

# PROFIT

Promoting Financial Investments and Transfers  
to Involve the Commercial Sector in Family Planning

Suite 601  
1925 N. Lynn Street  
Arlington, Virginia 22209

Telephone: (703) 276-0220  
Facsimile: (703) 276-8213



## *The PROFIT Project*

# A Compendium of Experience and Findings

**September 1997**

Submitted to  
USAID/Office of Population  
Family Planning Services Division

Contract No.: DPE-3056-C-00-1040-00



**Deloitte Touche  
Tohmatsu**

Deloitte Touche Tohmatsu International  
in association with:

Boston University Center for International Health

Multinational Strategies, Inc.

Development Associates, Inc.

Family Health International

## Contents

### 1. The PROFIT Project: A Compendium

*This section provides a brief introduction to the purposes, perspectives, and contents of this compendium report.*

### 2. A Glance at Keys to Success

*This section offers some keys to success for projects seeking to expand the involvement of the commercial sector in delivering family planning services in developing countries.*

### 3. Evolution of the PROFIT Project

*This section outlines the context, key assumptions, and goals and objectives of the project and explains how and why these have evolved over time.*

- A. Introduction to the Private, For-Profit Sector
- B. The Design and Evolution of the PROFIT Project
- C. Profiles of PROFIT Subprojects

### 4. Commercial Sector Involvement in Delivering Family Planning Services

*This section outlines the rationale for increasing the role of the commercial sector in family planning and an overview of how that role varies in different developing countries.*

- A. The Rationale for Commercial Sector Involvement in Family Planning
- B. Involvement of the Commercial Sector in Family Planning Services

## Contents

### **5. Conducting a Private Sector Family Planning Country Assessment**

*This section outlines a five-step process for assessing the environment for interventions to expand commercial sector involvement in family planning.*

### **6. The PROFIT Model for Implementing Partnerships**

*This section reviews PROFIT's experiences in initiating, negotiating, and managing partnerships with commercial entities, including the particular approaches used and the practical considerations that arose.*

### **7. Selected PROFIT Research and Studies In Brief**

*This section includes briefs on selected PROFIT research and activities.*

### **8. Lessons Learned**

*This section distills key lessons from the PROFIT Project for involving the commercial sector in family planning.*

- A. Lessons from the PROFIT Experience
- B. Perspectives on Future Efforts to Increase Commercial Sector Involvement in Family Planning

### **9. Appendices**

- A. PROFIT Subprojects
- B. Recommended Resources
- C. PROFIT Publications

### **10. Additional Information on PROFIT**

# **1. The PROFIT Project: A Compendium**

**This section provides a brief introduction to the purposes, perspectives, and contents of this compendium report.**

### The PROFIT Project: A Compendium

Between October 1991 and September 1997, the PROFIT Project worked on behalf of the U.S. Agency for International Development's Office of Population to mobilize the resources of the commercial sector to expand and improve the delivery of family planning services in selected developing countries. This compendium on the PROFIT Project is a single-source reference for information on this work.

This is not intended to be a comprehensive report on the topic of commercial sector involvement in family planning. Instead, it summarizes PROFIT's activities over the past six years and collects the lessons, insights, and recommendations that PROFIT staff members have drawn from their participation in those activities.

PROFIT pursued a number of subprojects in various developing countries to expand the delivery of family planning services. This compendium summarizes the results of this process, which involved identifying and developing subprojects, building partnerships with public sector and commercial entities, implementing the subprojects, and monitoring and evaluating the results. The lessons and recommendations included in this compendium are drawn from the subprojects that PROFIT implemented as well as from those that PROFIT assessed but did not implement. PROFIT's subprojects incorporated groundbreaking work in a number of areas:

- ◆ Extending credit to midwives who seek to establish or expand private practices (Indonesia)
- ◆ Integrating family planning into the services provided by managed care organizations (Kenya)
- ◆ Expanding commercial distribution of contraceptive commodities (Brazil)
- ◆ Augmenting employer-based family planning services (India)
- ◆ Broadening the involvement of private health care providers in family planning (Philippines and Zimbabwe)
- ◆ Enhancing the capacities of pharmacists to provide contraceptives (Romania)

## The PROFIT Project: A Compendium

- ◆ Improving access to health insurance among low-income groups and those outside the formal sectors of the economy (Philippines)
- ◆ Helping entrepreneurs to use a multilevel marketing approach to sell condoms (India).

PROFIT (Promoting Financial Investments and Transfers) was led by the international financial services and accounting firm of Deloitte Touche Tohmatsu International. Supporting subcontractors included the Boston University Center for International Health, Development Associates, Inc., Family Health International, and Multinational Strategies Inc. PROFIT had staff members in Brazil, Indonesia, India, Philippines, Romania, and Zimbabwe.

Section 2 of this compendium summarizes the keys to successful implementation of interventions to expand the involvement of the commercial sector in the delivery of family planning services in developing countries.

Section 3 outlines the context, key assumptions, and goals and objectives of the PROFIT Project and examines how these evolved over time. This section also provides summary descriptions of PROFIT's subprojects.

Section 4 examines the rationale for increasing the involvement of the commercial sector in family planning and provides an overview of how that involvement varies in different developing countries.

Section 5 offers practical information for conducting a private sector family planning country assessment. Included is a five-step process for determining the feasibility of a particular commercial sector intervention.

Section 6 summarizes PROFIT's unique approach to initiating, negotiating, and managing partnerships with commercial entities and draws practical lessons for overcoming some of the obstacles to successful public-private partnerships.

Section 7 includes a series of briefs on PROFIT research and activities, which provides an overview of PROFIT's experience.

Section 8 distills the key lessons to be learned from the PROFIT experience, by sector and in general, in the hopes that these will inform future efforts by donors, program planners, managers, and others involved in efforts to engage the commercial sector in family planning.

Section 9 includes more detailed information collected by the PROFIT Project, including a list of PROFIT subprojects, a bibliography of recommended resources, and a list of PROFIT publications.

We hope this compendium serves as an invitation to explore the wealth of information and experience generated by PROFIT, which is available from the addresses provided in Section 10.

## **2. A Glance at Keys to Success**

**This section offers some keys to success for projects seeking to expand the involvement of the commercial sector in delivering family planning services in developing countries.**

## A Glance at Keys to Success for Commercial Sector Involvement in Family Planning in Developing Countries

Over the past six years, the PROFIT Project has blended business and family planning expertise to increase the commercial sector's involvement in family planning activities in various developing countries. The depth of PROFIT's experience cannot be summarized in a few words, but below is a brief description of some important keys to success for efforts to mobilize the commercial sector for family planning.

### Supportive Environment

The trade, policy, regulatory, and general business environments should facilitate commercial sector activities in general and commercial family planning activities in particular. A country's level of economic development, the government's commitment to family planning, and the level of contraceptive prevalence all affect the success of commercial sector family planning initiatives.

### Market Potential

Opportunities must exist for the commercial sector to offer family planning products and services to consumers who can afford to pay for them. To help ensure adequate demand for commercial family planning, the public sector must target free and subsidized contraceptive products and services to those who are least able to pay.

## **Commercial Orientation**

All parties must recognize that the profit or business motivations of the commercial partners must be paramount if the partnership is to be sustainable. A commercial firm will enter a partnership only when doing so advances their long-run business interests and will not form partnerships solely for social or philanthropic purposes — even if serving social and philanthropic objectives is part of the firm's long-run business strategy.

## **Integrated Approach**

Projects should address the full range of supply, demand, policy, and regulatory barriers that constrain commercial involvement in family planning. Moreover, supporting the expansion of private family planning services almost always means supporting provision of a broader range of health services, because family planning is not commercially viable on its own.

## **Effective Partners**

Appropriate partners are those with credibility among the target audiences, a track record of commercial activity, a commitment to the project (particularly at senior management levels), and sufficient resources to fully implement all the activities.

## **Realistic Objectives**

Commercial sector family planning projects may have less family planning impact in the short-term than traditional USAID-supported projects. However, they are more likely to be sustainable and to require fewer public sector resources over the long term.

## **Flexibility**

Those who design and implement commercial projects must retain the flexibility to overcome unforeseen challenges and exploit new opportunities by responding to changes that affect the country or sector environment or the circumstances of the partnership.

### **3. Evolution of the PROFIT Project**

**This section outlines the context, key assumptions, and goals and objectives of the project and explains how and why these have evolved over time.**

- A. Introduction to the Private, For-Profit Sector
- B. The Design and Evolution of the PROFIT Project
- C. Profiles of PROFIT Subprojects

### Introduction to the Private, For-Profit Sector

The U.S. Agency for International Development's experience with several projects suggested that PROFIT focus specifically on mobilizing the resources of private, for-profit sector enterprises as a means to meet the increasing demand for family planning services in developing countries:

- ◆ The TIPPS (Technical Information on Population for the Private Sector) Project had worked to demonstrate to employers the potential economic benefits of providing family planning services as part of employee benefit packages.
- ◆ The Enterprise Project had provided employers with technical assistance and other resources to add such family planning services and worked with private providers to integrate family planning into the services they offered.
- ◆ The Social Marketing for Change Project (SOMARC) sought to expand and develop the commercial market for contraceptive products. PROFIT was to build on the efforts of these projects to increase the role of the private sector in family planning in developing countries.

In 1989, USAID's Office of Population commissioned a paper to assist in planning its future family planning activities involving the private sector.<sup>1</sup> Below is an edited excerpt from this paper, which significantly influenced the objectives and design of the PROFIT Project. (The following paper in the section, "The Design and Evolution of the PROFIT Project," outlines USAID's specific objectives for PROFIT.)

---

<sup>1</sup> David Logan, Matthew Friedman, and Marianne Lown, Mobilizing the Resources of the For-Profit Sector to Support the Expansion of Family Planning Services in the Developing World, Occasional Paper No. 3. (Arlington, VA: Population Technical Assistance Project, prepared for the Office of Population, Bureau for Science and Technology, U.S. Agency for International Development, December 7, 1989).

### Defining the For-Profit Sector

Family planning services that are provided by organizations other than public sector (e.g., governmental or donor) agencies are often referred to as “private sector services.” “Private sector” is an umbrella term that covers the work of both for-profit and nonprofit entities, but the term ignores fundamental distinctions in the character and motivation of these two widely different types of organizations. All organizations within the for-profit sector share one common feature: they live and die in the marketplace, where the goods and services they offer are traded for profit. Beyond that point, there are immense differences in the size, ownership, and purposes of individual businesses.

Private business is a network of highly specialized, tightly focused, cost- and image-conscious entities, some of which are at the leading edge of economic and social development. Opportunities exist to work with the local subsidiaries of major multinationals, indigenous large business, and small and medium-sized firms in every branch of the market economy. Working with private businesses requires a different approach than working with governmental and voluntary agencies.

#### ***For-Profit Sector Motives for Providing Family Planning Services***

Previous USAID experience suggests that for-profit businesses relevant to family planning can be grouped into three broad categories:

- ◆ **Companies as Employers:** Companies of all sizes, but particularly larger ones, provide benefits to employees, and the provision of family planning services can be an important additional benefit. Companies as employers have been the main focus of the work of USAID’s Enterprise and TIPPS Projects.
- ◇ **Dominant Motives:** As TIPPS demonstrated, certain types of companies can realize significant cost savings by providing family planning services for employees, even when the full costs are met by the company. Enterprise showed that many companies also are concerned about the health and welfare of their employees, even when no significant cost savings accrue.
- ◆ **Family Planning Service Providers:** These organizations provide health and family planning services to the public on a commercial (for-profit) basis.
- ◇ **Dominant Motives:** In this case, a company’s dominant interest in family planning is that it could potentially increase its market, gain a competitive advantage, and boost its profitability by supporting the expansion of family planning services. The work of SOMARC is well known in this field; TIPPS was successful in promoting family planning among insurance companies; and Enterprise developed some micro-businesses to sell family planning services that have established small market niches.

## Introduction to the Private, For-Profit Sector

- ◆ **Corporate Citizenship:** The for-profit sector has the resources to make significant voluntary contributions to support the growth of family planning services as part of a country's all-around development, including political lobbying, donations, sponsorship of events, and promotion of educational activities.
- ◇ **Dominant Motives:** Private businesses have a vested interest in the steady development of a country's economy. Population growth is a critical issue with a profound impact on the size and distribution of the market and the labor supply — matters of great importance to businesses. Furthermore, companies want good public relations; they want to be seen as socially responsible partners in a country's overall development. Both TIPPS and Enterprise had some limited experience in mobilizing corporate voluntary contributions in the cause of family planning, which showed that the mix of self-interest and public interest motives varies from project to project.

