a number of levels. Most importantly, the conversion factors used to translate the number of contraceptives distributed into an estimated period of protection assume that providing a contraceptive ensures use, and that use ensures protection, failing to account for compliance, continuation, consistency of use, and contraceptive failure. For further discussion on the limitations of CYP, see Fort (1996) and Shelton (1991).

<sup>2</sup> Specifically, we assumed that an average of three packets of pills or 15 condoms were distributed per visit. Moreover, in some cases, information on costs of revisits was not provided and we had to estimate these costs.

**Table 5.2. Corrected Average Cost per CYP by Method (1997 U.S. dollars)**

<i>Method</i>	<i>NCPD (1995)</i>	<i>Kimunya (1996)</i>	<i>Musau (1996)</i>	<i>Twahir et al. (1996)</i>	<i>AVSC (1994)</i>
Pills	28.01	18.03	8.87	10.28	
Condoms	29.75		12.56	29.67	
IUD	13.99	3.67	2.16	2.82	2.94
Injectables	29.71	18.15	9.40	18.29	9.02
Norplant	30.98		10.54	11.13	16.72
Tubal Ligation	13.92		5.75	5.59	3.62

compare results. The most common methodological problems appear to involve failure to include commodity and follow-up visit costs or method-specific cost estimate problems in the measurement of personnel time, and the allocation of personnel time to visit costs.

### Commodity costs

Some of the studies reviewed include commodity costs in their estimates, while others leave them out (see Table 5.3, column 2). Since most family planning programs in Kenya receive their contraceptive commodities free of charge from donor organizations, several of the authors reasoned that they should not include the cost of these supplies in their analysis. They focused purely on the direct financial burden incurred by the individual program under examination. Failure to include the cost of commodities, however, results in an underestimation of the true cost of family planning service delivery. Even though these supplies may be free to the program, they still constitute a cost of providing services. If donor monies were withdrawn, programs would be forced to cover these costs themselves.

### Follow-up visit costs

None of the studies examined included the costs of follow-up visits in their estimates of IUD, Norplant or tubal ligation costs. The cost per CYP for an IUD

insertion, for example, should be the cost of the visit for insertion, one or more follow-up visits, and removal, divided by the average period of use to determine an annual cost. When these costs are not included, the costs per CYP of IUDs, Norplant and tubal ligation are artificially low.

We corrected for the omission of both commodity and follow-up visit costs in the estimates shown in Table 5.2. For commodity costs, we used figures reported by Johnston (1994). For follow-up visit costs, we used the ratio of new to continuing client visit costs provided by Kimunya (1996) for IUD visits. Since this was the only follow-up visit cost estimate available, we also applied it to the Norplant and tubal ligation costs. We included the costs of two follow-up visits for both IUDs and Norplant (one of which would be for removal) and one follow-up visit for tubal ligations.

### Costs of personnel and the problem of underutilized capacity

A key methodological issue, which we were not able to correct for in the estimates provided in Table 5.2, is the apparent variation in the treatment of personnel costs by the five studies reviewed. The amount of staff time devoted to various types of visits and supporting activities, as well as the amount of unused time, has a significant influence on cost estimates. The more unused provider time there is in a program, the higher its visit costs.

**Table 5.3. Methodological Comparison of Family Planning Cost Studies in Kenya**

<i>Study</i>	<i>Commodity Costs Included?</i>	<i>Staff Time Measured?</i>	<i>All Staff Time Included?</i>	<i>Programs/Projects</i>
Chee, 1996	Yes	No	Yes	Staff time is allocated equally to all visits, and no attempt is made to estimate the costs of visits of different types. The study includes measurements of nurse/client ratios and workload analyses, which reflect the capacity and efficiency of each site.
Ashford, 1992	Yes	No	Yes	Labor costs were not handled separately from other direct costs. The author examined costs across all FPAK clinics and CBD programs/projects, and the cost of individual methods was not examined.
Barberis and Harvey, 1997	Yes	No	Yes	Data are derived from a representative sample of Pathfinder-funded projects in Kenya. The focus of the paper is a cross-country comparison, and the only discussion of the methodology states that "costs include U.S. and disbursements, estimated U.S. \$ value of grantee contributions, operating expenses, and, when available, yearly depreciation of buildings and equipment."
Kimunya, 1996	No	Yes	Unknown	Costs were distributed across types of visits according to the providers' estimates of time spent and materials used. Cost per visit included both direct and indirect costs, but there was no discussion of whether time estimates included non-client contact time.
Wilson and Cooke, 1995	No	No	Yes	Total direct and indirect costs were divided by the number of CYPs delivered per site. The cost of commodities was shown separately.
Musau, 1996	No	Yes	No	The staff time required per visit for different methods was presented, but the way this was determined was not discussed. It is therefore impossible to determine whether visit costs include only time spent with clients, or if they also include non-client contact time.
Twahir et al., 1996	Yes	Yes	Yes	Staff estimates of time spent per visit were used to allocate labor time to particular types of visits. Other direct and indirect costs were added to this to obtain total costs both by type of delivery site and by method.
National Council for Population and Development, 1995	No	No	Yes	Data on direct costs (including personnel) and information on visit costs in Bangladesh were used to estimate cost per visit for both clinics and CBD projects. Indirect costs were allocated according to the distribution of direct costs. Donated commodities were not included.
AVSC, 1994	Yes	Yes	No	Information on how personnel time was allocated across visits was not given. It cannot be determined, therefore, whether visit costs include only time spent with clients or if they also include non-client contact time.

