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Targeting: A Key Element of National Contraceptive Security Planning

- *Targeting is a practical approach to the achievement of program goals that directs scarce resources to those most in need.*
- *Targeting is part of a broader package of public sector interventions that creates a business environment conducive to private sector involvement.*
- *Targeting promotes equity, stimulates increases in available resources, and improves overall efficiency in family planning services.*

POLICY Issues in Planning and Finance, a series of policy briefs, presents the findings and implications of POLICY-supported research. The series is intended to focus attention on the importance of developing a favorable policy environment that encourages appropriate and adequate FP/RH/AIDS program financing.

Targeting: An Essential Element of National Contraceptive Security Planning

"'Targeting' refers to concentrating resources, particularly resources for social programs, on the people who need them most."

—Newbrander et al. (2001)

Global demand for family planning services continues to increase rapidly. By 2015, the number of women using modern contraceptives is expected to nearly double (Ross and Bulatao, 2001). This dramatic growth is due in part to an increase in the number of women of reproductive age. It also stems from the fact that national family planning programs are doing a better job of both reaching out to women in need of family planning products and removing barriers to family planning services. Demand for condoms is rising even faster as a "dual-use" product, protecting against unwanted pregnancies as well as against sexually transmitted infections (STI), including HIV.

New challenges for family planning programs have arisen from their success. In many family planning programs operated by the public sector, resources are falling short of growth in demand for services. At the same time, individuals with unmet need for family planning services are increasingly concentrated among hard-to-reach groups. Moreover, as low-cost public services come to dominate the family planning market, they compete with and crowd out the private sector. This brief explores one potential solution—targeting—to meet these challenges, alleviating barriers to the expansion and use of family planning services.

Targeting is a mechanism that directs scarce resources in a planned manner to achieve program goals equitably. Targeting can help remove barriers and improve access for underserved groups, making it possible to turn unmet need[1] into contraceptive use while permitting better use of scarce resources and improving equity (see Box 1). This brief also reviews the related concept of vulnerability and provides practical guidelines and approaches to targeting that can be applied in public sector programs as tools for enhancing contraceptive security.[2,3]

Roots of Untargeted Family Planning Programs

In the context of increasing contraceptive use and declining fertility, programs are finding it more difficult to meet the escalating costs associated with rapidly increasing demand for family planning services. Figure 1 shows the growing gap between the expected cost of providing subsidized contraceptives and expected donor financial contributions in 87 donor-recipient countries. Even under the most favorable scenarios of future donor contributions, the financing gap will be large.

Filling the gap will be complicated by several related factors.

Box 1. Targeting can help programs move toward contraceptive security by addressing:

- Unmet need (nonuse of family planning among women who want to space or limit fertility)
- Inequitable distribution of family planning commodities and services (bias toward better-off communities)
- Product availability (too large a program for available resources)
- Sustainability of family planning commodities and services (donor phaseout or structural adjustment conditions)

- **Demand**—Demand for public financing for other health and social services is also increasing, leaving little room for reallocation of resources to family planning. As a result, family planning programs are losing ground among competing health sector priorities (Aloo-Obunga, 2002).

[1] A woman who expresses a desire to postpone her next pregnancy for two or more years or who wishes to have no more children but who is not using any contraceptive method to reduce her chances of becoming pregnant is defined as having an unmet need for family planning.

[2] Contraceptive security is defined as a condition achieved when every person is able to choose, obtain, and use high-quality contraceptives and other reproductive health supplies whenever she or he needs and wants them. Countries can achieve contraceptive security regardless of the source of financial support for reproductive health programs. The definition of contraceptive security does not imply that reproductive health programs need to be independent of external assistance.

[3] A vulnerable group is one that, without special program effort, would not have ready and easy access to contraceptive supplies and services due to some physical, financial, social, or cultural access barrier.

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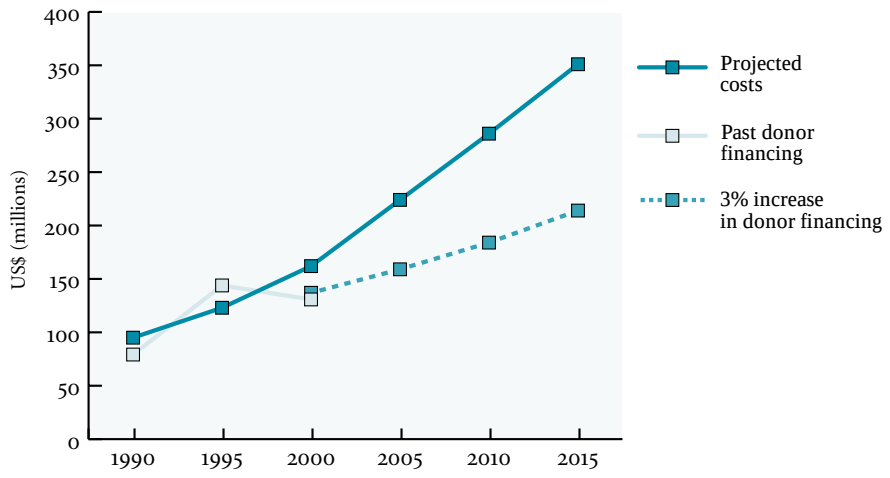
FIGURE 1.
Gap between Expected Costs of Subsidized Contraceptives and Donor Financial Contributions in 87 Donor-Recipient Countries



Adapted from Ross and Bulatao, 2001

- **Financing**—Public sector finances have deteriorated in many countries, making it difficult to fund any expansion of health and social services. In addition, donor commitments to development in general and to family planning in particular have not kept pace with increases in demand for public sector services.