### The Design and Evolution of the PROFIT Project

The PROFIT Project was designed by the U.S. Agency for International Development's Office of Population in 1990 and launched in 1991 to serve a wide-ranging and ambitious mission: to mobilize the for-profit private sector to engage in family planning activities in selected developing countries. The project's design was based on the belief that the private sector had both the potential and the willingness to invest much-needed resources in support of family planning projects.

The impetus for this effort was a recognition that there existed a critical "resource gap" between the growing costs of population programs and the donor and public sector funds available to meet them. Demographic projections showed that population growth in developing countries could be expected to double the costs of family planning programs between 1990 and 2000, to roughly \$9 billion. Donor agencies and governments could be expected to meet about half of these costs, given declining resources and demands for funding in other critical areas such as education and infrastructure. USAID felt that the commercial private sector could play a decisive role in meeting the growing need for family planning services, and it sought to "shift" the financial burden for those services to the private sector and away from the public sector and donors.

In designing the PROFIT Project, USAID relied extensively on the experiences of two predecessor projects that had pioneered collaboration with private sector organizations to expand family planning service delivery. TIPPS (Technical Information on Population for the Private Sector) was a policy project that was instrumental in demonstrating to employers the potential economic benefits of providing family planning benefits for their employees and dependents. The Enterprise Project also worked with employers, particularly industrial estates, mines, and plantations. Enterprise implemented subprojects to provide employers with technical assistance and other resources they needed to add family planning services for their employees. In addition, Enterprise initiated pilot programs to integrate family planning into the services delivered by private providers (clinics, hospitals) and covered by health insurance programs. The mid-term evaluations of these projects (both conducted in 1989) recommended

## The Design and Evolution of the PROFIT Project

that a successor project be developed to focus specifically on marshalling the resources of commercial organizations for population activities.

### Key Design Assumptions

USAID used the “lessons learned” from Enterprise and TIPPS to develop an innovative new project that represented a significant leap in efforts to mobilize the commercial sector. These ten key assumptions formed the core of PROFIT’s scope of work:

- 1) If provided with appropriate economic incentives and “start-up” subsidies, the private sector can be mobilized to invest in family planning activities in developing countries.
- 2) Collaborating with the commercial sector can provide substantial financial benefits for family planning programs and activities, particularly in high-risk/high-gain activities.
- 3) The PROFIT Project will be able to conduct financial leveraging transactions (e.g., debt swaps, use of blocked funds) to leverage USAID funds for subprojects or family planning programs.
- 4) PROFIT should work in developing countries with vibrant private sectors and supportive family planning environments.
- 5) PROFIT’s objectives can be achieved through 20 large and sustainable subprojects.
- 6) PROFIT should focus on working with commercial sector entities and not become involved with issues related to ensuring the sustainability of nongovernmental organizations (NGOs).
- 7) Opportunities exist to support local manufacturing of contraceptives, and exploiting them will likely require large capital investments.
- 8) Employer-based family planning programs should be pursued because employers who seek to be “good corporate citizens” can be persuaded to financially sustain such activities.
- 9) An effort should be made to engage market-based providers in activities that expand the delivery of private family planning services and private health insurance coverage for such services.
- 10) Trade and regulatory barriers that have a negative impact on private sector involvement in family planning can be removed with the collaboration of host governments.

## The Design and Evolution of the PROFIT Project

### Project Objectives

These ten core design assumptions were directly reflected in the PROFIT Project's five principal objectives, as outlined in the Five-Year Strategy Document:

- ◆ mobilizing the private sector in family planning activities
- ◆ establishing 20 large and sustainable subprojects
- ◆ leveraging USAID's financial resources
- ◆ achieving a measurable family planning impact
- ◆ creating a resource of skills and information on the private sector for USAID.

### Project Experience and Evolution

The core project design assumptions were tested during PROFIT's first three years (the start-up phase), and the project's approach for working with the commercial sector evolved and expanded as a result. Below is a description of how each of the ten core design assumptions was reflected in PROFIT's original strategy and how that strategy or approach evolved during the project's implementation.

#### ***1) The Private Sector Can Be Mobilized to Invest in Family Planning.***

The assumption that the private sector could be mobilized to invest in family planning activities was the cornerstone of the PROFIT Project. The PROFIT Five-Year Strategy Document proposed organizing the project as an investment fund for family planning and related projects, which was considered a practical, business-driven way to accomplish the project's five principal objectives.

The operational framework to implement this strategy was that USAID resources provided under the contract would be used to identify, finance, and implement 20 large family planning subprojects. As a financing and investment entity, PROFIT would primarily offer direct loans or equity investments in companies that sought to start up or expand commercial family planning activities.

The identification and financing of subprojects became the driving operational objective through which the other four objectives were to be pursued. By financing commercially sustainable subprojects, PROFIT would mobilize the private sector; leverage resources, primarily through partners' contributions to subprojects; and have a measurable family planning impact, to be defined at the subproject level. In addition, the project would provide

## The Design and Evolution of the PROFIT Project

technical assistance to other USAID projects and to traditional family planning organizations (including NGOs), which would help fulfill the objective of being a central resource for USAID on private sector issues.

This investment-led orientation was intended to fulfill PROFIT's contractual objectives in terms of intended results, but it had not been adequately defined in the project design or the original contract. For example, there were no provisions for PROFIT to act as a "lender" or "holder" of debt and/or equity instruments, and USAID's role in implementing such a program was not defined. This oversight was legally and contractually resolved by creation of a nonprofit foundation (The Summa Foundation), which was formally empowered to fund and legally hold PROFIT's investments.

In addition, PROFIT defined guidelines and criteria based on a commercial approach for selecting and structuring investments. PROFIT considered investments to be a mechanism for funding projects in a sustainable manner. This investment philosophy was pursued as a means to:

- ◆ enhance PROFIT's ability to leverage its resources, by securing partners' financial resources to support their subprojects
- ◆ ensure that partners were sufficiently committed to a family planning endeavor, by requiring repayment of PROFIT's resources
- ◆ impose analytical and financial discipline and rigor on potential subprojects, for example, on estimates of family planning impact or financial performance
- ◆ provide a mechanism to recover and redeploy financial resources once subprojects were terminated and to permit additional funding of subprojects for enhanced family planning impact.

PROFIT's experience indicates that there is interest among commercial sector companies in gaining access to capital for health-related activities that incorporate family planning. In its six years of operation, PROFIT identified over 80 subproject opportunities, of which 28 were seriously pursued. These subprojects did not generally require large capital inputs, unless a manufacturing opportunity was involved — most requests were for substantially less than \$500,000. However, PROFIT's partners were generally reluctant to assume financing on strict commercial terms due to the perceived risks of such investments.

Originally, PROFIT's criteria for pursuing subprojects stipulated a minimum subproject size of \$500,000, which reflected USAID's stated preference to pursue larger subprojects that would be capable of achieving a broad impact. PROFIT changed this criterion to consider investments of \$250,000 or more. More important, PROFIT also modified its strict commercial approach to structuring investments to accommodate the higher risk of financing family planning activities and the reluctance of many commercial partners to invest in such speculative subprojects. PROFIT began to provide funding through subsidized loans, "profit-

## The Design and Evolution of the PROFIT Project

sharing” arrangements, and (more recently) even grants, which removed the repayment burden from the subproject partners.

These moves represented an acknowledgment that PROFIT’s financial returns had to be subordinated to the pursuit of new models and strategies that would be viable over the longer term. Nonetheless, PROFIT adhered to its commitment to undertake rigorous analyses of the commercial viability, family planning impact, and longer-term sustainability of potential subprojects and to deal with commercial sector organizations in a business-like manner — a positive contribution of the project.

### **2) Collaborating with the Commercial Sector Can Financially Benefit Family Planning Activities.**

PROFIT’s early activities reflected the expectation that profits could be generated by providing commercial family planning services and used to support other USAID family planning activities. As noted, the project took an investment approach, generally avoided providing funding on a grant basis or at heavily subsidized rates of interest, invested instead in subprojects with higher potential returns (and higher risks), and established The Summa Foundation to hold investments, gains, and repayments.

In general, PROFIT’s partners saw the integration of family planning components or benefits into a broader set of health services as a positive contribution to their business activities and interests. This was in spite of the fact that provision of family planning services is a labor-intensive activity that may not generate high profits by itself.

The assumption that PROFIT’s investments would generate profits for other family planning efforts proved accurate but perhaps not as important as furthering the project’s overall objectives. In some cases, PROFIT’s investments were fully recovered and some earnings were realized, although other subprojects were not fully implemented. Some newer subprojects were not designed to generate a profit or to recover the initial investment. In fact, as the early subprojects failed to yield the expected impact on family planning, PROFIT placed more focus on providing technical assistance to achieve its family planning objectives and less emphasis on the potential financial returns. In the end, through the establishment of The Summa Foundation and the adherence to an investment-led approach, PROFIT made it possible for an estimated \$6.5 million of USAID funds to be invested in family planning and to be recovered and recycled into new USAID-supported activities.

The important lesson is that, while commercial sector projects can generate profits, testing the feasibility of innovative subprojects is more important than recovering the invested capital.

## The Design and Evolution of the PROFIT Project

### **3) PROFIT Can Leverage USAID Funds.**

USAID expected PROFIT to leverage scarce funds for subprojects and family planning programs through innovative mechanisms, such as:

- ◆ debt conversions and/or blocked funds, through which PROFIT would purchase developing country debt or corporate blocked funds at a discount, convert these at full face value into local currency, and use the proceeds to support local family planning programs, organizations, or PROFIT subprojects
- ◆ mixed credits, for example, by having PROFIT obtain official credits to leverage USAID or private funds to finance subprojects.

USAID implicitly assumed that PROFIT staff members would use their commercial sector expertise to identify and facilitate debt swaps or to attract mixed credits to PROFIT subprojects and thereby “leverage” USAID resources. This assumption was based on a growing body of positive experience during the 1980s with engaging the private sector in development activities. For example, leveraging mechanisms had been successfully used during the mid-1980s by some NGOs in debt-for-development, debt-for-nature, and debt-for-environment projects that generated significant proceeds for development purposes.

The success of this strategy, however, was constrained by the resurgence of developing country debt markets beginning in the early 1990s, which limited the prospects for debt conversion and the use of frozen corporate funds. Although PROFIT continued to seek debt conversion opportunities, very few of PROFIT’s target countries had viable debt relief programs after 1992. One exception was Mexico, but minimum size requirements on debt conversion transactions put the Mexican program beyond PROFIT’s reach.

PROFIT modified its leveraging strategies by concentrating on maximizing its partners’ financial contributions or securing co-financing in subproject investments.

### **4) PROFIT Should Work in Favorable Country Environments.**

Much emphasis was placed in the project design on the need for PROFIT to work in countries that had vibrant private sectors and government policies supportive of family planning. In practice, PROFIT’s list of target countries was determined by USAID’s Office of Population.<sup>1</sup> PROFIT was unable to work in some of the countries on the list that had more vibrant private sectors and/or positive family planning environments. For example, PROFIT’s visits to Morocco, Turkey, Thailand, Peru, and Pakistan were either prevented by the

---

<sup>1</sup>This list was defined to be the Office of Population’s priority countries, which became known as the BIG country strategy, which involved targeting resources to the USAID recipient countries that were the largest in terms of population, rather than to those with the highest degree of private sector “attractiveness.” The priority countries were India, Bangladesh, Nigeria, Indonesia, and Egypt.

## The Design and Evolution of the PROFIT Project

preferences of the local USAID mission or were substantially delayed. In addition, in key countries where PROFIT was allowed to work (including Brazil, Ghana, India, and Kenya), the range of subprojects was limited or constrained by USAID mission preferences about geographic regions, sectors, organizations, or the terms under which PROFIT could team up with local partners. These preferences typically reflected the missions' strategies of targeting the poorer segments of the population, which usually resided in the least developed areas of these countries.

Because of these constraints, PROFIT has been unable to assess whether favorable country environments ultimately affect the commercial success of family planning projects. In fact, PROFIT has actually faced greater implementation challenges in some countries that have both a strong private sector and government policies supportive of family planning. This is largely due to the pervasive role of public sector programs, which can "crowd out" or compete with private sector efforts, or to distortions in the marketplace that arise from donor-subsidized commodity distribution programs. Therefore, it is critical to assess each country environment on the basis of more than just economic criteria to determine what types of interventions are viable and desirable in that particular setting.