None of the studies reviewed includes a detailed discussion of these costs, so a detailed assessment of this issue as it applies to estimates of family planning costs in Kenya is not possible. The third column in Table 5.3 indicates whether staff time was measured in the cost studies reviewed in this chapter. Most did not disaggregate the time use of clinic or CBD staff. Most of the studies deal with personnel costs only perfunctorily, generally by stating simply that the cost of staff time was included with other direct costs. Since personnel costs usually constitute the largest percentage of total costs in both clinics and CBD programs, they merit greater attention than they generally receive. There are two steps to developing accurate estimates of staff time costs: first, accurately measuring staff time use, and second, accurately applying staff time measurements to cost estimates.

### Measuring personnel time

Measuring staff time by activity is not a simple process. (For more information, see Janowitz and Bratt, 1994.) The most accurate method of time measurement is direct observation — when a researcher actually watches and records the activities of personnel over a period of several days or weeks. This method is, however, both expensive and intrusive. Patient flow analysis provides accurate information on contact time, but provides no information on how non-contact time is allocated. It, too, is costly. Staff interviews can also be used to estimate time use. In this case, researchers ask providers for their estimates of how long they spend on various activities during a typical day. This method is prone not only to typical recall error, but also to the fact that providers are likely to be reluctant to report their own unproductive time. A third method is a self-administered timesheet on which providers record their own time use during the course of the day. This method, while possibly more reliable than provider interviews, is still prone to errors of underreporting of unproductive time. No method of time measurement is perfect. Nonethe-

less, estimates of staff time are necessary to assess the true costs of service provision; researchers must therefore choose the most appropriate among these imperfect measurement techniques.

### Allocating personnel time

Once it has been gathered, information on staff time use must be used appropriately to determine labor costs per visit. All time, including unproductive time, must be included when deriving estimates of staff costs per visit. If only the staff time spent on direct client-related activities is used in deriving cost estimates, the actual cost of service provision is underestimated. The fourth column in Table 5.3 specifies whether all staff time was included in the study's cost estimates. For those studies that did not measure personnel time by activity, the total staff cost (i.e., salaries) is used for labor costs, so all time is correctly included — including unproductive time. In the two studies that did assess staff time use, only the time spent per activity was included in the labor cost estimates, and the actual labor cost of family planning services is, therefore, likely to be underestimated. One study correctly included all staff time, while another did not clarify how labor costs were allocated to visits.

### Mobilizing underutilized capacity

When family planning workers have a significant amount of time not spent with clients or carrying out other productive activities, there is underutilized capacity. Staff are being paid for non-productive time, and costs per visit are therefore high. If staff were more fully utilized, more clients could be served without increasing labor costs.

Assessing the amount of underutilized capacity is especially important for the projection of future family planning costs. If demand for family planning rises, as it is expected to in all sub-Saharan African countries, the costs of providing family planning

services need not rise substantially; the increased number of clients could be absorbed within the existing network of providers, and programs might not be forced to hire significantly more family planning workers or add to buildings and equipment. In order to determine the extent of unused capacity, programs should conduct cost studies that address this issue and develop practical suggestions to refocus staff attention on direct client services and other productive activities.

In order to reduce underutilized capacity, work performance must be strengthened. Two interrelated changes need to take place in order to increase the level of staff work effort: more clients need to demand services, and staff need to spend their time meeting this demand. Financial or technical incentives such as increased salaries or further training can enhance staff productivity, which will improve services and attract more clients. Though a potentially difficult process, management and supervisory structures need to encourage better job performance and increased attention to clients.

## **The Costs of Medical Barriers**

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In recent years, work has begun to address what are referred to as “medical barriers” to contraceptive use — that is, practices that hinder clients’ access to services. Seven categories of medical barriers have been defined: inappropriate contraindications, eligibility barriers, process/scheduling hurdles, provider bias, regulatory barriers, limits on who can provide services, and inappropriate management of side effects (Bertrand et al., 1995). Some of these barriers — such as subjecting women to unnecessary tests and procedures, asking them to return for follow-up visits more frequently than is necessary (process hurdles), or only permitting medical personnel to provide contraceptive services — also represent an inefficient use of scarce resources.

Examples of process hurdles in sub-Saharan Africa abound. In parts of West Africa, for example, women must have a blood test performed before being prescribed combined OCs, to rule out the possibility of liver and cardiovascular disease (FHI et al., 1992). Research conducted by FHI found that more than half of family planning professionals considered these tests to be necessary. However, very few women are identified to be at risk through their use. In addition, the tests are expensive. In Senegal, for example, their cost was estimated to be between U.S. \$55 and U.S. \$216, as much as five times the monthly per capita income (Stanback et al., 1994). In most cases, taking a brief medical history is sufficient to identify those at risk.