- **Entitlements**—Gwatkin (2000) notes that the gap between the growing demand for and ability/willingness of governments and donors to fund family planning services is not just the result of changes in service demand and the financing environment. He suggests that the "health for all" movement of the late 1970s and 1980s encouraged many countries to develop free, publicly provided health services for all segments of their populations regardless of the users' ability to pay. Many national family planning programs continue to reflect the "health for all" approach; yet, political conditions sometimes undermine efforts to adopt an approach more appropriate to a country's public financing circumstances.[4] In addition, past donor policies with respect to supporting national family planning programs have encouraged governments to provide widespread access to free (or heavily subsidized) services and commodities, rewarding public sector programs for any expansion. These programs tended to grow disproportionately in urban and better-off communities, where it was easier (and perhaps less costly) to increase the number of users. Given that public programs lacked policies, regulations, and strategies to differentiate among consumer types and consumers' ability to pay, it is no surprise that large numbers of non-poor clients chose to obtain their family planning products and services from public sector sources. Such consumer choices have had the effect of stifling private sector growth and, in turn, fostering an attitude of entitlement among public program leaders and their citizenry.

The success of untargeted programs in contributing to fertility decline is now colliding with the realities of today's resource constraints. Without reform, these constraints threaten to prevent countries from progressing toward contraceptive security.[5] Any rethinking about the role of government in the provision of family planning services should look at the lessons to be learned from the broader context of poverty reduction. The experience of countries that have adopted targeting approaches in their poverty-alleviation efforts makes it clear that targeting should be extended to the family planning sector (Adams, 1998).[6]

Consequences of Not Targeting

Targeting enhances a country's prospects for contraceptive security because it expands access to family planning products and services. It directs public resources to those in greatest need by helping to bridge access barriers. Targeting as a mechanism to influence contraceptive security is therefore a subject for discussion within the context of equity (Gwatkin, 2000; Price, 2001; Newbrander et al., 2001). Faced with resource constraints, policymakers must decide what services should be provided to whom, and how best to ensure that those services reach those who will most benefit from them.

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[4] For example, user fees for health services provided in government facilities are sometimes abolished for political reasons.

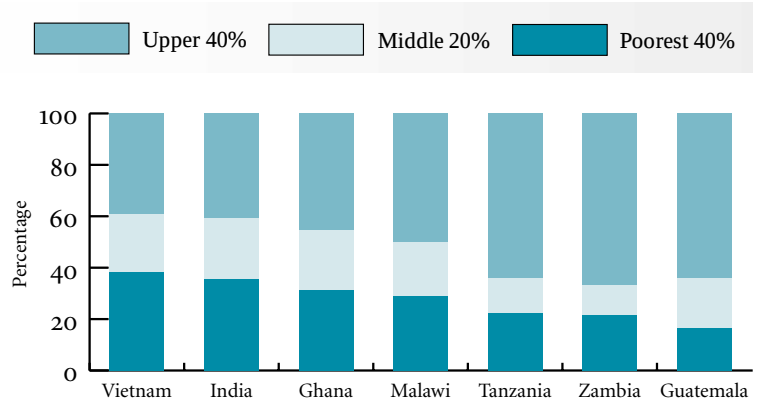
[5] Citing the World Bank, Mills (1998: 33) refers to inefficiencies in public provision of services and calls for a redefinition of the government role from primarily service delivery to financing and empowering the private sector. Such a role redefinition would in effect require public services, whether directly provided or financed through the private sector, to become better targeted.

[6] The wisdom of targeting in public sector STI and HIV prevention programs is perhaps more debatable, especially in countries emphasizing the reduction of STI and HIV transmission regardless of social class. However, the intersection of family planning and STI/HIV programs suggests that how STI and HIV prevention programs handle the targeting issue will influence the supply of condoms available to family planning programs, making policy linkages between the programs appropriate. In Kenya, for example, about 80 percent of condoms are used for disease prevention. Only 20 percent are used for contraception (POLICY Project, 2002).

Failure to adopt targeting allows a substantial share of public sector subsidies to go to the non-poor while vulnerable groups remain underserved. Figure 2 illustrates distortions in the public sector family planning programs of several developing countries.

In some countries, public sector family planning programs tend to benefit the better-off segments of the population more than the poor. In Tanzania, Zambia, and Guatemala, for instance, clients in the lowest two standard-of-living quintiles constitute 40 percent of the total population, yet they consume only 22, 21, and 16 percent, respectively, of public sector family planning services. In a well-targeted program, the poor would be over-represented in the public sector program's client base. Even in Vietnam and India, countries with better-targeted programs, all income groups are more or less equally represented in public sector programs; the poor are not over-represented. The fact that the poor are, at best, equally represented in many public sector programs reflects a lack of explicit targeting policies, socioeconomic differentials in contraceptive use, and the distribution of public sector infrastructure that favors better-off segments of society. Regardless of the mix of reasons in a given country, the failure to target public resources to those most in need must be overcome if countries are to achieve equitable coverage and contraceptive security. Appropriate targeting is particularly important in donor-dependent countries where donated products form the backbone of public sector programs.