### ***5) PROFIT's Objectives Can Be Achieved through 20 Large, Sustainable Subprojects.***

The assumption that PROFIT should focus on a limited number of large subprojects was based on the experience of the Enterprise Project, which had supported over 80 subprojects and was seen to have lessened its potential impact by dispersing its resources so widely. The premise was that large subprojects would result in extensive family planning service delivery outcomes. Large subprojects were defined as those that would require a minimum investment by PROFIT of \$500,000. This did not occur, for two main reasons.

First, many of PROFIT's subprojects involved broader health services in addition to family planning services, and PROFIT's partners considered family planning to be one service among many to be offered to clients. Second, PROFIT had to compete with other providers of family planning services in both the private and the public sector, and shifting clients away from these traditional sources proved to be far more difficult than anticipated. For example, many eligible clients did not utilize family planning services even when they were offered free (e.g., in combination with other services), which indicates that health-seeking behavior does not always change in response to lower prices.

Although PROFIT's impact on the quantity of family planning services delivered was not as high as expected, the project was successful in enhancing private sector participation in the delivery of such services and in enhancing the quality of care being offered by private sector providers. These results were achieved through extensive training of midwives, physicians, and pharmacists in both modern contraceptive methods and technology and in interpersonal communication skills (e.g., with their patients). PROFIT also trained providers

## The Design and Evolution of the PROFIT Project

in business skills, which allowed them to manage their private practices on a more sustainable basis.

It is unreasonable to measure the family planning impact of projects like PROFIT by gauging their ability to attract new clients or to shift clients from the public sector. These results can be achieved only when such projects are accompanied by interventions to promote the availability and benefits of private sector providers are undertaken and when these efforts are supported by public sector agencies. In addition to supporting such interventions, the public sector agencies should make every effort to avoid competing with private sector providers and should provide services only to those segments of the population that cannot pay for services from the private sector.

### **6) PROFIT Should Focus on Commercial Sector Entities, Not NGOs.**

PROFIT's contract directed to avoid activities related to improving the sustainability of family planning NGOs because it was assumed they would detract from the project's commercial orientation. This was modified after it became evident that certain family planning NGOs had a genuine interest in pursuing commercially oriented activities for which they requested financial assistance from PROFIT.

An example is FEMAP, a Mexican family planning NGO which proposed an expansion of their Community Doctors Loan Program and the development of a loan facility to assist their affiliates establish laboratory facilities. Neither of these proposals led to PROFIT subprojects, primarily because PROFIT's strict commercial criteria was in place at the time.

At PROFIT's First Year Management Review, USAID concurred that PROFIT could investigate the feasibility of collaborating with NGOs in establishing commercial sector service delivery activities. This change was made formal through a contract amendment (Modification 3: November 1992). PROFIT became involved in assessing for NGOs the feasibility of various financial mechanisms, particularly debt conversion opportunities (Ecuador and Mexico) and financial endowments (Bangladesh, Bolivia, Colombia, Dominican Republic, and Ecuador). PROFIT's assistance was further expanded to assess for NGOs the feasibility of specific commercial activities, such as the sale of new products (Dominican Republic), various sustainability activities (Kenya), and financial support of new commercial projects (Indonesia).

PROFIT's experience showed that, while it is important to assist NGOs with sustainability issues and while bringing private sector skills is helpful in this process, most NGOs are unable to understand or implement fully commercial strategies. Therefore, working with NGOs may distract attention from commercial approaches for expanding family planning.

## The Design and Evolution of the PROFIT Project

### **7) Opportunities Exist to Support Local Manufacturing of Contraceptives.**

A key component of PROFIT's initial design was support for local production of contraceptives, with PROFIT financing the costs of local manufacturing in order to improve the quality, method mix, or availability of modern contraceptive products. The expectation was that sufficient opportunities existed in developing countries to support local manufacturing efforts that would supplement or replace donor-supported contraceptive supplies or USAID commodity donations that were to be phased out. Such local manufacturing activities were to account for a number of PROFIT's 20 anticipated large subprojects.

PROFIT did not find many viable local manufacturing projects, for a number of reasons. In many countries, the markets for contraceptive products were insufficient to support manufacturing endeavors. Where the markets were large enough, established pharmaceutical companies (multinationals) were already manufacturing or supplying contraceptives, or low-cost products were being imported or donated through the public sector or through other social marketing programs. The availability of such low-cost products distorted the markets, pricing, and potential profitability of any commercial efforts. In other cases, potential projects proved to be technically or financially unfeasible, for example by the financial or managerial weakness of potential partners or by USAID policy prohibitions against supporting products that had not been approved by the U.S. Food and Drug Administration (FDA), such as Cyclofem.<sup>®</sup>

The lack of manufacturing opportunities led PROFIT to focus on distribution and/or marketing ventures as a means to expand the availability, method mix, or quality of modern contraceptive products. Such ventures were explored in Mexico, Brazil, Russia, Romania, and India, with some positive results.

### **8) Employer-Based Family Planning Programs Should Be Pursued.**

PROFIT was expected to continue the TIPPS and Enterprise models of collaborating with employers to add family planning services as employee benefits. The driving assumptions for continuing this strategy were that

- ◆ employers could be persuaded to provide family planning benefits to their employees as one aspect of good "corporate citizenship"
- ◆ such programs could be implemented in a sustainable manner
- ◆ employer-provided medical benefits in developing countries were sufficiently prevalent that including family planning services within such benefit packages could result in a significant expansion of family planning services.

In contrast to the experiences of both TIPPS and Enterprise, PROFIT found a lack of interest among USAID missions and employers in pursuing employer-based projects. There is a widespread belief among USAID mission personnel that such programs are not sustainable or

## The Design and Evolution of the PROFIT Project

that they are already being sufficiently pursued (often to the point of saturation) by family planning NGOs operating in target countries. The exceptions were India and Zimbabwe, where PROFIT was specifically asked by the USAID missions to pursue employer-based approaches, largely to build on previous USAID-funded projects. In some countries, such as Mexico, PROFIT found that employers felt they were meeting their social obligations through their contributions to social security schemes, which covered employees' health care, and were generally reluctant to assume financial responsibility for family planning, which they considered a public sector program.

PROFIT's research showed that many employers in some countries, including Zimbabwe and Philippines, do provide family planning services and that their motivations for doing so differ considerably and are not always tied to economic incentives. Therefore, there is no single approach or strategy to follow in implementing these programs. In those countries where there was an interest in employer-based programs, PROFIT designed subprojects that would involve the commercial sector in meeting employees' family planning needs in more sustainable ways, either through pre-paid insurance programs or through managed care programs targeted to employers on a fully commercial basis. In other countries, PROFIT implemented more traditional employer-based programs.

### ***9) Market-Based Providers Can Be Engaged to Expand Family Planning Services.***

PROFIT's mandate was to expand Enterprise's efforts to integrate family planning into basic health service delivery through private provider networks, including clinics, physicians, midwives, as well as through health care financing intermediaries such as insurance companies and health maintenance organizations. The premises for expanding this strategy differed slightly depending on whether the activities involved service providers or health care intermediaries. Technical training and financial assistance were expected to lead commercial health care providers to add family planning to their services. The motivation for health care intermediaries to add family planning was the potential financial savings that would result from averting unplanned pregnancies and maternity-related costs for their clients — which would also be a selling feature to employers, who could avert lost productivity due to employees' maternity leaves, etc.

#### Private Providers

In working with private providers, PROFIT encountered a challenge that had been faced by the Enterprise Project: how to integrate family planning into basic health service delivery in a commercially sustainable way. The initial models employed by Enterprise depended on adding family planning and "cross-subsidizing" such services by other, more profitable services (e.g., laboratory tests). This reflected the fact that family planning was too narrow a service to be commercially viable on its own and that its economic appeal was therefore too marginal to entice providers to start offering such services.

## The Design and Evolution of the PROFIT Project

PROFIT followed this “integration” strategy and attempted to encourage the provision of family planning alongside other basic health services, such as maternal and child health services, rather than as a specialized “niche” service. This strategy did not lend itself to large or significant subprojects, in particular because family planning is not a capital-intensive activity. Therefore, PROFIT began to take on more difficult models, such as adding family planning under a low-cost health insurance program to individuals in the informal sector or including family planning in new managed care systems. However, a great deal of effort was required to develop the basic health service delivery frameworks that would underpin these programs, which meant that relatively less emphasis was given to the family planning component.

PROFIT also tried to reach individual, private providers, such as physicians and midwives, who play a key role in delivering family planning services to under-served populations in many countries. The model used by PROFIT was to establish on-lending programs administered by a financial intermediary as a means to reach large numbers of individual providers (some of whom contacted PROFIT for individualized financial assistance). PROFIT established loan funds for physicians in the Philippines and for midwives in Indonesia. Both programs included business training and family planning training (primarily for new physicians) to enable these providers to expand or establish private practices that would emphasize family planning. The midwives loan fund also achieved significant financial leveraging by involving a local micro-enterprise development institution, which had the potential to attract additional donor funding.

### Insurance Models

PROFIT also sought to add family planning as a covered benefit to private health insurance programs. The challenge of this approach stems from the fact that although the potential family planning impact of adding family planning coverage would be greater for plans that covered lower-income groups, in most developing countries private insurance covered mostly middle- or upper-income people who already use modern contraceptive methods. Despite the limited potential family planning impact, PROFIT promoted inclusion of family planning coverage in order to demonstrate to insurers the long-term benefits of offering such benefits (e.g., maternity costs averted, pediatric care costs eliminated, etc.). PROFIT underwrote such efforts because the short-term incremental costs exceeded the increased insurance premium that could be charged.

PROFIT developed several approaches:

- ◆ A “low-cost” managed care health plan targeted to informal sector workers and their dependents in the Philippines: The insurer contracted with participating hospitals on a capitated basis to provide basic health and family planning services to members of the low-cost plan. PROFIT shared in the start-up costs for this program, which targeted a new (unserved) population whose needs could be easily be served through participating hospitals with adequate (unused) facilities. This new model, though difficult, addresses the need to integrate family planning into general

## The Design and Evolution of the PROFIT Project

health services and the need to target a population that normally is served only by the public sector or by NGOs.

- ◆ A new managed care program in Kenya targeted to employers in the industrial area of Nairobi: As in the Philippines, the strategy was to target employee populations that had potentially higher family planning needs, particularly those currently served by the public sector. The program involved provision of extensive technical assistance to the insurer to market the services to employers and to introduce and implement managed care concepts to contain service costs. This model marketed health care services paid by employers on a commercial basis and thereby redefined and built upon both the “employer-based” and “market-based provider” strategies pioneered by Enterprise.

### ***10) Trade and Regulatory Barriers Can Be Removed with the Collaboration of Host Governments.***

PROFIT’s contract contained a “policy” component that entailed identifying and working to remove barriers to the expansion of the private sector in family planning, such as import duties on contraceptives, onerous regulations on private providers or insurance companies, and the like. The assumption was that such barriers were significant, that they could be identified and targeted for removal, and that host country governments could be motivated to change such regulations if they became aware of the detrimental effects on population objectives.

For practical reasons, PROFIT did not initially pursue issues dealing with such trade and regulatory barriers: this overlapped directly with the USAID-funded OPTIONS for Population Policy (OPTIONS) Project, which had a primary mission to address regulatory concerns through policy dialogue. The overlap with OPTIONS was raised early in PROFIT’s implementation, and USAID agreed that PROFIT would defer all work in this area unless OPTIONS was not active in a particular country. (This working arrangement was documented in PROFIT’s First Year Management Review, conducted in August 1992.)

PROFIT did address regulatory issues on a more “systemic” level, by analyzing such barriers as part of the Country Assessments it conducted in each target country. PROFIT summarized the major trade or regulatory constraints in each country and assessed how these would affect PROFIT’s subproject opportunities.

On some occasions, a USAID mission specifically requested that PROFIT assess trade and regulatory issues through its technical assistance efforts. Such requests gave PROFIT an opportunity to review how these regulatory barriers limited commercial sector opportunities and involvement in family planning activities. PROFIT conducted these reviews in Romania (August 1994), El Salvador (November 1994, and January 1996), the Philippines (through a private sector strategy development effort during October 1995–March 1996), and Zimbabwe (November 1995). Extensive follow-on activities were undertaken or planned in each of these

## The Design and Evolution of the PROFIT Project

countries as a result of these assessments. However, PROFIT lacked the resources to work directly with government ministries to actively seek the removal of such barriers.