According to a World Health Organization (WHO) survey, requiring users to return for follow-up visits more often than necessary is perhaps the most common medical barrier to access (WHO, 1992). Most of WHO’s collaborating centers, for example, prescribe OCs for only two to three months at a time, and recommend that IUD users return every four to six months. In Great Britain, by contrast, an IUD follow-up visit is required six to eight weeks after insertion, and annual visits are required thereafter (Cottingham and Mehta, 1993). It is also recommended that women be counseled to return whenever they experience side effects. Using data from clinical trials, Janowitz et al. (1994) found that a reduction in the number of recommended IUD revisits is safe.

Limiting the types of personnel who can provide contraceptive services presents another barrier to access with significant resource implications. In some countries, only physicians — the most costly category of health personnel — are permitted to perform such family planning procedures as IUD insertions, despite a growing body of evidence from numerous countries that such procedures can be performed well by non-physician staff with appropriate training and supervision (Cottingham and Mehta, 1993). Other research has shown that

nurse-midwives can perform postpartum sterilizations (Dusitsin and Satyapan, 1984; Kanchanasinith et al., 1990).

### Medical barriers and quality of care

There are concerns that efforts to remove medical barriers might worsen the quality of care — if, for example, necessary tests and procedures are also abandoned. According to Shelton et al. (1992), “many clinical practices both help to make the best contraceptive choice and provide secondary health benefits such as screening for sexually transmitted diseases (STDs). The challenge is to separate the wheat from the chaff.” There is, however, disagreement on what constitutes the wheat, and what constitutes the chaff, as discussed further below. The WHO survey — as well as other recent analyses (e.g., Adrian et al., 1992, Angle et al., 1993) — found a complete lack of consensus as to the minimum but necessary elements of family planning care. Part of the problem is that many of the guidelines for contraceptive provision are based on information that is now out-of-date, or were designed based on contraceptives that have been radically reformulated in recent years (King et al., 1993).

### Service delivery guidelines

Two efforts have been made to improve the guidelines and criteria for contraceptive service delivery. WHO has developed eligibility criteria for contraceptive methods (WHO, 1995), and USAID convened a group of international experts to develop technical guidelines on the provision of a

*Where no consensus exists, programs should make decisions about the practices they will endorse based on the most up-to-date scientific information, their program goals, the context in which they operate, and resource availability...*

wide range of methods (Technical Guidelines Working Group, 1994 and 1997).

While these efforts will go some way toward counteracting the outdated criteria and procedures currently used, debate on appropriate practices continues in many key areas (Hardee et al., 1996). For example, while there is consensus on

the benefits of non-physician provision of condoms, there is no consensus on whether or not OCs should be made available over-the-counter, or on whether a physician or nurse should evaluate clients before OC use is initiated. Similarly, while there is consensus that STD screening is important for IUD users in areas with high prevalence of STD, there is no consensus on the number of follow-up visits IUD users should be required to make, or on how often, if at all, OC users should be required to make a follow-up visit for weight or blood pressure measurement and other assessments.

Hardee et al. (1996) recommend that programs regularly update their guidelines where consensus exists on the “necessity or superfluity of a specific practice.” Where no consensus exists, programs should make decisions about the practices they will endorse based on the most up-to-date scientific information, their program goals, the context in which they operate, and resource availability, among other factors.

There is a need to find ways to ensure that such an effort is undertaken by family planning programs in sub-Saharan Africa. An assessment of existing

service guidelines can serve as a starting point. In Africa, however, explicit guidelines often do not exist. This was the case in eight countries that developed national standards with assistance from the International Program for Training in Health (INTRAH, 1993). The effort began with a detailed examination of current practices “as espoused through scant documentation,” and on current scientific information on contraceptives. This enabled policy-makers and physicians in each country to reach consensus on new guidelines. Some of the changed standards will not only improve access to services but also represent more efficient use of scarce resources — for example, lifting restrictions for non-clinical distribution of OCs. A different approach was used in Kenya, where group discussions with policy-makers and providers were convened during a contraceptive technology update seminar in an effort to elucidate medical barriers and possible steps to overcome them (Huber and Jesencky, 1993). One of the efficiency-enhancing outcomes of this exercise was the elimination of the pelvic examination requirement for women to initiate or continue use of OCs.

It should be noted that changing guidelines will not necessarily change practices in a manner that reduces medical barriers. In Cameroon, for example, a study was conducted to assess provider adherence to MCH/FP service policy standards and medical protocols. For the most part, practices did not change (Thompson et al., 1995). Improved monitoring and supervision are key to ensuring that improved guidelines translate to improved practice.

## **Costs of Providing Additional Reproductive Health Services**

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In response to calls for the provision of more comprehensive reproductive health care, many family planning programs are diversifying their services to include the management of RTIs, including the subset of STDs, as well as other reproductive health program components. These

services are critical to sub-Saharan African women, given the high prevalence of RTIs in the region and their devastating sequelae, which can include pelvic inflammatory disease (PID), chronic pelvic pain, neonatal disease, infertility, social ostracism, and, in some cases, death. RTI management is particularly important in the context of family planning services, and particularly IUD services, insofar as the insertion of an IUD in a woman with an untreated infection may lead to upper reproductive tract infection with serious consequences. In addition, family planning programs can play a critical role in STD prevention, through condom provision, education, and counseling. Without adequate attention to RTIs, family planning services risk worsening the reproductive health of their clients.