FIGURE 2.
Income Groups as a Proportion of Public Sector Family Planning Clients[7]



Sources: Vietnam DHS 1997, India DHS 1998/9, Ghana DHS 1998, Malawi DHS 2000, Tanzania DHS 1999, Zambia DHS 2001/02, Guatemala DHS 1998

Failure to target also has consequences for health outcomes. Programs that do not explicitly designate target groups tend to put in place services and systems that are designed for the largest numbers of users. Given that the largest number of users tends to be better-off, married women, other women may not find services easily accessible. When adolescents are explicitly targeted, for instance, program managers are more likely to pay closer attention to their particular needs as they develop services that are physically and socially accessible to young people.

Targeting is also consistent with international conventions such as the International Covenant on Economic, Social and Cultural Rights. As the United Nations (1990) commentary on that covenant noted, "…even in times of severe resource constraints whether caused by a process of adjustment, or economic recession, or other factors, the vulnerable members of society can and indeed must be protected by the adoption of relatively low-cost targeted programmes." Chapman (2000) writes that "… [t]o be consistent with a human rights approach … funds should be invested to bring about the greatest health benefit for the population. This requires giving priority to public health measures … and governments should accord priority to efforts to rectify existing inequities and imbalances in the distribution of resources in the health sector so as to bring currently underserved and disadvantaged groups up to mainstream levels."

Putting a Targeting Strategy in Place

Like most policy-change initiatives, the process of establishing targeting involves several steps. Multiple stakeholders need to participate, political consensus must be reached at several points in the process, development of information based on sound analysis is essential, and advocacy is needed to support every stage of the process. A year or more may be required to complete the process.[8] Figure 3 outlines the basic process and its three main steps: defining target groups, selecting targeting approaches, and operational planning.

Step 1: Determine Need for Targeting

The process of implementing a targeting strategy begins with defining groups that are in special need of subsidized family

[7] Figure 2 uses an asset-based standard-of-living variable as a proxy for income data sets, which was derived from asset data in Demographic and Health Survey data sets using the Filmer-Pritchett wealth index methodology developed by Davidson, Gwatkin, and Rohini Pande (World Bank).

[8] In Turkey, obtaining political consensus, defining target groups, and developing an approach took one year. Operational planning and pilot testing occurred over another year. Scaling-up began in the third year (see POLICY Project, 2001).

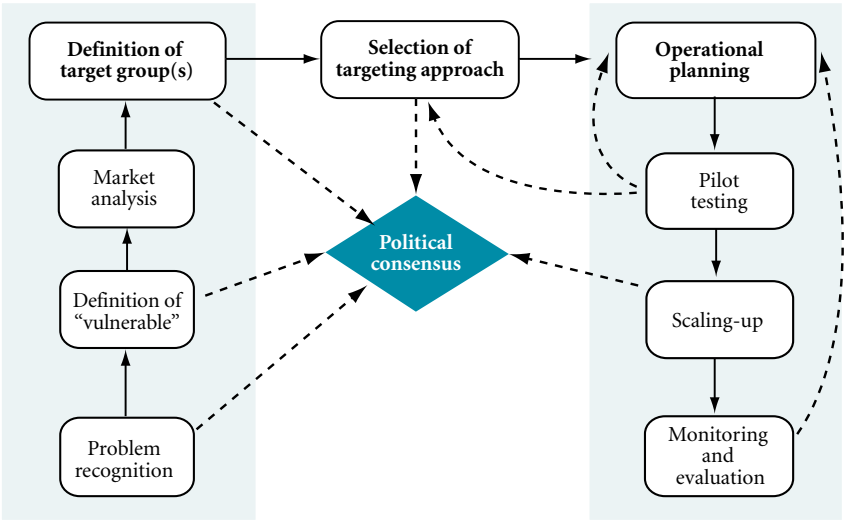
planning services. There are both political and technical dimensions to defining target groups. Determining the degree to which target groups are currently underserved is an important aspect of achieving political consensus that a targeting strategy is necessary to address an existing inequity.[9] At this early stage, consensus among planners and managers of the national family planning program is generally sufficient. Planners and managers must lead the way in considering targeting options. Other stakeholders can be drawn into the dialogue as planning proceeds. Defining target groups requires consideration of who is vulnerable; that is, who faces physical, social, or financial barriers to needed family planning products and services (Price, 2001). The time required to achieve consensus depends on the degree to which planners and managers encounter resistance to targeting as a strategy for rationing public resources and the extent to which key stakeholders agree or disagree about who is most vulnerable and in need of targeted assistance.

Often vulnerability is conceptualized in terms of socioeconomic status. But the concept of vulnerability may also include groups other than the poor, such as ethnic minorities, geographically isolated populations, rural residents, urban slum residents, the uninsured, newly married couples, adolescents and young adults (especially unmarried, sexually active youth), traditional method users, and stigmatized groups such as HIV-positive persons and tuberculosis patients. Box 2 provides country examples of vulnerable groups that have been targeted for special program attention.

Analysis of who is served and who is not served in the family planning market is essential in identifying groups around which a targeting strategy may be built. The characteristics and sizes of underserved groups need to be determined. Analysis should also show the extent to which public resources are distributed to groups not considered to be in need of subsidized services (for example, well-off urban residents). Once consensus is achieved as to who is in fact most vulnerable and underserved, planners and managers can undertake more detailed analysis of the social, demographic, and geographic characteristics of those groups before developing a strategy to reduce barriers to family planning services.

Many countries lack the public resources to serve all vulnerable groups. They must therefore assign priorities to different groups and include a financial analysis to ensure that resources match program scope. No targeting strategy will be perfect, and some clients who are not members of priority groups will always receive program services. (See below for a discussion on limitations of targeting.) As decisions about who is to benefit from public subsidies are in part political, the broadest possible range of stakeholders, including representatives of vulnerable groups, should participate in the policy dialogue. If the needs of the truly vulnerable are to be reflected in policy decisions, dialogue must be supported by sound analytic information.