### Conclusions

Underlying the original PROFIT contract was a large degree of confidence in the efficiency of market mechanisms and motivations for bringing the commercial sector into family planning activities. However, this confidence was based on many untested assumptions, including that family planning per se represented a commercially attractive undertaking for providers or insurers or an acceptable basic health care benefit to be subsidized by employers. In addition, there was insufficient operational experience to know how best to attract or motivate providers and insurers to engage in family planning activities or how best to work with the commercial sector to develop family planning projects, even in such circumscribed areas as local contraceptive manufacturing. The private sector was presumed to be a powerful engine that could be mobilized to help meet the critical resource gaps faced by donors and host governments. *In sum, the PROFIT Project was extremely experimental and was based on notions that had not been adequately tested.*

As a result of its work over six years and in more than 15 countries, PROFIT has learned important lessons about the prospects of mobilizing the commercial sector for family planning. Although these lessons are fairly general, they have been remarkably consistent across the range of PROFIT's experience:

- ◆ Commercial sector entities are willing to invest in family planning, but they require concessionary financing, technical assistance, and support to become involved in delivering family planning services. In addition, the full impact of such efforts cannot be realized in the short term (i.e., a single five-year project).
- ◆ Family planning is a very narrow activity, and investments must encompass a broader range of health activities or services in order to attract most private providers or insurers.
- ◆ Successfully expanding the provision of family planning through the commercial sector cannot happen in a vacuum; efforts to engage commercial entities must involve public sector agencies, donors, and traditional NGOs because of their potential to distort the commercial market through their own family planning activities.

PROFIT attempted to mobilize the commercial sector through an investment-led strategy. Its experience shows that the commercial sector can be mobilized to invest in family planning, and that doing so requires an ability to offer attractive financing terms and technical assistance. When it became clear that some potential partners were unable to submit to full

## The Design and Evolution of the PROFIT Project

commercial financing terms, PROFIT modified its approach to financing subprojects in order to share the risks faced by local partners.

PROFIT also shifted its approach to include a greater reliance on technical assistance and less reliance on financial leveraging. PROFIT's more recent subprojects (in El Salvador, India, Romania, and Zimbabwe) have been implemented almost exclusively through extensive technical assistance and have taken a broader, sectoral approach to involving the commercial sector. For example, these subprojects include activities aimed at different provider groups, consumers, pharmacists, and distributors as well as efforts to work with public sector agencies to effect policy changes necessary for commercial activity to flourish.

Another shift in PROFIT's focus was the initiation of a program of research to synthesize PROFIT's experiences with those of other organizations and projects engaged in commercial sector health or family planning endeavors. The research has analyzed efforts in PROFIT's mandated areas of focus, including local manufacturing, market-based providers, and employer-based programs. The organizations and projects examined have included the Partnership for Applied Technology in Health (PATH), Basic Support for Institutionalizing Child Survival (BASICS), OPTIONS, the Social Marketing for Change Project (SOMARC), Enterprise, TIPPS, and others. PROFIT has attempted to highlight the lessons learned from these efforts and from its own subprojects so that they can be disseminated to the broader family planning community.

The evolving approaches and strategies that have marked the design and implementation of PROFIT's subprojects and the results of its research activities comprise a body of practical knowledge that can inform the continuing efforts of USAID and other donors to work with the commercial sector. Indeed, many of the lessons from PROFIT are just now becoming clear and are included for the first time in this compendium, while others remain to be gleaned.

## **Profiles of PROFIT Subprojcts**

## Brazil: CEPEO Commodities Procurement Organization

**INITIATED** 1994

**LOCATION** Salvador, Bahia, Brazil

### BACKGROUND

The U.S. Agency for International Development (USAID) plans to phase out its provision of contraceptive commodities to Brazil by 2000, because of the country's high contraceptive prevalence (70 percent). To facilitate this objective, PROFIT established a commercial company, the Contraceptive Procurement Organization (CEPEO), to provide a reliable source of high-quality, affordable contraceptives to the public, private, and NGO sectors. In addition, CEPEO sponsors provider training in insertion of IUDs (intra-uterine devices), which supports the objective of USAID/Brasilia to improve the quality of family planning programs.

### PROFIT'S STRATEGY AND GOALS

Goals of this subproject are to:

- ◆ offer high-quality affordable contraceptives to public and nonprofit entities in Brazil;
- ◆ improve Brazil's contraceptive method mix through the promotion and sale of a long-term reversible method, the IUD, as an alternative to sterilization; and
- ◆ make the subproject sustainable over the long term by establishing a financially independent for-profit company that successfully commercializes contraceptives and other health care products.

CEPEO was established in 1994 as a commercial distributor of contraceptive products in order to support USAID/Brasilia's plan to phase out donations of contraceptive commodities to Brazil. CEPEO has focused on IUDs to improve Brazil's contraceptive method mix, which relies heavily on female sterilization. CEPEO sells its brand-name IUD, the CEPEO-T, to government and nonprofit entities at reduced prices and to the commercial sector at market prices. Sales are conducted primarily through mail order and telemarketing.

### PARTNERS

PROFIT has collaborated extensively with the Contraceptive Social Marketing (SOMARC III) Project and with Pathfinder International to implement this subproject. SOMARC has provided substantial

marketing support, and Pathfinder facilitated the transfer of its commodity recipients to become clients of CEPEO.

## **ACTIVITY UPDATE**

- ◆ CEPEO sold 142,317 condoms in 1995, and 178,087 condoms in 1996.
- ◆ IUD sales, which began in March 1995, totaled 55,832 units in 1995 and 58,749 units in 1996. The total of 103,637 units sold during this period:
  - ◇ was approximately the same number of IUDs as USAID donated to Brazil over the four-year period from 1990 through 1993 (123,000 units), and
  - ◇ represented 360,500 couple years of protection (CYP) ,which exceeded the CYPs provided during the same period by the local affiliate of the International Planned Parenthood Federation (IPPF) and by a condom social marketing program.
- ◆ CEPEO has surpassed original revenue targets, and losses have been lower than originally projected.
- ◆ As of December 1996, over 150 private physicians had been trained in IUD insertion through a CEPEO-sponsored training program held at six sites in five different states.
- ◆ In July 1997, in anticipation of the close of the PROFIT Project in September 1997, PROFIT sold CEPEO to current management through a competitive bid process. The new ownership is committed to the company's social mission and long-term viability.

## **RELATED PROFIT PUBLICATIONS**

- ◆ *Brazil Country Assessment* (September 1992)
- ◆ *Family Planning and Socio-Economic Status of HMO Members in Urban Northeast Brazil* (April 1994)
- ◆ *CEPEO Evaluation Report* (January 1997)

## India: Mawana Sugar Works

**INITIATED** February 1996

**LOCATION** Near Meerut, Uttar Pradesh, India

### BACKGROUND

The state of Uttar Pradesh (UP) in northern India has high fertility rates and low contraceptive prevalence rates. Among rural women in UP, 84 percent obtain family planning through public sources, which means there is significant opportunity exists to involve the private sector in family planning. The only population project run by the U.S. Agency for International Development (USAID) in India, Innovations in Family Planning Services (IFPS), works solely in UP.

Uttar Pradesh is also a major sugar-producing area, with more than 100 sugar processing plants, each of which employs about 1,000 people and interacts with sugar cane growers within a radius of 25–30 km. This means that the sugar industry impacts the lives of two million people in UP.

PROFIT is supporting Mawana Sugar Works (MSW), a sugar processing plant, in establishing a comprehensive, in-house maternal and child health and reproductive health (MCH/RH) program for workers and dependents. This subproject will initially reach an estimated 7,500 individuals, but MSW may later expand these services to 45,000 farmers who regularly supply MSW with sugar cane.

### PROFIT'S STRATEGY AND GOALS

PROFIT's strategy in India supports the USAID-funded IFPS Project by assisting in developing employer-provided family planning programs. PROFIT's goals in this subproject are to:

- ◆ create a model for employer-provided health services in rural Uttar Pradesh which could be replicated in other sugar processing plants; and
- ◆ provide access to family planning services through private employers.

### PARTNERS

- ◆ Shriram Industrial Enterprises Limited (SIEL), which owns Mawana Sugar Works, is a diverse company with operations in edible oils and fats, sugar, chemicals, refrigeration, and power genset equipment. In addition to Mawana Sugar Works, SIEL operates five other sugar factories in Western UP. SIEL will provide or fund all facilities, including basic infrastructure, staffing, and other ongoing operational expenses, for MSW's MCH/RH program.

- ◆ Parivar Seva Sanstha (PSS), which is affiliated with Marie Stopes International, is a highly regarded local nongovernmental organization. In addition to operating family planning clinics, PSS has helped private Indian companies to develop the skills and infrastructure to continue to provide reproductive health services after PSS's involvement ends. Over three years, PSS will assist MSW in designing and implementing an in-house MCH/RH facility. PSS's assistance will include:
  - ◇ designing and implementing a survey to assess needs;
  - ◇ implementing an information, education, and communication campaign;
  - ◇ training health workers; and
  - ◇ establishing a contraceptive supply system.

## ACTIVITY UPDATE

- ◆ A baseline survey of MSW workers' family planning practices was conducted. PSS developed the proposed project design based on findings of the survey.
- ◆ Implementation began in May 1997.

## OTHER PROFIT ACTIVITIES IN INDIA

- ◆ *India: Community-Based Social Marketing.* See separate subproject profile.
- ◆ *Employer-Based Programs in Uttar Pradesh.* In 1995, PROFIT collaborated with the Society for Innovation in Family Planning Services Agency (SIFPSA) to appoint a full-time family planning specialist to identify and coordinate employer-based projects in Uttar Pradesh.
- ◆ *Employer Manual.* In 1995-1996, PROFIT collaborated with the Confederation of Indian Industry (CII), to develop a manual to guide CII's 3,000 organizations (which employ a total of two million people in 50 sectors) in providing family planning and reproductive health services.
- ◆ *Contraceptive Manufacturing, Marketing and Service Delivery Opportunities.* PROFIT collaborates with the Industrial Credit and Investment Corporation of India (ICICI) to identify and assess investment opportunities in contraceptive manufacturing, marketing, and service delivery.

## RELATED PROFIT PUBLICATIONS

- ◆ *India Country Assessment* (January 1995)
- ◆ *CII Manual for Corporate Initiatives in Family Health Care* (September 1996)
- ◆ *Analysis of Employer-Provided Family Planning Services* (November 1996)
- ◆ *India: Community-Based Social Marketing.* See separate subproject profile.

## Involvement of the Commercial Sector in Family Planning Services

Demand for family planning services in developing countries is increasing rapidly. The number of couples of reproductive age is growing, as is the proportion of those couples who seek modern methods. Because public sector institutions have neither the resources nor the staffs to provide those services, there is considerable interest in increasing the involvement of the commercial sector in delivering family planning services.

This paper provides an overview of the current role of the commercial sector in family planning services in developing countries. It describes some of the major constraints to broader commercial sector involvement and describes some approaches that have been used to overcome those obstacles.

### Commercial Sector Involvement

The commercial sector plays a significant role in providing family planning services in developing countries. The most recent Demographic and Health Surveys (DHSs) from 55 developing countries indicate that approximately 7 percent of married women of reproductive age (MWRA) —aged 15 to 49 — receive modern contraceptive methods from commercial sources.<sup>1</sup> This represents approximately one-fifth of all women in developing countries who use modern contraceptive methods.

As Figure 1 demonstrates, the involvement of the commercial sector in family planning services varies widely across developing countries. In 10 of the 55 countries, the commercial

---

<sup>1</sup>These data are analyzed in detail in Paul Hopstock, Ann Sherpick, and Carla Briceno, *Providers and Consumers of Commercial Sector Family Planning Services in Developing Countries* (Arlington, VA: PROFIT Project, September 1997).

## **The Commercial Sector Role in Family Planning in Developing Countries**

sector served more than 10 percent of MWRA, while in about half the countries (28), the commercial sector served 2 percent or fewer of MWRA. (Note that, because the DHS does not systematically differentiate between private, nonprofit and private, commercial providers, Figure 1 is assumed to include private pharmacies, shops, private doctors, nurses and midwives, and other traditional practitioners.)

The most common commercial providers include pharmacists (4.0 percent of MWRA), doctors (1.4 percent), midwives (0.7 percent), and shops and markets (0.6 percent). Commercial providers are more likely to provide pills, condoms, and injectables than are other providers, and they are much less likely to provide female sterilization services. They are also more likely to provide services to clients in higher socioeconomic groups, who have more education, fewer children, and live in urban areas.

## **The Family Planning Service Delivery System**

To understand the role of the commercial sector, it is important to define the key components in the delivery system for family planning services. Figure 2 presents a simplified model of this system. The model distinguishes between family planning counseling and medical services, on one hand, and distribution and sales of contraceptive products, on the other. At the same time, the model emphasizes the relationships between these two major parts of the system.