Mayhew (1996) suggests that the critical question for decision makers is “whether the greater costs of staff training, drugs and clinical equipment will be outweighed by the money saved from reducing (the prevalence of) STDs and sequelae needing treatment.” It is often suggested that extensive screening and treatment of family planning clients is likely to be cost effective, given the high costs — both to individuals and the health system — of treating the sequelae of RTIs. The results of limited research to date on the costs and cost savings of alternative RTI management strategies, as well as the costs of providing integrated RTI and family planning services, are presented below.

### **Costs and cost savings of alternative RTI management strategies**

Alternative strategies for RTI management include laboratory testing and treatment, presumptive treatment of all women, syndromic management, no screening or treatment, or a combination of these strategies. The costs and cost savings associated with alternative approaches hinge on the prevalence of RTIs in a population and on the costs of screening and treatment.

There is a large literature on the costs and cost savings of alternative strategies for detection and treatment of STDs in the context of family planning programs in developed countries. For example, Marrazzo et al. (1997) compared the cost-effectiveness of universal, selective and no screening for chlamydia trachomatis infection among women attending family planning clinics. The study found that universal screening was most cost effective unless the prevalence of infection was very low. This finding was due to the high costs associated with failing to treat existing infection, both to the entities providing treatment and to the individual.

No complete analysis of the costs and cost savings of alternative RTI screening and treatment strategies for family planning clients has been carried out in any developing country to date. Such an analysis would need to focus on the costs and cost savings of alternative strategies in two areas: 1) identifying women with RTIs; and 2) treating women with RTIs. The costs of both screening and treatment are anticipated to be lower in sub-Saharan Africa than in developed countries, given the high proportion of these costs that are made up by the wages of health personnel and lower wage rates in these countries. However, the cost savings associated with treating the sequelae of infections will also be lower, since women in the developing world are less likely than their developed country counterparts to seek treatment for such problems as pelvic pain and infertility. Cost savings are also lower because foregone earnings associated with women's ill health are lower in sub-Saharan Africa than in the developed world. However, analyses of cost savings do not take into account such intangible but very real benefits as reductions in women's physical and emotional suffering related to RTIs. If these were taken into account, the benefits of screening and early treatment would be far more significant.

Miller (1998) suggests using cost-effectiveness analysis to decide who should receive lab testing. He argues that the only relevant costs to consider are those for lab testing incurred by the organization that provides these services. One possible strategy is to use lab tests on only those women at moderate risk, empirically treat those women at high risk and not test women who have no or very low risk. This approach needs to be evaluated.

Because lab facilities are scarce in the developing world, and because lab testing is costly, management strategies that do not rely on lab tests are of interest. Such strategies, known as the syndromic approach to STD management, generally involve initiating treatment based on symptoms, rather than on a definitive diagnosis. This approach was developed to treat STD clients. Recently, it has been used, sometimes in combination with risk assessment, for clients at family planning clinics. Unfortunately, recent research suggests that this approach, as it is currently used, may not be effective in treating family planning clients for a cervical infection like chlamydia. For example, positive predictive values are very low, indicating that many women who are treated for cervical infections are not infected. Thus, costs are unnecessarily incurred. Moreover, the approach fails to identify a high percentage of women who are infected (for more information, see Mayaud et al., 1995 and Dallabetta et al., 1998).

### **Costs of providing integrated RTI and family planning services**

There is limited literature on the costs of providing RTI services to symptomatic family planning clients in developing countries. Recent research does suggest that these clients are most efficiently served in integrated programs, where they can receive both family planning and RTI services during the same visit, rather than during separate

visits. We refer here to the combined provision of existing services, rather than the addition of new services to an existing package.

Two recent studies of integrated family planning and STD services in the sub-Saharan region did conclude that this approach was more efficient. The first (Twahir et al., 1996) concluded that integrating family planning and STD services for symptomatic clients in Mombasa, Kenya, reduced costs per visit — i.e., the cost per integrated STD and family planning visit was lower than the joint cost per visit of separate consultations for each service. However, no objective information was obtained by this study on the amount of time providers spent with clients; instead, this information was obtained from interviews with providers, which was not validated using observation or other methods. Since staff time constitutes a significant proportion of costs, any inaccurate assessment of time spent with clients will have a significant impact on cost estimates. A similar analysis of two clinics in Botswana (Maribe and Stewart, 1995) also found that integrated services were less costly. While some effort was made to allocate staff costs based on observations of provider-client interactions as well as interviews with staff, it is not clear how these data were used. Other methodological problems (e.g., failure to take into account the impact of capacity utilization) make it impossible to draw firm conclusions on the cost of integrated services from these studies.

Perhaps more importantly, neither of these two studies nor other research conducted elsewhere in the developing world has considered the costs of providing RTI services to asymptomatic clients. Many women with RTIs present without symptoms, and it is much more difficult, and more costly, to provide these clients with appropriate screening and treatment. In this case, it is not a question of integrating the provision of existing services, but of adding a new service to an existing care package.

## Conclusions

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An important way to reduce the gap between needs and resources is to reduce the cost of meeting needs. Too often, the focus has been on ways to increase resources. Insufficient attention has been paid to the efficiency with which services are produced. In this chapter, we have raised a number of issues relevant to the potential for reducing the costs of service provision.