FIGURE 3.
Process for Targeting Strategy Development



Step 2: Select an Appropriate Targeting Approach

There are two main categories of targeting approaches: characteristic targeting and individual targeting.[10] Figure 4 outlines the two types of targeting approaches and the types of access barriers each can address.[11]

Characteristic targeting. Characteristic targeting approaches (also known as indirect targeting) attempt to deliver public subsidies to groups of individuals with specific, readily observable characteristics

[9] As noted in Leighton (2001), "Specific equity goals are rarely explicit" in national policy documents. Remedying the absence of explicit goals may be useful for the sustainability of implementing targeting approaches, but it may not necessarily be a starting point in encouraging countries to adopt better-targeted approaches to family planning service delivery.

[10] A third category, provider-based targeting, is much less common (see Cotlear, 2000). The goal of a provider-based targeting is to encourage providers to change practice patterns (as opposed to changing consumer behavior) in such a way as to create better access for clients (Leighton, 2001)

[11] See Newbrander et al. (2001) for a typology and descriptions of major targeting approaches.

that make them vulnerable to poor access to services. Lower contraceptive prevalence rates, for instance, are often associated with certain social characteristics, such as membership in an ethnic minority group, young age, or marital status as a newlywed. Lower contraceptive prevalence rates are also often associated with geographic characteristics such as rural residence or residence in an urban slum. Given that these characteristics are either directly observable or easy to establish, minimal means-testing is required to determine eligibility for services.

Individual targeting. Individual targeting approaches (also known as direct targeting) attempt to deliver subsidies to individuals according to less observable characteristics. Such approaches are appropriate when the access barrier to be addressed is financial, such as poverty and the inability to pay, or when the major determinants of vulnerability are associated with personal choices, such as unwillingness to seek mainstream services. Given that poverty and ability to pay are generally not as readily observable as social and geographic characteristics, more rigorous means-testing is required to determine eligibility.[12]

Mixed approaches are also possible. For instance, an individual approach (with means-testing) may be implemented in a specific geographic area, or vulnerable groups may be defined on the basis of a particular characteristic (such as young age or membership in an ethnic minority group) with group members means-tested to determine eligibility for subsidized or free services. Box 3 provides examples of targeting approaches used in family planning programs.

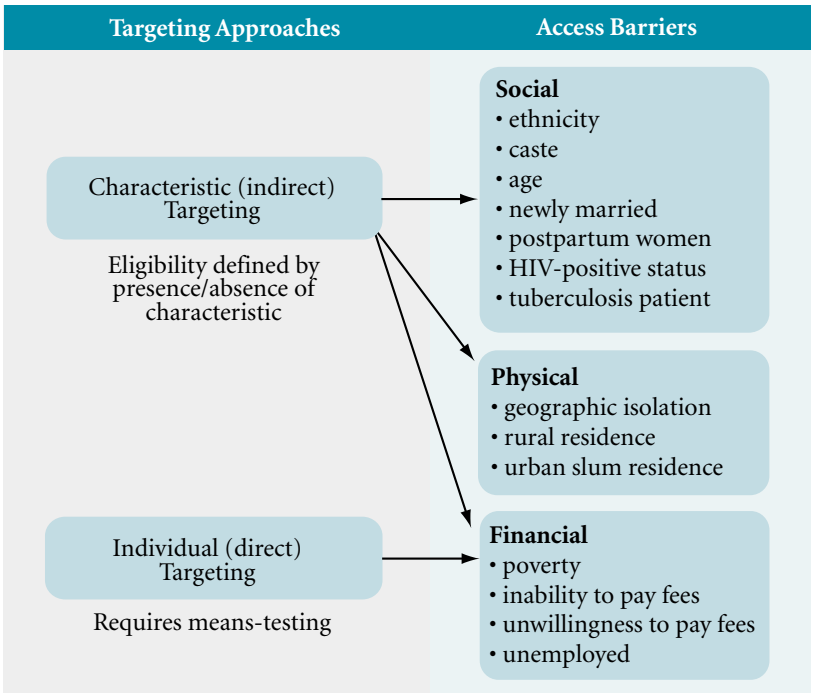
Discussions about access barriers to family planning and STI and HIV prevention programs and services and what constitutes vulnerability (see Step 1) will help shape decisions about the type of targeting approach to be adopted. If the priority access issue is financial and poverty or inability to pay is generalized rather than concentrated, then an individual approach may prove most reasonable. If access barriers are concentrated among certain social groups or in certain geographic areas, then a characteristic targeting approach may be more appropriate.

During the planning stage, planners and managers should consider the relative costs and effectiveness of various targeting

Box 2.
Examples of target groups in public sector health and family planning programs

Country	Target Groups
Romania	Students, the unemployed, the poor (Feranil, forthcoming)
Turkey	Clients unable to pay fees (POLICY Project, 2001)
Guinea	Chronic disease patients (Newbrander et al., 2001)
Peru	Residents in "poorest" departments (Cotlear, 2000)
Ghana	Leprosy and tuberculosis patients (Nyonator, 2002)

Figure 4.
Targeting Approaches and the Access Barriers They Can Address



[12] Depending on the degree of rigor in means-testing, clients may be required to provide public employees with access to personal information. Another challenge to the success of means-testing is, therefore, to create an environment of trust and confidence that the information will be held in confidence.

approaches. If the degree of means-testing required for individual targeting is expected to be administratively or financially infeasible, then a characteristic approach may be preferable. In some situations, even though a characteristic approach would be reasonable from an administrative or financial perspective, it may be politically infeasible to distribute subsidies on the basis of social or geographic characteristics. Ethnic politics, for example, may impede a program's ability to target one group over another, even when that group is clearly more underserved than other groups. In such a situation, it may be easier to generate support for an individual approach.