Three components of the system involve distributing and selling contraceptive products: manufacturing, distribution, and retail marketing and sales. Two key components involve delivery of family planning counseling and medical services: training of providers and provision of counseling/medical services. Two components — promotion and financing — affect the demand and supply of both products and services.

The activities within each component of the delivery system may be provided by a range of public, private nonprofit, and commercial entities. Figure 3 provides examples of how the types of organizations are involved in family planning service provision. It is important to note that no component of the system is handled solely by one sector and that the commercial sector is involved in all components. For example, distribution and retail sales of contraceptive products often involve a combination of public health clinics and/or pharmacies, private nonprofit organizations, and commercial pharmacies. Insurance programs that cover family planning may be administered by public agencies through social security systems or by private insurance companies and individual employers.

## The Commercial Sector Role in Family Planning in Developing Countries

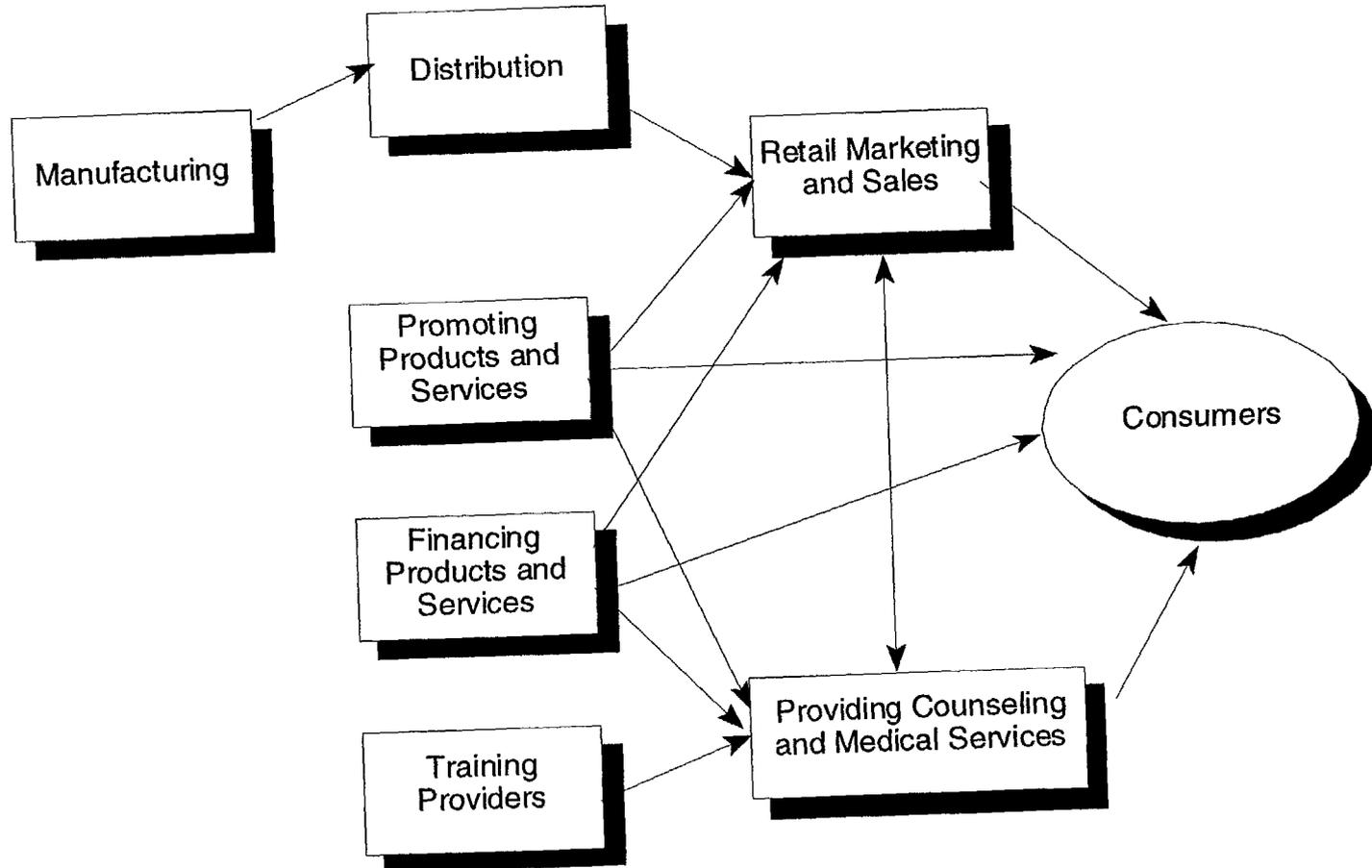
FIGURE 1			
The Proportion of Contraception Provided by the Commercial Sector in Various Countries			
Country (Year of Demographic and Health Survey)	Married Women of Reproductive Age Obtaining Contraception from the Commercial Sector* (percent of total)	Country (Year of Demographic and Health Survey)	Married Women of Reproductive Age Obtaining Contraception from the Commercial Sector* (percent of total)
Dominican Republic (1991)	27.3	Pakistan (1990/91)	2.0
Brazil (1996)	26.0	Yemen (1991/92)	2.0
Egypt (1995)	21.8	Cote d'Ivoire (1994)	2.0
Colombia (1995)	21.7	Sudan (1989/90)	1.8
Trinidad & Tobago (1987)	18.0	Tanzania (1996)	1.8
Paraguay (1990)	17.3	Cameroon (1991)	1.6
Morocco (1995)	14.5	Botswana (1988)	1.5
Ecuador (1987)	14.3	Namibia (1992)	1.5
Turkey (1993)	13.9	Nepal (1996)	1.4
Indonesia (1994)	12.2	Kenya (1993)	1.1
Jordan (1990)	9.4	Mali (1995/96)	1.1
Tunisia (1988)	9.1	Madagascar (1992)	1.0
Mexico (1987)	8.9	Benin (1996)	1.0
Romania (1993)	8.2	Togo (1988)	1.0
Peru (1996)	7.7	Liberia (1986)	1.0
Bolivia (1994)	7.5	Uganda (1995)	0.9
El Salvador (1993)	6.6	Comoros (1996)	0.9
Bangladesh (1993/4)	5.6	Central Africa (1994/95)	0.8
Ghana (1993)	4.9	Senegal (1992)	0.8
Thailand (1987)	4.7	Kazakstan (1995)	0.7
Haiti (1994/5)	3.8	Nigeria (1990)	0.6
Guatemala (1995)	3.6	Malawi (1992)	0.5
Sri Lanka (1987)	3.1	Burkina Faso (1993)	0.4
Zimbabwe (1994)	3.0	Guinea (1992)	0.3
India (1992/3)	2.7	Rwanda (1992)	0.2
Philippines (1993)	2.5	Uzbekistan (1996)	0.1
Zambia (1996)	2.3	Niger (1992)	0.1
		Burundi (1987)	0.0

\*Commercial sector sources include private pharmacies, shops, doctors, nurses and midwives, and other traditional practitioners.

Source: Paul Hopstock, Ann Sherpick, and Carla Brisceno, *Providers and Consumers of Commercial Sector Family Planning Services in Developing Countries* (Arlington, VA: PROFIT Project, September 1997).

**Figure 2**  
**Key Components of Family Planning Service Delivery**

**Distribution and Sales of Contraceptive Products**



**Family Planning Counseling and Medical Services**

### The Rationale for Commercial Sector Involvement in Family Planning

Although a majority of people in developing countries obtain their health care services from the private sector, most get their family planning services from the public sector. There are several reasons for this. Government family planning services have long been free or heavily subsidized in order to serve long-range objectives for sustainable growth and to overcome the lack of knowledge about and/or resistance to family planning. In addition, people seem more willing to pay for curative care than for preventive services such as immunization or family planning.

Increasingly, however, developing country governments find it appropriate to tap the commercial sector to become more involved in the provision of family planning, for the following reasons:

- ◆ Donors and governments have only limited resources to meet the growing demand for family planning services and are focusing on meeting the needs of people who have no alternative sources for such services.
- ◆ Expanding commercial sector family planning services for those who are most able to pay can help free up government and donor resources to target public sector services to those who are least able to pay.
- ◆ Many people have only limited access to public sector family planning services, particularly those who live in remote areas, work outside the formal economy, or are discouraged from using public services by long lines, a lack of equipment or products, or concerns about quality.
- ◆ Many people who can afford to pay for family planning services come to prefer private providers for reasons of convenience, privacy, wider method choice, and quality.

## The Rationale for Commercial Sector Involvement in Family Planning

- ◆ Past efforts to increase the acceptance and use of family planning have succeeded, and families increasingly consider such services to be a private good worth buying.

In many countries, the most effective strategy for expanding the commercial supply of family planning may be for the public sector to get out of the way. However, there are also proactive approaches that governments and donors can take, including:

- ◆ removing regulatory and other barriers that constrain the commercial sector's ability to deliver family planning services
- ◆ reforming and rationalizing the overall business regulatory environment to facilitate the creation and continuing viability of private health practices (for example, by reducing import duties or simplifying business licensing procedures)
- ◆ motivating those who use public sector services but can afford private services to switch to commercial providers (for example, through public education campaigns or by means testing for public services)
- ◆ improving the quality of the services provided by commercial health facilities (for example, through regulation, training, or improving the curricula at medical, nursing, and pharmacist schools)
- ◆ motivating commercial providers to add or expand family planning services and products.

By engaging the commercial sector in efforts to expand and improve family planning services, governments and donors can help enlarge choices for consumers, improve the quality of services, and free up limited public sector resources to provide services to those who currently need them most.

## Involvement of the Commercial Sector in Family Planning

<b>FIGURE 3</b>			
<b>Examples of Public, Private Nonprofit, and Commercial Involvement in Family Planning</b>			
Component of Family Planning Delivery	Type of Organization		
	Public	Private Nonprofit	Commercial
Manufacturing	Government-owned manufacturing facilities		Contraceptive manufacturing by private companies
Distribution	Government warehouses	Warehouses of nonprofit organizations	Pharmaceutical distribution companies
Retail Sales	Public pharmacies; community-based distribution through government channels	Community-based distribution by nonprofit organizations	Private pharmacies
Promotion of Products and Services	Government-sponsored education campaigns	Public service announcements for nonprofit service providers; social marketing through NGOs	Advertising of commercial and social marketing products
Financing of Products and Services	Social security systems	Medical aid societies	For-profit health insurance plans; health coverage and provision by employers; consumers' out-of-pocket expenditures
Training of Providers	Public universities	Private universities	Commercial training institutions
Provision of Counseling and Medical Services	Public health clinics, public hospitals	Clinics run by nonprofit organizations; private hospitals	Private doctors, nurses, midwives

### Limitations on Commercial Sector Involvement

There are a number of conditions in developing countries that inhibit the development and growth of commercial sector involvement in family planning services. These conditions fall into three major categories:

- ◆ policy, trade, and regulatory barriers to commercial sector activities
- ◆ a general business environment that weakens the commercial sector
- ◆ factors that limit the demand for family planning services.

#### *Policy, Trade, and Regulatory Barriers*

When asked how best to facilitate commercial sector development, most business people respond that the government “should get out of the way.” By this they mean that the government should seek to ensure that the broad range of policies and trade and regulatory activities it undertakes should not have a negative effect on the commercial environment. These activities include, for example:

- ◆ government provision of free or very inexpensive family planning services and products, even for those who can afford them, which cripples the commercial sector market
- ◆ high tariffs on contraceptive supplies imported into the country
- ◆ high taxes on commercially provided family planning services and contraceptive products
- ◆ bans on the sale or usage of particular contraceptive products
- ◆ unreasonably difficult licensing requirements for specific contraceptive products
- ◆ restrictions on who can provide family planning services and products
- ◆ unreasonable certification or licensing requirements for commercial sector providers of family planning services and products.

## **Involvement of the Commercial Sector in Family Planning**

### ***The General Business Environment***

The general nature of the business environment can limit the development of the commercial sector, including:

- ◆ the unavailability of credit for capital investments
- ◆ absence of commercial codes that facilitate business transactions
- ◆ failure of health insurance plans to reimburse for family planning services
- ◆ lack of entrepreneurial knowledge, skills, and attitudes
- ◆ a generally weak commercial sector
- ◆ negative views toward business, commerce, and profit-making among the population.