1. **What are the current and projected costs of family planning service provision?** If programs are to develop plans for meeting their resource needs, they need information on current and projected service delivery costs. Our analysis for Kenya indicates that existing data are deficient and that additional work is needed to develop reasonably accurate estimates of both current and projected costs.
2. **What are the costs of various method-delivery system combinations?** Program managers need to quantify the costs of various method-delivery system combinations to enable them to understand the cost implications of their programming decisions. Our results indicate that costs per CYP are lower for long-acting methods (IUD and sterilization) and lower in clinics than in CBD programs. While costs are but one criteria upon which decisions about method-delivery system combinations are made, they do need to be considered. Programs need to understand the trade-offs they face — in terms of costs, service quality, access, and reproductive choice — when they consider broadening or narrowing the method mix, introducing or reducing the provision of high-cost methods, and expanding or contracting more expensive distribution systems. For example, ensuring that rural populations have access to contraceptive services may mean that more costly CBD programs need continued

funding. In addition, younger and lower parity women's choices would be constrained if they did not have access to re-supply methods.

**3. How can excess capacity in delivery systems be tapped?** There is some evidence of excess capacity in family planning service delivery systems. If this capacity is tapped, then the additional costs of expanding services may be low: additional services could be produced using existing staff and infrastructure; added costs would include only those of contraceptives and supplies. However, it may not be easy to tap such capacity. Potential interventions — which may be costly, and which often require changes in the “culture” of service delivery — include salary increases to improve motivation and performance, additional staff training, and improved management and supervisory structures.

**4. How can costly regulations and unnecessary procedures be eliminated or minimized?** Some tests and procedures currently required before contraceptives are provided to clients are not necessary. These practices not only represent an inconvenience to users, but can add significantly to the costs of service delivery. Regulations may require that certain procedures be performed by a physician despite evidence that trained non-physicians can safely perform them. Use of non-physicians to provide additional services not only increases access, but also reduces the costs of service provision. One way to reduce adherence to costly and unnecessary regulations and procedures is to develop or revise guidelines for clinical practice that eliminate those that are unnecessary. Such efforts are now ongoing in several sub-Saharan African countries.

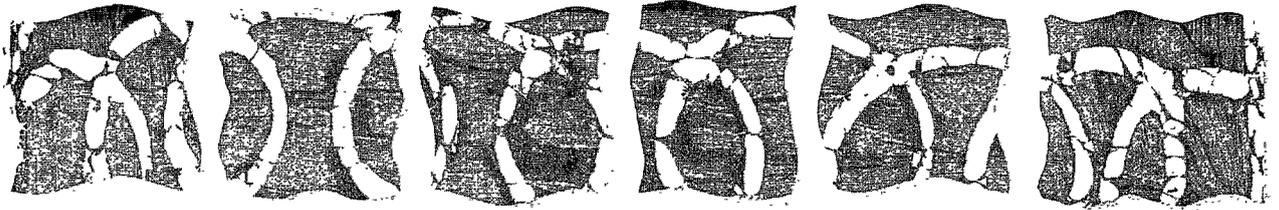
**5. Will the integration of reproductive health services into family planning programs reduce costs?** If additional reproductive health services are provided to family planning clients, then the costs of service provision will clearly rise. Adding RTI management to family planning services can be particularly costly — particularly if services aim to treat asymptomatic as well as symptomatic women. However, there is evidence that existing services now provided separately could be provided at lower cost both to programs and to the clients if they were integrated. Integrating the provision of vertical family planning and RTI services to symptomatic clients provides an example. Programs need to consider the cost implications of integrating existing services as well as those of providing previously unavailable reproductive health services to family planning clients.



## P O L I C Y   A C T I O N S

1. Efforts should be made to mobilize under-utilized capacity in family planning services in the region. This capacity is substantial, and could be used both to expand services and improve their quality, without substantial new resources. However, the costs, financial and otherwise, of capacity mobilization should not be underestimated.
2. In light of the potentially high costs but low effectiveness of treating family planning clients for cervical infections based on risk assessment or the syndromic approach, these approaches should either be revised and retested or phased out.

3. A major effort should be made to develop and promote standards and guidelines for family planning service provision, with an emphasis on eliminating unnecessary or outdated tests and procedures. Existing, updated international standards should be assessed, modified, and implemented at the national/local levels, based on local circumstances. Such an effort will not only reduce the costs of service provision, it will also enhance access.
4. While individuals should be given a choice of contraceptive methods, the costs of these methods cannot be ignored in determining the method mix. Given limited resources, the universal provision of methods based on demand and without regard to cost will restrict the number of individuals whose need for family planning services can be met.
5. Non-physician personnel should be trained and mobilized to play a greater role in family planning service provision, with due regard for safety and quality. There is evidence that nurses can be trained to insert IUDs safely and effectively. Similarly, lower level personnel can provide OCs and injectables. Not only will this approach diminish service costs, it will also enhance access.



## Chapter VI

# CONCLUSION

**T**his report has addressed major issues related to the financing of family planning services in sub-Saharan Africa by consolidating available information, much of which is not published or readily available. It has also identified gaps in the information base that will need to be filled to facilitate policy and program change.