Step 3: Undertake Operational Planning and Implementation

Operational planning, pilot testing, and scaling-up are required to transform the agreed-upon targeting approach into an operational plan. The goal is to ensure that sufficient commodities and services reach places where targeted populations are located and that targeted populations are aware and avail themselves of those services. Targeting often requires reconfiguration of some existing program elements as well as the introduction of new elements. Operational planning is generally the most time-consuming part of the process; it can take a year or more to develop operational plans and to complete a pilot test of those plans. Figure 5 shows the main components of operational planning and implementation for a targeting strategy.

Planning logistics and service delivery systems to accommodate expected changes in demand. Targeting is likely to affect the demand for services, increasing it in some places, decreasing it in others. Logistics systems must be modified according to the expected changes. If geographic targeting is to be implemented, for instance, logistics systems will need to be reconfigured to increase the flow of contraceptive commodities to target regions and perhaps reduce the flow to nontarget regions. If young adults are to be targeted, then contraceptives need to be delivered in sufficient quantities to the service delivery sites most frequented by them. Projections are needed to estimate where demand is likely to increase (where concentrations of the target group are expected to be served) and where it is likely to decrease (where those who are not members of the target group are expected to switch to other sources).

Defining eligibility criteria and determination mechanisms. Eligibility criteria must be defined and an operational mechanism developed to apply them. For characteristic targeting approaches, setting criteria and defining screening mechanisms are relatively straightforward tasks. For example, a person presenting for services in a geographically defined target region can be deemed eligible for the subsidy without further screening. In the case of targeting based on social characteristics, some characteristics are more easily observed than others such that screening mechanisms need to be tailored

Box 3.
Country approaches to targeting in family planning programs

Characteristic Targeting

Guinea—Chronic disease patients are exempted from paying fees for other health services (Newbrander et al., 2001).

Indonesia—All residents in designated "poorest" villages are issued health cards entitling them to free maternal health and family planning services at the nearest health facility (Newbrander et al., 2001).

Romania—All students and all rural residents are eligible to receive free contraceptives on presentation of proper identification (Feranil, forthcoming).

Individual Targeting

Romania—The poor who are neither students nor rural residents are eligible to receive free contraceptives after completing a means-tested certification process (Feranil, forthcoming).

Turkey—Public sector family planning clients are asked if they are willing to make a donation to cover the cost of their commodities. Those who self-declare that they are unable to make the donation receive their contraceptives for free (POLICY Project, 2001).

Korea and Costa Rica—Early in their family planning programs, Korea and Costa Rica distributed vouchers to the poor on the basis of means-testing. These vouchers entitled the holder to family planning services at his or her choice of source. The government reimbursed providers for vouchers submitted (Kim et al., 1972; Lemkin, 1972).

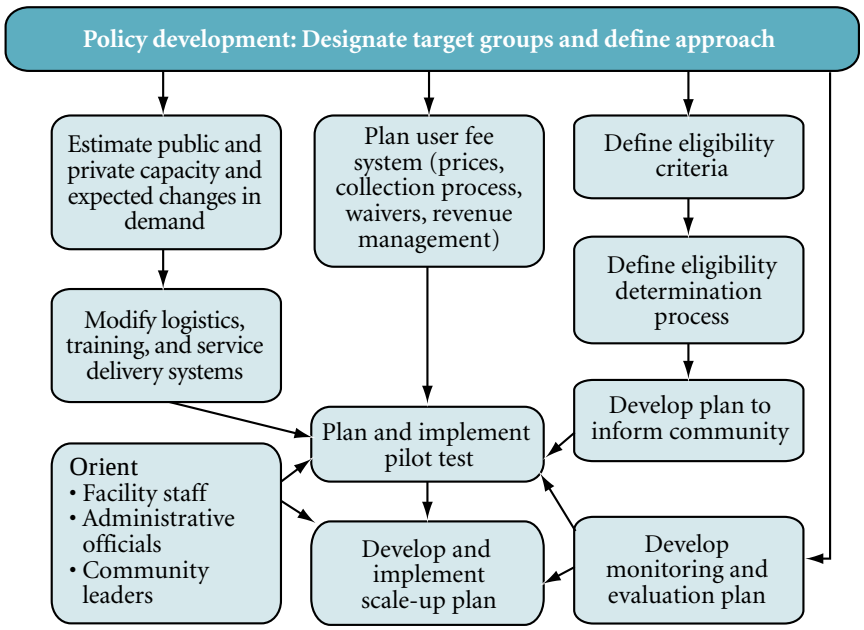
Mixed Approaches

Thailand—Means-testing identifies those who fall below an income threshold (individual targeting) among unmarried couples, single households, children, the elderly, the handicapped, and veterans. Those below the income threshold are eligible for free access to a designated health center (Giedion, 2002).

accordingly. For individual targeting approaches, the eligibility determination process is often more difficult. Characteristics—for example, being poor or unable to pay fees—are less easily observable compared with characteristics such as ethnicity, residence, or age. Means-testing is a mechanism to determine eligibility based on formal consideration of information about the client.