### ***Limited Demand for Family Planning***

Commercial sector involvement in family planning can be constrained by factors that limit the demand for family planning services, including:

- ◆ governmental, cultural, and/or religious opposition to family planning
- ◆ a lack of knowledge about family planning options
- ◆ high levels of poverty and the absence of a cash economy.

## **Approaches for Developing the Commercial Sector**

The U.S. Agency for International Development and other donor agencies have supported a number of efforts to expand commercial sector involvement in family planning services in developing countries. These projects can be categorized by the major emphasis or approach (which are summarized in Figure 4):

- ◆ Stimulating demand for family planning by explicitly promoting commercial sector providers: Social marketing is a common approach for creating demand. Social marketing projects negotiate with manufacturers of contraceptives to sell quality products at affordable prices. The sales of those products are then promoted through the use of project-related brand identification and project-supported advertising. Another approach to demand creation has involved the use of information,

## Involvement of the Commercial Sector in Family Planning

education, and communications (IEC) campaigns that specifically promote commercial sector providers of family planning services.

- ◆ Increasing the supply and quality of commercial sector providers: The most common approach has involved training doctors, nurses, midwives, and pharmacists in the commercial sector to enable them to begin or expand family planning services. Doctors and midwives also have been provided grants and loans to help them expand and improve their practices.
- ◆ Increasing the supply of contraceptives available through commercial sources: Among the approaches that have been employed are providing financing (grants, loans, or equity investment) to establish or expand contraceptive manufacturing and distribution companies and encouraging manufacturers and distributors to introduce their products into new outlets and markets.
- ◆ Promoting commercial sector financing of family planning services: The most common strategy has been to encourage large employers to include family planning in the package of health services offered to employees by providing technical and other assistance. Another approach has been to facilitate and support private health insurance plans that include family planning in their packages of health services.
- ◆ Eliminating policy, trade, and regulatory barriers to commercial provision of family planning services: The most common approaches include conducting research on the impact of policy, trade, and regulatory barriers and convening and facilitating meetings to discuss how to overcome those barriers.

## Involvement of the Commercial Sector in Family Planning

FIGURE 4 Approaches to Developing the Commercial Sector Role in Family Planning	
1. Stimulating demand for family planning by promoting commercial sector providers	<ul style="list-style-type: none"><li>◆ social marketing projects</li><li>◆ information, education, and communications (IEC) campaigns</li></ul>
2. Increasing the supply and quality of commercial sector providers	<ul style="list-style-type: none"><li>◆ training programs</li><li>◆ grants and loans to providers</li></ul>
3. Increasing the supply of contraceptives available through commercial sources	<ul style="list-style-type: none"><li>◆ financing manufacturing and distribution companies</li><li>◆ encouraging manufacturers and distributors to expand markets</li></ul>
4. Promoting commercial sector financing of family planning services	<ul style="list-style-type: none"><li>◆ encouraging and supporting large employers to provide services</li><li>◆ supporting private insurance plans including family planning</li></ul>
5. Eliminating policy, trade, and regulatory barriers to commercial provision of family planning services	<ul style="list-style-type: none"><li>◆ researching the impact of barriers</li><li>◆ facilitating meetings to discuss how to overcome barriers</li></ul>

## Conclusions

The demand for family planning services in developing countries is increasing rapidly, and public sector institutions have neither the resources nor the staffs to meet the demand. In response, a number of efforts have focused on increasing the involvement of commercial sector organizations in delivering family planning services.

There is wide variation among developing countries in the role played by the commercial sector in providing family planning services and products. The commercial sector plays a major role in a few developing countries and a significant role in many others. Commercial sector organizations are involved in all of the major components of the family planning service delivery system.

Further development of commercial sector involvement is constrained by policy, trade, and regulatory barriers to commercial sector activities; business environments that weaken commercial sector development; and factors that limit the demand for family planning services.

## **Involvement of the Commercial Sector in Family Planning**

Efforts to expand commercial sector involvement and overcome these barriers have generally fallen in one of five approaches:

- ◆ stimulating demand for family planning by promoting commercial sector providers
- ◆ increasing the supply and quality of commercial sector providers
- ◆ increasing the supply of contraceptives available through commercial sources
- ◆ promoting commercial sector financing of family planning services
- ◆ eliminating policy, trade, and regulatory barriers to commercial provision of family planning services.

## **4. Commercial Sector Involvement in Delivering Family Planning Services**

**This section outlines the rationale for increasing the role of the commercial sector in family planning and an overview of how that role varies in different developing countries.**

- A. The Rationale for Commercial Sector Involvement in Family Planning
- B. Involvement of the Commercial Sector in Family Planning Services

## Brazil: UNIMED/Maceio

**INITIATED** 1992

**LOCATION** Maceio, capital city of the state of Alogoas in northeastern Brazil

### BACKGROUND

Health maintenance organizations (HMOs) offer an opportunity to expand family planning service delivery through thousands of practitioners and service delivery sites. UNIMED/Brazil, a large, well-managed HMO of 62,000 physicians and 8 million clients, is the country's largest HMO and physician cooperative. PROFIT sought to form a joint venture with a local branch of this HMO to establish a family planning and maternal and child health (FP/MCH) clinic in a hospital in northeastern Brazil, a priority region for USAID/Brazil.

### PROFIT'S STRATEGY AND GOALS

In late 1992, UNIMED/Maceio and PROFIT negotiated the joint purchase of a hospital in Maceio, the Clinic of San Sebastian (CSSS). UNIMED/Maceio agreed to add and operate a FP/MCH clinic in the hospital. In March 1993, PROFIT and UNIMED/Maceio signed a Contract of Association, and in June 1993, they purchased CSSS.

UNIMED/Maceio directs its HMO members to use the hospital services in order to better control utilization costs; UNIMED/Maceio formerly had to pay more expensive third parties for these services. The savings are to be used to supply FP/MCH activities.

The subproject goals were to:

- ◆ promote the FP/MCH clinic among low-income women
- ◆ expand access of quality FP/MCH services to low-income women by promoting the FP/MCH clinic as an affordable and available service
- ◆ improve the quality of family planning services by providing contraceptive counseling and education to all family planning clients of the FP/MCH clinics.

### PARTNERS

With its 1992 membership of 62,000 physicians and client base of 8 million, UNIMED/Brazil is among the largest HMOs in the world. UNIMED/Brazil's 196 local chapters are independent financial and legal entities with elected boards of directors.

UNIMED/Maceio provides complete medical services to its 32,000 enrollees. Ambulatory services are rendered in the private offices of member physicians. Diagnostic and inpatient services are provided either through third parties or in UNIMED's own facilities.

## ACTIVITY UPDATE

- ◆ There was a two-year delay in implementation for several reasons, including financial issues internal to UNIMED/Maceio, the fact that FP/MCH services were not a top priority for UNIMED, and a redefinition of the subproject's goals.
- ◆ PROFIT provided considerable technical assistance, including planning and conducting eight workshops to update more than 20 UNIMED/Maceio physicians on modern contraceptive methods and working with UNIMED management to develop operational and IEC plans.
- ◆ In March 1995, an external evaluation team assessed USAID/Brazil's population assistance strategy and recommended that PROFIT exit from UNIMED/Maceio.
- ◆ In September 1995, the FP/MCH clinic opened. The clinic provides the following services: OB/GYN consultations, diagnostics, family planning, and vaccinations. Family planning client volume was low: of the 150 patients seen each month, about 30 received OB/GYN services, and about 20 of these received family planning services.
- ◆ In February 1997, PROFIT and UNIMED signed a contract for UNIMED to buy PROFIT's share of CSSS for \$1.5 million. In August 1997, PROFIT transferred the divestment contract to Pathfinder International, which will use the funds to promote USAID's objectives in Brazil.

## RELATED PROFIT PUBLICATIONS

- ◆ *Family Planning and Socio-economic Status of HMO Members in Urban Northeast Brazil* (April 1994)
- ◆ *UNIMED/Maceio (Health Insurance) Baseline Survey (Brazil)* (April 1994)
- ◆ *UNIMED Maceio Final Evaluation Report* (May 1997)

### Indonesia: PT Bonnys Arsila Immucenters

**INITIATED** 1992

**LOCATION** Jakarta, Indonesia

#### **BACKGROUND**

Because USAID/Jakarta and the local government sought to expand private sector initiatives in family planning, Indonesia was a priority country for PROFIT.

#### **PROFIT'S STRATEGY AND GOALS**

PROFIT's goals in Indonesia were to:

- ◆ expand the role of the private sector in financing and providing family planning services
- ◆ shift middle-income users of public sector family planning to private sector family planning in order to enable scarce public sector resources to be targeted to lower-income groups
- ◆ support the government's goal of improving Indonesia's contraceptive method mix by increasing the use of more permanent contraceptive methods.

#### **PARTNERS**

PT Bonnys, established in 1989, was the first commercial chain of immunization clinics and the leading provider of Hepatitis B vaccinations in Indonesia. Its network included nine urban immunization clinics and six mobile units in greater Jakarta that delivered on-site vaccination services to large companies, government institutions, communities, and individuals. PT Bonnys was a wholly owned subsidiary of PT Toby Mezza company, a private, for-profit business.

PT Bonnys sought to diversify its services to include family planning and other preventive services and to expand its clinic network. PT Bonnys expected to build on its strengths: a wide service delivery network, convenient locations and hours, and medical personnel specializing in preventive health care. It planned to enter the family planning market via injectables — a logical extension of its vaccination services. The company sought to attract middle- and upper-income women who used government services and were willing to pay for more convenient, better-quality services.

## ACTIVITY UPDATE

- ◆ PROFIT funded the development of a new company management information system to track customers, sales, and service statistics.
- ◆ In January 1994, PROFIT gave PT Bonnys a \$650,000 loan to add family planning to its six stationary clinics and six mobile units. The funds were to pay for clinic renovations, family planning products and equipment, staffing, and marketing. Before PROFIT funds were disbursed, PT Bonnys's contracted with YKB, a local family planning NGO, to begin training staff.
- ◆ In order to target the family planning market and direct family planning efforts, PT Bonnys hired a knowledgeable director who had been a senior member of the Government of Indonesia's population ministry (BKKBN). In January 1994, PT Bonnys held a well-publicized opening ceremony for its clinics, which were renamed "PT Bonnys Familycare Centers."
- ◆ In 1994, PT Bonnys experienced financial difficulties due to problems importing its core product, the Hepatitis B vaccine, from Pasteur and low sales of family planning services. In particular, the clinics were in upper-class areas where women already received family planning from private sources (i.e., physicians) and were not close enough to the middle-income clients who could be drawn away from government family planning clinics. PT Bonnys did not hire sufficient staff to implement a marketing plan, and the owner did not utilize the expertise of its family planning director.
- ◆ Given the company's growing financial crisis and the improbability of achieving the family planning objectives, PROFIT negotiated an accelerated payback of its loan plus interest. The loan was repaid by May 1995.

## RELATED PROFIT PUBLICATIONS

- ◆ *The Feasibility of Producing Falope Rings in Indonesia* (August 1994)
- ◆ *Test Market of a Family Planning and Preventive Health Care Program for the JIEP Industrial Estate*
- ◆ *Rural Midwives: Loan Fund Testing, Service and Delivery in a District of Central Java* (December 1994)
- ◆ *Midwives Revolving Loan Fund: First Year Evaluation Report* (September 1996)
- ◆ *Lending a Hand to Midwives: The PROFIT Revolving Loan Fund for Midwives* (brochure, June 1997)

## Zimbabwe: Private Sector Initiative

**INITIATED** September 1995

**LOCATION** Urban Areas throughout Zimbabwe

### BACKGROUND

Zimbabwe is considered to have one of the most successful family planning programs in Sub-Saharan Africa but faces a major challenge as it tries to meet the increasing need for family planning services with declining resources. The Government of Zimbabwe is attempting to meet this challenge by increasing the proportion of contraceptive services delivered by the private sector.

### PROFIT'S STRATEGY AND GOALS

PROFIT's strategy is to increase the number of private providers who are capable of delivering family planning services and simultaneously to persuade people who can afford to pay for services to use private sector services. The goals of this subproject were to

- ◆ encourage pharmacists to more actively promote and provide family planning products
- ◆ increase use of family planning among those covered by private medical insurance
- ◆ increase provision of family planning services at work sites
- ◆ increase provision of family planning services by private doctors and nurse/midwives
- ◆ motivate consumers to seek family services from private providers.