### **The Resource Gap**

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As illustrated in Chapter II, the need for family planning services is high and rising. While trends in donor funding for family planning have been quite positive over the last decade, the most recent data must be interpreted with caution, given changes in the definitions of funding categories. Specifically, it appears that a substantial proportion of recent funding increases for family planning and other elements of reproductive health care has been designated for the latter. Funding for family planning alone may have even declined. While the global emphasis on prioritizing broader reproductive health issues is laudable and long overdue, its potential negative impact on funding for family

planning alone should not be underestimated. Eventually, countries will need to replace donor funds for both family planning and other elements of reproductive health care with in-country resources. Failure to take these realities into account encourages the development of service delivery systems that are neither efficient nor sustainable.

While estimating current levels of government expenditure is a colossal task and results in a broad array of estimates of limited accuracy, one fact is clear: Governments in sub-Saharan Africa contribute significantly less toward overall family planning expenditures than those in other regions, and this is unlikely to change.

While donor funds are increasingly directed at broader reproductive health care, and government expenditure on family planning remains minimal, resource requirements for family planning will increase dramatically in the future. There is, therefore, an urgent need to mobilize alternative sources of funding for family planning. This will be necessary even to sustain current, inadequate

levels of service provision. Meeting high and rising levels of unmet need increases the need for additional resources substantially. Alternatively, or additionally, resources can be conserved by providing services more efficiently.

There are several options available to mobilize or conserve revenue.

Unfortunately, the information base on the potential of these strategies is limited. Most have not been attempted with great success, particularly in the sub-Saharan context; those that have been attempted have not been evaluated, or their evaluations have questionable results due to methodological flaws. The development of a coherent, systematic regional family planning financing strategy must be preceded by targeted efforts to improve this information base. Conclusions about each strategy — based on the limited information available — and recommendations for further research are presented for each approach later in this chapter.

### Key issues

A meaningful regional strategy for family planning finance will depend on the development of an improved information base on family planning needs and expenditures. Policy-makers need relevant, practical information that could be obtained from:

- assessments of donor funding trends, including a delineation of funding on family planning and reproductive health care;
- detailed, country-level assessments of government expenditure on family planning;

*The information base on the potential of strategies [to mobilize or to conserve revenues] is limited.*

- assessments of the impact of donor funding on government expenditure through, for example, research on donor “graduate” countries (e.g., Botswana) or on countries that do not (or did not) receive donor funds (e.g., South Africa, which only recently began receiving donor funds);

- assessments of the functional use of donor funds for family planning, to determine whether these funds are expended in areas that support, rather than detract from, sustainability goals; and
- country-level assessments of the costs of an integrated package of reproductive health care, including family planning.

### Key areas for action

Some actions can be taken immediately to address the growing resource gap. These include the following:

1. The sub-Saharan region has high levels of unmet need for family planning services, as well as a large gap between user needs and both actual and potential resources. As a result, **this region should continue to receive a disproportionate share of donor resources in the short and medium term.**
2. In the short term, **donors should increase their support to African family planning programs in order to sustain them in the face of increasing demand for services.** In order to prevent dependence and to minimize host-country displacement of resources, donors should set clear time frames for phase-out of

increased assistance and assist countries to develop their own plans for domestic resource mobilization.

3. The resources needed to implement the broad *Programme of Action* from the ICPD in Cairo are not available. Donors must prioritize among the various elements of the *Programme*. **Care must be taken to ensure that funding for family planning services is not diminished as implementation of the Cairo agenda moves forward.**

## **Charging Fees for Services**

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Chapter III presented available information on the potential for raising revenue by charging or increasing fees to users of public sector and NGO service outlets, so that users pay a higher share of service costs. Information was also presented on the impact of this strategy on access to services, particularly among vulnerable groups. The pricing literature for sub-Saharan Africa is very limited and does not provide a sufficient base upon which to make decisions about instituting or increasing prices. It does suggest that marginal increases in currently low (or zero) fees might raise a limited amount of revenue without seriously compromising access to care. Available studies also find that higher, private sector prices do have a negative impact on demand. This may imply that efforts to raise public sector or NGO prices to levels high enough to generate the significant resources needed would probably dampen demand to the extent that both users' access and revenue potential would be compromised.

### **Key research questions**

A careful examination of options for sustainable financing of family planning services would include study of the following questions:

- **What is the impact of price changes on contraceptive use?** Experimental research on the impact of prices on both revenues and access to family planning in sub-Saharan Africa must be conducted to give policy-makers the information they need to develop rational pricing policies. This research must assess the impact of prices at individual facilities on demand for family planning overall — not simply at the facility instituting prices. It must also assess whether or not the impact of price changes varies depending on the length of effectiveness of contraceptive methods.
- **Are certain groups more likely to stop using services when fees are introduced?** There is a growing body of evidence that fees may cause large reductions in service use among poorer groups. This effect is masked in research conducted on the general population of family planning clients. More research should be conducted to ascertain the differential effects of fees on service use among clients at different income levels. Similar information is needed to determine if fees have a differential impact by gender and age.
- **Can means testing be used to provide a safety net for the poor?** To the extent that there is a safety net for those who cannot afford to pay for services, prices can be increased and revenue obtained from individuals with the ability to pay. However, evidence from the health-care field indicates that means testing works poorly, particularly in sub-Saharan Africa. If means testing cannot be counted on to protect the poor, institutions will face tough choices about whether or not, and by how much, to raise prices.