There is a continuum of possible means-testing mechanisms, all with varying degrees of complexity. The simple forms of means-testing ask for clients' self-declaration of poverty or inability to pay, as is the case in Turkey, where "donations" from non-poor clients subsidize contraceptives for the poor. More complex means-testing may involve multiple stages of documentation and certification by local community, administrative, and health officials. In Romania, clients must first obtain appropriate certification of poverty or unemployment from the mayor's office and then present the certification at the health care facility to indicate eligibility for subsidized contraceptives. If an individual cannot provide documents to support eligibility, a local administration official must visit his or her home and community for verification and documentation before issuing the needed certification. In one rural district in Cambodia, poor people are targeted to receive free health services at local health care facilities. Pagoda volunteers and village chiefs determine eligibility for exemption from fees using a list of households considered too poor to pay user fees. The chief monk of the pagoda reviews and verifies the list and then provides a copy to the health facility and a signed letter to each eligible household. On matching the name on the letter (presented by patients at the time of service) against the list of eligible households, health staff exempt the letter bearer from user fees (Jacobs, 2002). Determination of eligibility may be required for each client visit or may be granted for a longer period.Individualized screening may decrease the likelihood that ineligible clients will obtain subsidies (an occurrence termed leakage). However, complex mechanisms are administratively burdensome and costly and may not work. They may also have the unintended effect of deterring some vulnerable individuals from availing themselves of services (Gilson et al., 1995). The appropriate level of complexity must be determined in accordance with the public sector's desired degree of efficiency and its administrative and financial capacity to implement means-testing properly. Adopting a characteristic targeting approach can reduce the administrative burden of means-testing, particularly when, for example, eligibility is determined by geographic residence or attendance at a particular clinic. Political considerations are also important; some leakage may be politically necessary as a condition of obtaining sustained support for targeting (Ravallion, 1999).

FIGURE 5.
Operational Planning and Implementation for a Targeting Approach



Other aspects of operational planning. Additional planning and advocacy are required to ensure that the intended target population is made aware of its eligibility and how to obtain services. In Cambodia, user fees and exemption criteria are set in consultation with catchment-area communities. In addition, decisions need to be made as to where means-testing is to occur (in the health facility, outside, or both) and who will collect and process information for the eligibility determination process (providers, social workers, administrators, and so forth). If user fees are to be collected from nontargeted clients, a process is needed for handling and using the revenue. If target clients are to receive waivers from user fees, funds to compensate providers need to be identified, and a mechanism to process those compensatory payments must be established. An orientation plan needs to be developed for all parties

required to participate in implementation of the targeting strategy—from those who will determine client eligibility to those who will be responsible for the management and reporting of user fees.

A sound monitoring and evaluation plan should be developed to track performance of the targeting strategy. Information must be collected, analyzed, and linked to program and policy decisions. Shifts in vulnerability, both group and individual, must be monitored after the targeting strategy is in place. Those who are disadvantaged when targeting is introduced may not be the most disadvantaged at a later date. It may be difficult to obtain data on individual or community vulnerability (national surveys, for example, are generally conducted only at four- or five-year intervals). Effective targeting requires periodic review to ensure that the most vulnerable consistently benefit most from scarce public resources. Changing demographic and poverty patterns, migration within countries, changes in public budget environments, and political considerations are just some of the factors that may indicate a need to revise targeting policies.

As programs implement targeting strategies, they must take care that groups not targeted for subsidized services also have access to family planning services. Often, these groups are better off financially and can afford to pay for family planning products and services. Identifying alternative, private sources of products and services is important for building political support for targeting. If private sector services are not readily accessible to all nontargeted groups, then the public sector may consider serving a broader clientele by instituting user fees for nontargeted groups.[13]

Piloting and scaling-up. Piloting and scaling-up (expanding implementation to a national scale) are two other components necessary for implementing a targeting strategy.[14] The pilot test permits early identification of trouble spots and provides an opportunity for revision of the operational plan before full-scale implementation. It also provides an early indication of impacts on demand among both current clients and new target groups. After a pilot test, additional planning is required to scale up the strategy to the broader program. Human and financial resource requirements for scaling-up can be substantial. Phasing in the scale-up spreads some of the costs over time; however, defining the sequence of the phasing may involve considerable political dialogue and logistics planning.

Box 4.
Indicators of an effective targeting strategy

- Decreased differentials in contraceptive prevalence or STI, including HIV infection
- Increased contraceptive or condom use among defined target groups
- Decreased unmet need in target group populations
- Decrease in reports of problems with access among target group members
- Decreased differentials in unwanted/unintended pregnancies

Source: Price, 2001

Measuring Success of Targeting Strategies

Targeting is intended to increase equity and promote contraceptive security by improving access to family planning services among disadvantaged groups, including people with unmet need, by channeling public resources to those least able to tap the private sector. However, targeting can miss its mark. Expectations about effectiveness and efficiency of different targeting options should be incorporated into the early planning stages of strategy development.