### PARTNERS

PROFIT works with the *Zimbabwe National Family Planning Council (ZNFPC)*, the government's coordinating council for all family planning programs. In addition, PROFIT works with the leaders and members of a number of organizations of health professionals, including:

- ◆ Retail Pharmacists' Association (RPA)
- ◆ Zimbabwe Occupational Health Nurses' Association (ZOHNA)
- ◆ Zimbabwe Nurses Association (ZINA)
- ◆ Zimbabwe Medical Association (ZIMA)

- ◆ Zimbabwe Midwives' Association (ZMA)
- ◆ College of Primary Care Physicians (CPCP)
- ◆ National Association of Medical Aid Societies (NAMAS).

## **ACTIVITY UPDATE**

- ◆ In January 1996, PROFIT established an office in Harare and completed the assessment of the private medical sector which was presented at a planning workshop.
- ◆ In May 1996, PROFIT hired key staff members, and a Coordinating Committee was organized to oversee PROFIT in Zimbabwe. The committee includes USAID staff members and representatives from the public and private health sectors.
- ◆ In June 1996, PROFIT collected data from 100 companies in order to plan the employer-based initiative. In July 1996, PROFIT sponsored the ZOHNA conference, which included sessions on family planning. During the conference, a working group of occupational health nurses planned the employer-based initiative. By June 1997, 21 nurse/midwives from employer-based health facilities had received an update on contraceptive technology and training in clinical methods.
- ◆ By July 1996, working groups had been organized with private doctors, pharmacists, and nurse/midwives.
- ◆ In July 1996, six pharmacies were identified to incorporate the model elements of the program including a private space, staff to provide education, counseling, and minimal screening tests, and client educational materials. By November 1996, the staff members of these pharmacies had received training in contraceptive methods, communication skills, and recordkeeping.
- ◆ In September 1996, PROFIT and SEATS began collaborating on a plan to assist private nurse/midwives in integrating family planning services into their practices. By July 1997, 15 private nurse/midwives had been trained.
- ◆ In November 1996, PROFIT convened a meeting of key private and public sector representatives to discuss the availability of appropriately priced contraceptives. By December 1996, the import tariff on contraceptive commodities had been reduced from 10 percent to 5 percent.
- ◆ By January 1997, PROFIT trained 60 private doctors in contraceptive technology (theoretical). By June 1997, 28 of these private doctors had received clinical training in insertion of IUDs and Norplant.
- ◆ In March/April 1997, 40 pharmacists were trained in two cities, and by June 1997, 68 pharmacists had been trained throughout the country. The media campaign was launched to motivate clients to seek contraceptive services from the private sector. A pharmacists' manual was prepared.

## **RELATED PROFIT PUBLICATIONS**

- ◆ *Assessment of the Private Medical Sector in Zimbabwe* (January 1996)
- ◆ *Private Sector Subproject Evaluation Report* (March 1997)

## Romania: Promotion of Modern Contraceptives and Pharmacist Services

**INITIATED** October 1995

**LOCATION** Urban Areas throughout Romania

### BACKGROUND

Despite a high level of awareness of modern contraceptive methods (98 percent), their use in Romania remains low (14.5 percent). PROFIT is working to educate young adults (15–24 years old) about modern contraceptive methods, to motivate them to use contraceptives, and to advise consumers about the availability of contraceptive services from commercial pharmacies. In order to respond to an increase in demand, PROFIT is training staff members of private pharmacies in sound business practices, contraceptive technology, and ways to provide quality client care.

### PROFIT'S STRATEGY AND GOALS

PROFIT's strategy in Romania supports the objectives of the U.S. Agency for International Development mission (USAID/Bucharest) to increase the supply of modern contraceptives by the private sector and to increase use of alternative (private, nongovernmental) family planning systems.

PROFIT assessed opportunities to expand private sector involvement in providing modern methods. Based on the assessment, PROFIT developed a subproject to provide young adults with accurate information and to correct misinformation via a media campaign.

### PARTNERS

PROFIT works with the National Pharmacists' Association, major university departments of pharmacy, advertising and market research firms, and pharmaceutical distributors.

### ACTIVITY UPDATE

- ◆ In March 1996, PROFIT established an office in Bucharest.
- ◆ In May 1996, data was collected among a representative sample of 600 private pharmacists. The results were used to design a program with pharmacists, which included family planning and business training.

- ◆ In August 1996, PROFIT conducted research among young adults and used the results to design a media campaign to educate young adults about modern contraceptive methods and to motivate them to use modern methods.
- ◆ In October 1996, PROFIT launched a nationwide media campaign.
- ◆ In October 1996, PROFIT trained 13 trainers and adapted and translated the pharmacists' training curriculum and materials. In addition, the "Contraceptive Technology and Quality Services: Guide for Pharmacists" was drafted.
- ◆ In December 1996, PROFIT trained 21 private pharmacists in Bucharest. By June 1997, more than 200 pharmacists had been trained throughout the country.
- ◆ In March 1997, the "Contraceptive Technology and Quality Services: Guide for Pharmacists" was finalized, printed, and distributed to 3,500 private pharmacists in Romania. Another 1,500 copies were distributed to university pharmacy departments, nongovernmental organizations, and government agencies.
- ◆ In May 1997, PROFIT conducted a mid-term evaluation of the media campaign. The results of this research will be used to determine if any elements of the campaign should be modified.

#### **RELATED PROFIT PUBLICATIONS**

- ◆ *Marketing Assessment for the Sale of Contraceptives in the Private Sector of Romania* (September 1994, updated in May 1997)
- ◆ *Study of Romanian Private Pharmacists* (November 1996)

## Philippines: Physicians' Loan Fund

**INITIATED** March 1995

**LOCATION** Manila

### BACKGROUND

Access to health care in the Philippines is relatively poor, a dilemma compounded by emigration of a significant proportion of the country's physicians. Further, few economic incentives encourage physicians to establish local private practices, and even fewer incentives encourage them to provide primary health care services such as family planning. Moreover, lending institutions often perceive physicians to be poor credit risks.

### PROFIT'S STRATEGY AND GOALS

PROFIT's strategy in the Philippines supported the objective of the U.S. Agency for International Development mission (USAID/Manila) to expand private sector family planning service delivery. In particular, PROFIT's goals were to:

- ◆ increase availability of family planning services delivered through private practices;
- ◆ shift family planning clients from the public to the private sector;
- ◆ assist doctors in expanding or establishing private practices; and
- ◆ assist doctors in adding or increasing family planning services.

PROFIT established a \$300,000 Physicians' Loan Fund which provided credit and training to physicians to establish or expand private practices. To be eligible for a loan, physicians agreed to provide family planning and reproductive health care services. Loans were made through the Bankers' Association of the Philippines Credit Guaranty Corporation (BCGC). BCGC evaluated and processed loan applications, disbursed loans, monitored the borrowers, and collected loan repayments. The physicians were allowed up to three years to repay the loans, which averaged about \$6,800. Loan recipients were also provided with family planning and business management training through programs designed and implemented with support from PROFIT.

## **PARTNERS**

BCGC, a local lending institution created by members of the Bankers Association of the Philippines, lends to small and medium-size enterprises traditionally considered poor credit risks due to their small size and lack of credit history or collateral. BCGC was created in response to legislation requiring that 25 percent of a bank's loan portfolio be earmarked for small enterprises. BCGC had no experience in lending to health care providers, but considered the loan fund as a way to broaden its client base.

## **ACTIVITY UPDATE**

- ◆ PROFIT designed and implemented a family planning curriculum adapted for private physicians, which was accredited by the Philippine Medical Association in September 1995.
- ◆ PROFIT designed and implemented a business training curriculum for private physicians.
- ◆ As of July 1996, loans had been made to 31 physicians, 24 borrowers had attended the family planning training course, and 29 had attended the business training course. Twenty-one borrowers experienced an increase in monthly revenues, and 43 percent of the borrowers' clients previously received family planning services from the public sector.
- ◆ This subproject was terminated in July 1996 because of various obstacles to implementation, including the fact that the provision of family planning is a highly charged issue in the Philippines; there was a lack of demand for the loans among the target market (young doctors); and USAID/Manila changes its strategic objectives.

## **OTHER PROFIT ACTIVITIES IN THE PHILIPPINES**

- ◆ *The HealthSaver Low-Cost Health Plan.* A low-cost, pre-paid health care plan called HealthSaver provides health care services, including family planning, to people in the informal economic sector.

## **RELATED PROFIT PUBLICATIONS**

- ◆ *The Philippines Country Assessment* (June 1993)
- ◆ *Health Care Providers in the Philippines: Testing the Concept of a Loan Fund for Private Provision of Family Planning* (January 1994)
- ◆ *Physician Education in Reproductive Medicine/Family Planning* (October 1994)
- ◆ *Attitudes and Practice Survey Among Health Professionals in the Private Sector, Philippines* (January 1996)
- ◆ *Consumer Survey on Preferred Source of Basic Health Care and Family Planning Services, Philippines* (March 1996)
- ◆ *A Strategy to Increase Private Commercial Sector Involvement in the Philippines Family Planning Program: Situation Analysis* (September 1996)
- ◆ *Philippine Physicians Loan Fund Evaluation Report* (July 1997)

### Philippines: Low-Cost Health Care Pla

**INITIATED** MAY 1994

**LOCATION** Manila and Cebu

#### **BACKGROUND**

Workers in the informal sector are not covered by the Philippines national health insurance program and therefore have had only limited access to quality health care.

#### **PROFIT'S STRATEGY AND GOALS**

PROFIT's strategy in the Philippines supported the objectives of the U.S. Agency for International Development mission (USAID/Manila) to expand private sector service delivery. In particular, the goals of this subproject were to:

- ◆ provide lower-income populations with access to health services;
- ◆ shift family planning clients from the public to the private sector;
- ◆ increase availability of family planning services through the private sector; and
- ◆ increase use of modern family planning methods.

A low-cost, pre-paid health care plan called HealthSaver offers outpatient and inpatient health care services, including family planning, to members of the Philippines' informal economic sector. HealthSaver was designed by PROFIT, in collaboration with PhilamCare Health Systems, Inc., which is the leading health maintenance organization (HMO) in the Philippines. PROFIT provided a loan to PhilamCare to cover start-up costs of implementing the plan. PROFIT also provided technical assistance in managed care and provision of family planning services.

Services are provided at two participating hospitals, one in Manila and one in Cebu. With premiums of \$3.20 per month per covered individual, HealthSaver is priced at about half the cost of the least expensive health care plan offered by PhilamCare. HealthSaver is the first private plan in the Philippines targeted to the informal sector, and the first to include family planning services.

## **PARTNERS**

PhilamCare Health Systems, Inc. (PhilamCare) was founded in 1983 by nine physicians. PhilamCare is now the leading HMO and the largest insurance company in the Philippines. It is owned by the physicians who founded it (40 percent) and by Philamlife (60 percent), a wholly owned subsidiary of the American Insurance Group (AIG). As of December 1995, PhilamCare served more than 130,000 plan members. Prior to introduction of the low-cost health care plan, PhilamCare's members were primarily grouped into one of three plans that targeted the formal sector. PhilamCare's interest in the low-cost health care plan reflects its desire to broaden its reach to include lower-income population groups, including those employed in the informal sector.

## **ACTIVITY UPDATE**

- ◆ The health plan was launched on a pilot basis in Manila and Cebu in May 1994.
- ◆ By August 1996, enrollment had reached 2,100.
- ◆ The Philamcare Board decided that the plan would be discontinued unless enrollment reached a break-even enrollment level of about 4,000, given that PROFIT could not continue to underwrite the plan.

## **OTHER PROFIT ACTIVITIES IN THE PHILIPPINES**

- ◆ *Physicians' Loan Fund.* PROFIT established a \$300,000 loan fund that helps Philippines physicians to establish or expand private practices which include family planning and reproductive health care services. See separate subproject profile.

## **RELATED PROFIT PUBLICATIONS**

- ◆ *The Philippines Country Assessment* (June 1993)
- ◆ *Health Care Providers in the Philippines: Testing the Concept of a Loan Fund for Private Provision of Family Planning* (January 1994)
- ◆ *Physician Education in Reproductive Medicine/Family Planning* (October 1994)
- ◆ "Philippines HMO Innovations" and "Managed Care in the Philippines," PROFIT newsletter (Spring 1995)
- ◆ *Attitudes and Practice Survey Among Health Professionals in the Private Sector, Philippines* (January 1996)
- ◆ *Consumer Survey on Preferred Source of Basic Health Care and Family Planning Services, Philippines* (March 1996)
- ◆ *A Strategy to Increase Private Commercial Sector Involvement in the Philippines Family Planning Program: Situation Analysis* (September 1996)
- ◆ *Assessment of Family Planning and Health Insurance Programs* (September 1997)
- ◆ *PhilamCare Low-Cost Health Plan Evaluation Report* (September 1997)

## Kenya: Managed Health Care System

**INITIATED** July 1995

**LOCATION** AAR Health Services, Nairobi, Kenya

### BACKGROUND

Despite increased availability of contraceptives and family planning services in Kenya, there is significant unmet need for family planning. Although the Government of Kenya has a goal to reduce population growth, public resources to promote family planning service and delivery are diminishing.