- **Will quality improvements increase willingness to pay and, if so, at what cost?**  
There is evidence from the health care field that users will pay more for services if the quality of those services is simultaneously improved. The limited available evidence on family planning suggests that this relationship between willingness to pay and quality enhancements does not hold to the same extent. In addition, quality improvements are costly: Increasing quality to a level that would increase willingness to pay for services would probably require far more resources than fee revenues could provide.

be to charge fees at a very low level, and to use simple targeting strategies that do not require means testing, such as targeting by geographic area, facility type, etc. This implies accepting both limited cost recovery and mis-targeted exemptions as inevitable until more is known about ways to institute effective means testing in the circumstances that prevail in the region, at reasonable cost. At that time, higher fee levels, and more effective, specific means testing systems, can be instituted.

### Key areas for action

Many issues must be taken into account in the development of research and policies on user fees for family planning. Although additional research will be useful in determining what actions to take regarding cost recovery, there are some steps that can be taken immediately:

1. **Government and NGO programs should consider introducing limited fees for family planning services.** Without some level of cost recovery, programs will be unable to expand services to meet high and growing levels of demand for services, make urgently needed quality improvements, or expand their service base to include elements of the ICPD *Programme of Action*. Indeed, the inadequate, existing service base will be increasingly under threat unless some cost recovery is instituted.
2. Means testing cannot be relied upon as a strategy to ensure that the poor and other vulnerable groups have access to services in a fee-charging system. Available evidence suggests that means testing — as currently implemented — is extremely costly and fails to protect many who need protection, while providing exemptions for those who are able to pay. **The imperfect, short-term solution may**

3. **At least some fee revenues should be retained by the service delivery outlets that collect them and, to the extent possible, used to improve service quality.** This will enhance revenue collection and may mitigate the demand-dampening effects of fees. Quality improvements are also important in their own right.

### Mobilizing the Commercial Sector

As discussed in Chapter IV, the commercial sector plays a limited role in family planning in sub-Saharan Africa, particularly in comparison to other regions. Given the concern that high fees may deter contraceptive use coupled with the poor performance of means testing, greater attention should be given to encouraging the growth of the commercial sector. Programs should center their resource mobilization efforts on strategies such as encouraging public sector users with the ability to pay to use commercial sector services, and creating an environment conducive to commercial sector growth.

There appears to be ample room for mobilizing a greater commercial sector role, particularly in the provision of re-supply methods. There is also evidence that a substantial proportion of the public sector subsidy is being used by individuals who appear to have the ability to pay for commercial sector services.

Many of the factors that stymie commercial sector growth are not amenable to short-term policy intervention. There is evidence that such factors as income and urbanization levels, for example, are significantly correlated with commercial market share in sub-Saharan Africa. On the other hand, there are several areas where intervention could have an effect. Unfortunately, available evidence suggests that resources have been used to support those interventions with the least promise in terms of reducing the pressure on the public purse.

One of the major constraints to commercial sector growth is, in fact, donor and government funding of low- or no-cost public and NGO services — since the commercial sector cannot compete in this environment. Charging fees for these services would stimulate commercial sector growth. Other promising interventions include general efforts to minimize and simplify the regulations, taxes, and import duties that currently make family planning service delivery a burdensome venture. A range of interventions to promote a greater role for private health-care providers and pharmacists should also be considered.

Interventions to expand employer-based family planning services have received perhaps the most attention. However, it is not clear that this approach can play a major role in family planning service delivery in the region. The small size of the formal employment sector, the limited involvement of women in this sector, and the small number of companies large enough to consider providing such services limit its overall potential. Its potential for shifting users out of the public sector is even more limited, since formal sector employees are among those most likely to be using commercial services already. Interventions to promote the role of managed care in family planning financing are also receiving growing attention. Again, however, this approach has very limited potential for freeing public sector resources, since potential beneficiaries are already least likely to be using public services.

One promising approach to increasing the commercial sector is social marketing. These programs are expected to decrease reliance on African government and donor funds by inducing users to switch from more to less highly subsidized services. However, evaluations of whether social marketing programs accomplish this goal are lacking in the sub-Saharan Africa region.

## Key research questions

Research in the following general areas would facilitate the development of a strategic plan for commercial sector mobilization:

- **Is it possible for donors to support simultaneously the growth of commercial and noncommercial sources of family planning?** Policy-makers need to realize that their efforts to support service provision in the public sector and in NGOs may discourage commercial providers. Research is needed to determine whether there are ways for donors both to support the provision of quality services for low-income women and simultaneously encourage commercial service provision.
- **Is it reasonable to expect a thriving commercial market for family planning to develop without substantial economic development?** To the extent that commercial sector growth is tied to longer-term economic considerations, short-term policy interventions may have limited impact. It is important to be realistic about the potential size of the commercial sector, particularly in the poorer countries of the region.
- **Do governments use resources that are freed by the transfer of users to the commercial sector to expand or improve public sector services?** Research should be conducted to determine both the quantity of public sector resources freed by commercial sector

mobilization, and how the public sector uses these resources. If freed resources are not used to finance services for needier groups, it is difficult to justify investment in efforts to expand commercial sector services.