- **Effectiveness (Coverage)**
  The extent to which target group members make use of a service is a measure of the service's effectiveness. Higher participation rates (or coverage) among the target population indicate a more effective strategy. Effectiveness can also be measured in terms of impact on other indicators (see Box 4).
- **Efficiency (Leakage)**
  The extent to which beneficiaries belong to the target population is a measure of a targeting strategy's efficiency. With an efficient strategy, few ineligible people obtain benefits; that is, fewer benefits "leak" to ineligible people. The cost per client served is not necessarily a good measure of program efficiency. The cost of reaching more vulnerable populations is often higher than the costs of reaching populations with better physical or social access to services (World Bank, 2002).
- **Trade-Off between Coverage and Efficiency**
  Often, there is a trade-off between effectiveness in reaching a target population and efficiency in limiting subsidies to those who need them. Lenient criteria may reduce the administrative and financial burdens of implementing a targeting strategy and increase the proportion of individuals in the target population

[13] This paper focuses on how to target public resources to vulnerable populations. Another important issue is how to ensure that adequate alternatives are available to serve the needs of better-off populations not included in the public sector's designated target groups. That issue, however, is beyond the scope of this paper.

[14] An example of piloting a targeting strategy in Turkey is provided in POLICY Project (2001).

who avail themselves of program services. At the same time, lenient criteria reduce efficiency. Characteristic targeting approaches, whereby eligibility is based on social group membership or residence, may permit subsidies for target group members who are not disadvantaged and do not face access barriers. For instance, not all rural residents are poor and unable to access services; yet, all would be eligible for services under a targeting strategy based on area of residence. The desired balance between coverage and efficiency is therefore a matter of political judgment.

While individual targeting may be more precise (efficient) in ensuring that the truly disadvantaged receive subsidies, it tends to be more costly. Carefully specifying criteria for determining disadvantaged status, implementing an accurate process for assessing those criteria, and ensuring objective eligibility decisions all translate into higher costs. Yet, simpler means-testing or poor implementation leads to lower efficiency. In some places, ineligible persons such as civil servants or relatives of personnel who determine eligibility may be unfairly granted access to the target service (Gwatkin, 2000). Individual targeting approaches can also be prone to low effectiveness if target population members find the eligibility determination process daunting.

In summary, in the absence of an ideal targeting approach, decisions about which targeting strategy is most appropriate depends on whether a program is more committed to ensuring that as many eligible people as possible receive services or that as few noneligible persons as possible gain access to services. Table 1 summarizes the possible effectiveness and efficiency combinations of targeting approaches.

TABLE 1.
Efficiency and effectiveness of targeting strategies

		Effectiveness (Coverage)	
		High	Low
Efficiency (Leakage)	High	■ High proportion of target population participates ■ Few nontarget population clients benefit *(Characteristic approaches in areas with high concentrations of target group members or well-designed and implemented individual approaches)*	■ Low proportion of target population participates ■ Few nontarget population clients benefit *(Individual approaches with stringent and well-administered means-testing but poor outreach to target groups)*
	Low	■ High proportion of target population participates ■ Many nontarget population clients benefit *(Characteristic approaches in areas of low concentrations of target group members or individual approaches with lenient means-testing)*	■ Low proportion of target population participates ■ Many nontarget population clients benefit *(Individual approaches with lenient and poorly administered means-testing and poor outreach to target groups)*

Why Don't More Family Planning Programs Use Targeting?

Targeting, which is one policy option for rationing scarce resources, would seem to be a sensible approach to contraceptive security in a world that foresees a major gap between the demand for publicly financed family planning services and the resources available to meet that demand. A number of factors may explain why targeting is not used as extensively as it could be in national family planning programs.

First and foremost, the concept of targeting is sometimes viewed as out of step with the ideology of "health for all" that evolved in the late 1970s, when that idea was interpreted as free public services for all. Family planning programs of that era emphasized an overall increase in contraceptive use with less regard for equity, thus fostering a sense of entitlement to heavily subsidized family planning services. More than two decades later, many country programs have evolved to a point where contraceptive prevalence is relatively high, particularly among the better-off segments of society, but the sense of entitlement to public subsidies persists.

If entrenched programs are to serve disadvantaged groups more fully, they must reorient themselves by overcoming political resistance and achieving consensus on target groups and approaches. It is more difficult to withdraw benefits from groups that can influence public policy (such as urban, high-income groups) than to offer new benefits to a disenfranchised group. Yet, this is precisely what targeting requires if a program lacks the resources to serve everyone. There is also legitimate concern that private sector alternatives may not be adequate to serve better-off clients who would need to seek services elsewhere.

Accordingly, viable alternatives must be in place to prevent the creation of a newly disenfranchised group. Clearly, the public sector bears some responsibility for creating a policy environment conducive to private sector growth in the family planning market.

In addition, targeting may require major changes in the way complex family planning systems are organized and operated. Some health care facilities may need to be closed, others reduced in scale, and still others opened or expanded, with staff and commodities redeployed as appropriate. In addition, provider retraining may be needed to reduce social access barriers, such as biases against providing services to unmarried adults and newly married couples, and to improve the quality of communication with poor and less educated clients. Furthermore, for political as well as administrative reasons, instituting targeting in family planning programs may be more difficult in the absence of targeting for other health services.

Some national family planning programs already include elements of targeting (Gilson et al., 1995), but they may not be using those elements effectively. As noted earlier (see Figure 2), in some programs, better-off clients account for a substantial proportion of the public sector program's clientele. In these programs, fees may be in place for cost recovery purposes and not as part of a targeting scheme to improve equity. If so, waivers can help minimize the impact of fees on the poor. It may also be that poorly targeted programs are a consequence of poorly planned or poorly implemented targeting strategies.

Targeting is not relevant only to mature family planning programs; it can also be an effective tool for countries with low contraceptive prevalence rates. Improved targeting at early stages of program development can help avoid some of the more difficult aspects of reorienting programs as they grow larger and more complex.

Conclusions

As with all policy processes, targeting requires considerable effort. Empirically based planning needs to occur in parallel with efforts to build consensus, turn resistance into support for targeting, and find common ground regarding who should benefit from targeting. Despite these challenges, maintaining progress toward contraceptive security requires countries to find ways to ensure that access for the most vulnerable clients is improved, even when resources do not grow as fast as overall demand for family planning services.

While a well-targeted public sector program can help ensure that resources are directed to those most in need, public sector resources alone will not be sufficient to meet the fast-growing demand for family planning services, even in better-off, middle-income countries. The private sector, both the commercial and nongovernmental segments, needs to be encouraged and supported to increase its participation. How to encourage greater private sector involvement in delivery of family planning services is, of course, a complex issue of its own. One important way to promote private sector growth is to demonstrate a client base that can pay for family planning products and services and, through targeting policies, convince the private sector that the public sector will tailor its programs and services to those less able to pay. However, targeting alone will not produce a more active private sector; it must be part of a broader package of public sector interventions that create a business environment conducive to private sector involvement. Depending on the country and the context, interventions may include reexamining policies on pricing, advertising, distribution, service provision, and import taxes.

Despite the challenges associated with targeting, public sector programs in poor as well as in middle-income countries must protect the most vulnerable groups in their populations. Trends in donor financing clearly show that governments in all but the poorest countries will not be able to rely on external funding to finance future growth of public sector programs. The non-poor currently consume significant proportions of public sector family planning services while unmet need is increasingly concentrated among the poor. Failure to implement more targeted approaches to public sector service delivery could mean that vulnerable groups will become increasingly marginalized as resources become scarcer and that growth in contraceptive prevalence will stagnate. When well planned and properly implemented, targeting is a practical approach that can move a country substantially closer to contraceptive security. ◆

References

Adams, John. 1998. "Structural Adjustment, Safety Nets, and Destitution." *Economic Development and Cultural Change* 46(2): 403-420.

Aloo-Obunga, Colette. 2002. "Country Analysis of Family Planning and HIV/AIDS: Kenya." Unpublished paper. Washington, D.C.: POLICY Project.

Chapman, Audrey R. 2000. "Indicators and Standards for Monitoring the Right to Health." Unpublished paper.

Cotlear, Daniel. 2000. "Peru: Reforming Health Care for the Poor." LCSHD Paper Series No. 57. Washington, D.C.: World Bank, Human Development Department, Latin America and Caribbean Regional Office.

Feranil, Inday. Forthcoming. "A Policy Approach to Contraceptive Security in Romania." Washington, D.C.: POLICY Project.

Giedion, Ursula. 2002. "User Fees for Health Care, Protecting the Poor: The Case of Thailand." Presentation slides for World Bank Seminar.

Gilson, Lucy, Steven Russell, and Kent Buse. 1995. "The Political Economy of User Fees with Targeting: Developing Equitable Health Financing Policy." *Journal of International Development* 7(3): 379.

Gwatkin, D.R. 2000. "Health Inequities and the Health of the Poor: What Do We Know? What Can We Do?" *Bulletin of the World Health Organization* 78(1): 3-18.

Jacobs, Bart. 2002. "Equity Fund at Kirivong Operational District." Unpublished paper.

Kim, Taek-Il, John A. Ross, and George C. Worth. 1972. "The Korean National Family Planning Program" (Appendix 5). Pp. 211-214 in *Universal Coupon of the Korean Family Planning Program*. New York: Population Council.

Leighton, Charlotte. 2001. "Decision Making for Equity in Health Sector Reform." *PHR Primer for Policymakers*. Bethesda, MD: Partnership for Health Reform Project, Abt Associates.

Lemkin, Richard. 1972. "The Coupon System for Distribution of Oral Contraceptives in Costa Rica." Unpublished paper. New York: Population Council.

Mills, Anne. 1998. "To Contract or Not to Contract? Issues for Low and Middle Income Countries." *Health Policy and Planning* 13(1): 32-40.

Newbrander, William, David Collins, and Lucy Gilson. 2001. "User Fees for Health Services: Guidelines for Protecting the Poor." Boston: Management Sciences for Health.

Nyonator, Frank. 2002. "Mechanisms to Protect the Poor When User Fee Systems Are in Place: The Ghana Case Study." Presentation slides for World Bank Seminar.

POLICY Project. 2001. "Report on a Pilot Study: Collecting Donations for Contraceptives from Public Sector Family Planning Clients as a Component of Turkey's National Self-reliance Strategy." Washington, D.C.: POLICY Project.

POLICY Project. 2002. "POLICY Assistance in Contraceptive Security." PowerPoint presentation. Washington, D.C.: POLICY Project.

Price, Neil. 2001. "The Performance of Social Marketing in Reaching the Poor and Vulnerable in AIDS Control Programmes." *Health Policy and Planning* 16(3): 231-239.

Ravallion, Martin. 1999. "Is More Targeting Consistent with Less Spending?" Unpublished paper. Washington, D.C.: World Bank.

Ross, John and Randy Bulatao. 2001. "Contraceptive Projections and the Donor Gap." Arlington, VA: Family Planning Logistics Management Project, John Snow, Inc.

United Nations. 1990. General Comments 3, issued by the Committee on Economic, Social and Cultural Rights (1990) on the Nature of States Parties Obligations under the International Covenant on Economic, Social, and Cultural Rights. New York: United Nations.

World Bank. 2002. "Choosing, Designing, and Implementing Programs: What Are the Associated Costs of Targeting?" http://www.worldbank.org/poverty/safety/choosing2p12.htm.

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