- **Does the introduction of social marketing save donor and public funding?** Research should be conducted to determine if the introduction of social marketing induces users to switch from more highly subsidized sources and whether it reduces costs.

## Key areas for action

Immediate policy actions include the following:

1. Many clients who use free or low-cost public services can afford to pay (or pay more) for services. **Mechanisms should be developed to shift such individuals to commercial sector sources.** Governments should develop explicit policy statements describing their target clientele (i.e., market segmentation).

Urban markets are likely to offer the greatest potential for commercial sector growth. As a result, policy-makers should first devote attention to segmenting the urban market and promoting urban-based commercial sector development.

2. **Governments should create incentives for commercial sector growth**, particularly in urban areas, e.g., by reducing associated taxes, liberalizing regulations, and reducing or eliminating other barriers to market entry — while taking care to ensure service safety and quality, as well as vigorous and fair competition.
3. Employers have limited incentives to provide family planning services. Insurance companies and other managed care arrangements have even less incentive to cover family planning

services. Further investment in these approaches should be undertaken cautiously; **it is likely that the limited resources available for commercial sector promotion could be used to far greater effect in other areas.**

4. **Governments should create incentives for commercial sector growth, particularly in urban areas.** Programs need to determine whether they should devote additional resources to social marketing in order to stimulate the growth of the commercial sector.

## Reducing the Cost of Services

Chapter V examined prospects for reducing the costs of family planning services. Reducing service costs is one way to narrow the gap between needs and resources. Too often, we focus almost exclusively on increasing resources, and little, if at all, on the efficiency with which services are provided.

### Key research questions

Key decision points and information gaps include the following:

- **What are the current and projected costs of family planning services?** Information on current and projected service costs is essential to making plans to reduce these costs. The existing base of information on costs is woefully inadequate. Suggested improvements in costing methodologies were outlined in Chapter V.
- **What are the costs of various method-delivery system combinations?** Programs face difficult tradeoffs when making decisions about the range of methods and distribution systems they employ. Given resource scarcity, the costs of available options must be considered along with other important concerns, such as access, quality of care, and the principles of reproductive choice.

- **How can excess capacity in delivery systems be tapped?** Existing staff and infrastructure are not fully utilized. This implies that services could be expanded, at relatively little cost. However, the training, supervisory, and other interventions required to tap this underutilized capacity are often costly, and may require changes in the “culture” of service delivery that are only possible in the longer term.
  - **How can costly regulations and unnecessary procedures be eliminated?** Some of the regulations, tests, and procedures that govern and accompany contraceptive service provision are unnecessary. Not only do they compromise access to services, they increase service costs. Efforts to minimize these medical barriers should be expanded.
  - **Will the integration of family planning and reproductive health services reduce joint service costs?** Providing new vertical services in an integrated package is likely to reduce costs both to programs and to clients. Adding new reproductive health services to the existing package will increase costs, often substantially. These issues merit further exploration.
2. In light of the potentially high costs but low effectiveness of treating family planning clients for cervical infections based on risk assessment or the syndromic approach, these approaches should either be revised and re-tested or should be phased out. **Priority should be given instead to the promotion of behavior change and condom distribution.**
  3. **A major effort should be made to develop and promote standards and guidelines for family planning service provision**, with an emphasis on eliminating unnecessary or outdated tests and procedures. Existing, updated international standards should be assessed, modified, and implemented at the national and local levels, based on local circumstances. Such an effort will not only reduce the costs of service provision, it will also enhance access.
  4. While individuals should be given a choice of contraceptive methods, **the costs of methods cannot be ignored in determining the method mix**. Given limited resources, the universal provision of methods based on demand and without regard to cost will restrict the number of individuals whose need for family planning services can be met.

## Key areas for action

Immediate policy actions include the following:

1. **Efforts should be made to mobilize underused capacity in family planning services** in the region. This capacity is substantial, and could be used both to expand services and improve their quality, without substantial new resources. However, the costs, financial and otherwise, of capacity mobilization should not be underestimated.
5. **Non-physician personnel should be trained and mobilized to play a greater role in family planning service provision**, with due regard for safety and quality. There is evidence that nurses can be trained to insert IUDs safely and effectively. Similarly, lower level personnel can provide oral contraceptives and injectables. Not only will this approach diminish service costs, it will also enhance access.

## Final Comments

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There is potential for mobilizing revenues to finance current and future needs for family planning in the region. Each strategy, however, must be implemented based on information about its impact on revenues, access to care, reproductive choice, and many other issues. The information gaps in this document should be prioritized by decision makers in the region. This priority-setting exercise should be followed by targeted research, the results of which should be widely disseminated to promote financing reform through rational family planning

pricing policies, targeted commercial sector mobilization, and cost-minimizing strategies. However, some actions can be taken immediately to recover costs, promote the development of the commercial sector and reduce costs. Policy-makers need to draw up action plans to implement the immediate actions that we have outlined in this chapter. Without research on financial issues coupled with some immediate policy actions, it will be difficult to maintain current, inadequate levels of service provision. Meeting unmet needs for family planning and broader reproductive health care — today and in the future — will remain unattainable goals.

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