### PROFIT'S STRATEGY AND GOALS

PROFIT's strategy in Kenya is to increase private sector financing of health care. Goals of this subproject are to:

- ◆ assess the financial sustainability of a managed care clinic network which provides family planning and primary health services;
- ◆ shift family planning service provision from public to private sector;
- ◆ increase the number of new family planning users; and
- ◆ expand availability of health care services.

With support from PROFIT, AAR Health Services (AAR) developed a managed health care system (including maternal and child health and family planning services) targeted to employees and their dependents in Nairobi's industrial area. The managed health care system includes one large medical center, the Odyssey Plaza Medical Center (OPMC), and three outreach clinics to be established in nearby residential areas. All family planning methods approved in Kenya will be provided in the clinics by trained medical staff. All family planning services and counseling will be provided through the outreach clinics, except for surgical contraceptive methods (which will be provided in the OPMC). The managed health care system will be able to serve over 20,000 members.

### PARTNERS

AAR Health Services (AAR), a privately owned Kenyan company, began operations in 1984 as an emergency rescue company. AAR has since developed into a rapidly growing health care service

company that primarily offers prepaid health services through its own medical centers. It also provides laboratory services for its members and outside clients.

In 1994, PROFIT assessed private health insurance opportunities in Kenya and identified AAR as a promising local partner. Because AAR's existing medical center in Nairobi was operating near capacity, AAR proposed to expand its services to new members through a new medical center, and the OPMC was established. PROFIT also supports AAR's training program in family planning and managed care, as well as an extensive communications effort.

## ACTIVITY UPDATE

- ◆ In September 1995, the OPMC opened.
- ◆ In January 1996, AAR began offering family planning services at the OPMC.
- ◆ In November 1996, AAR conducted a media campaign to showcase the OPMC, featuring the U.S. Ambassador to Kenya.
- ◆ In January 1997, the Kariobangi Outreach Clinic was opened.
- ◆ By April 1997, AAR had nearly doubled its membership and showed signs of continued strong growth.

## OTHER PROFIT ACTIVITIES IN KENYA

- ◆ *An assessment of the commercial health insurance sector in Kenya.* In 1994, PROFIT collaborated with Management Sciences for Health (MSH) in assessing the commercial health insurance sector in Kenya in order to identify commercial organizations interested in expanding health insurance and services, particularly in the area of family planning.
- ◆ *An assessment of the sustainability of a local NGO.* In 1995, PROFIT assessed the feasibility of various strategies to increase the institutional and financial independence of the Family Planning Association of Kenya (FPAK), Kenya's largest NGO provider of family planning services.

## RELATED PROFIT PUBLICATIONS

- ◆ *Kenya Country Assessment* (September 1993)
- ◆ *Developing Prepaid Health Programs in Kenya: A Private Insurance Assessment* (May 1994)
- ◆ "Managed Care Moves Along Two Paths," PROFIT newsletter (Spring 1995)
- ◆ *Analysis of Employer-Provided Family Planning Services* (June 1996)
- ◆ *Assessing an NGO (FPAK) Regarding Financial Sustainability* (December 1996)

### Indonesia: Revolving Loan Fund for Midwives

**INITIATED** April 1995

**LOCATION** Indonesian Provinces of East, Central, and West Java, Jakarta, and Bali

#### BACKGROUND

Midwives provide 57 percent of private family planning services in Indonesia and therefore play an important role in achieving the population and health goals of the Indonesian government. These goals include achieving replacement-level fertility rates, shifting more family planning users from the public to the private sector, and training and placing a midwife in every village in the country.

According to a survey conducted by PROFIT, midwives were interested in establishing or expanding private practices, but had little access to affordable credit. As a result, in April 1995, PROFIT initiated a \$1 million Revolving Loan Fund to help Indonesian midwives establish or expand private practices which include family planning and reproductive health care services.

#### PROFIT'S STRATEGY AND GOALS

PROFIT's strategy supports the strategy of the U.S. Agency for International Development mission (USAID/Jakarta) to improve the sustainability and impact of family planning services delivered through commercial and nongovernmental sectors. The goals of the PROFIT Revolving Loan Fund for Midwives are to:

- ◆ assist midwives in establishing or expanding private practices by providing them with low-interest loans;
- ◆ shift family planning clients from the public to the private sector;
- ◆ leverage USAID funds through the creation of a revolving loan fund and by obtaining matching funds from a local lending institution; and
- ◆ sustain lending to midwives on a permanent basis.

PROFIT collaborates with three Indonesian institutions: Bank Rakyat Indonesia (BRI), the Indonesia Midwives Association (IBI), and the National Family Planning Coordinating Board (BKKBN). The Loan Fund is administered by BRI which is matching PROFIT's contribution of \$500,000 to capitalize the \$1 million fund. Borrowers are identified through IBI member chapters. Until early 1997, midwives were able to borrow up to \$2,300, and had up to three years to repay the loans. However, to

make the loans more widely accessible to the midwives, the maximum loan amount was lowered to \$1,400, and the repayment period shortened to two years.

## **PARTNERS**

- ◆ BRI, a state-owned commercial bank and the largest micro-enterprise financial institution in Indonesia, has the largest banking network in the country (325 branches and 3,874 units and posts). Furthermore, BRI has a successful history of lending to poor and rural groups. BRI matches PROFIT's funds, makes loans to Indonesian midwives, and administers the fund.
- ◆ BKKBN, the National Family Planning Coordinating Board, conceptualized the idea of the loan fund and was instrumental in convincing BRI to match PROFIT's funds. BKKBN assists in marketing the fund.
- ◆ IBI, a professional organization for Indonesian midwives founded in 1951, supervises midwives' private practices. IBI markets the Loan Fund to its members, recommends loans to be funded, organizes borrowers, presents proposals to BRI, and oversees the quality of services provided by loan recipients.

## **ACTIVITY UPDATE**

- ◆ As of March 1997, loans had been made to 490 midwives. A typical borrower graduated from midwifery training school 22 years ago and has had a private practice for 14 years. Nearly all borrowers combine private practice with government work.
- ◆ Due to the continued demand for loans, PROFIT is transferring oversight of the project to a local foundation, which will continue the loan fund beyond the end of the PROFIT Project in September 1997.

## **RELATED PROFIT PUBLICATIONS**

- ◆ *The Feasibility of Producing Falope Rings in Indonesia* (August 1994)
- ◆ *Rural Midwives: Loan Fund Testing, Service and Delivery, in a District of Central Java* (December 1994)
- ◆ "Indonesian Midwives Loan Fund," PROFIT newsletter (Spring 1995)
- ◆ *Midwives Revolving Loan Fund: First Year Evaluation Report* (September 1996)
- ◆ *Lending a Hand to Midwives: The PROFIT Revolving Loan Fund for Midwives* (brochure, June 1997)

### India: Community-Based Social Marketing

**INITIATED** March 1996

**LOCATION** Madras, Tamil Nadu, India

#### BACKGROUND

Knowledge in India about modern temporary contraceptive methods is limited, according to the 1992–1993 National Family Health Survey (NFHS). Modern methods such as pills, IUDs, injectables, and condoms are used by less than 6 percent of currently married women. Indian women rely heavily on sterilization for family planning, and more than 80 percent of sterilization acceptors never used any other method of contraception before sterilization.

Knowledge of AIDS is also extremely limited. In Tamil Nadu, the NFHS indicated that only 23 percent of currently married women have knowledge of AIDS. While 71 percent knew that AIDS can be avoided by practicing “safe sex,” only 14 percent cited using condoms during intercourse to prevent AIDS. Further, 33 percent of women believe AIDS is curable, and 22 percent believe that there is an AIDS vaccine.

#### PROFIT’S STRATEGY AND GOALS

Given the heavy reliance on sterilization and the limited method mix, PROFIT’s strategy in India is to support distribution of modern, temporary contraceptive methods. PROFIT will use a community-based social marketing (CBSM) strategy to do this. In particular, PROFIT’s goals are to determine whether a CBSM strategy can:

- ◆ increase condom usage;
- ◆ shift condom users from public to private sources;
- ◆ enable entrepreneurs to profitably distribute reproductive and sexual health products and messages.

Through technical assistance and financial support from PROFIT, local entrepreneurs will sell condoms and sanitary napkins using a CBSM approach. The CBSM approach is a multilevel marketing structure that allows entrepreneurs to earn profits through sales of products and the recruitment of other entrepreneurs. Entrepreneurs are allowed to adapt marketing messages to specific concerns of their buyers.

The subproject will emphasize condom usage and reproductive health messages, while relying on profits from sanitary napkin sales to support its operations. An independent “Club” to be established by PROFIT’s partners will handle all procurement, storage, training, payment of entrepreneurs, and other operational aspects of the subproject. The Club also will conduct mass media campaigns, and develop

promotional materials and other activities to support the entrepreneurs' sales. New entrepreneurs can join the Club after receiving health and family planning training and passing a competency test.

## **PARTNERS**

- ◆ International Family Health (IFH), a registered charity based in London, has more than 25 years of experience in the research, design, and management of family planning and AIDS prevention projects. IFH uses social marketing principles to distribute modern contraceptive methods and emphasizes sustainability and cost recovery in its programs. IFH developed the CBSM approach and will be responsible for the overall implementation of this subproject.
- ◆ Y.R. Gaitonde Centre for AIDS Research and Education (YRG CARE), a local nongovernmental organization established in 1993, has proven success in HIV/AIDS education, counseling, and treatment. YRG has implemented creative outreach programs to educate people about HIV/AIDS.

## **ACTIVITY UPDATE**

- ◆ This subproject was approved by USAID in February 1996.
- ◆ After the initial development phase, recruitment of entrepreneurs began in June 1997.

## **OTHER PROFIT ACTIVITIES IN INDIA**

- ◆ *Mawana Sugar Works*. See separate subproject profile.
- ◆ *Employer-Based Programs in Uttar Pradesh*. In 1995, PROFIT collaborated with the Society for Innovation in Family Planning Services Agency (SIFPSA) to appoint a full-time family planning specialist to identify and coordinate employer-based projects in Uttar Pradesh.
- ◆ *Employer Manual*. In 1995-1996, PROFIT collaborated with the Confederation of Indian Industry (CII), to develop a manual to guide CII's 3,000 organizations (which employ a total of two million people in 50 sectors) in providing family planning and reproductive health services.
- ◆ *Contraceptive Manufacturing, Marketing and Service Delivery Opportunities*. PROFIT collaborates with the Industrial Credit and Investment Corporation of India (ICICI) to identify and assess investment opportunities in contraceptive manufacturing, marketing, and service delivery.

## **RELATED PROFIT PUBLICATIONS**

- ◆ *India Country Assessment* (January 1995)
- ◆ *CII Manual for Corporate Initiatives in Family Health Care* (September 1996)
- ◆ *India: Mawana Sugar Works*. See separate subproject profile.

## **5. Conducting a Private Sector Family Planning Country Assessment**

**This section outlines a five-step process for assessing the environment for interventions to expand commercial sector involvement in family planning.**

### Conducting a Private Sector Family Planning Country Assessment

One mandate of the PROFIT Project was to identify appropriate countries for activities to promote the expansion of family planning services in the private sector, with a specific focus on the for-profit (commercial) private sector. In particular, PROFIT was to attempt to shift users of family planning from government sources to self-financing, private sector sources. The primary motivations for this effort were to:

- ◆ encourage people who can afford to pay for family planning to use private products services rather than free or subsidized government products and services
- ◆ allow government resources to be targeted toward increasing access to services by those who are least able to pay
- ◆ develop more sustainable systems for providing and financing family planning products and services.

This paper outlines a framework for analyzing the feasibility of developing projects to increase private family planning services in a given country, based on the experience of the PROFIT Project.

#### **Step 1. Assess General Suitability for an Intervention**

The first step in analyzing whether a country is appropriate for efforts to expand private sector family planning services is to review key country indicators and readily available secondary data. Often, the information available is sufficient to make a preliminary determination of whether a country is appropriate for a commercial sector intervention. PROFIT has used the following indicators:

## Conducting a Private Sector Family Planning Country Assessment

- ◆ Population: All other things being equal, large countries are more appropriate for commercial sector interventions than small countries because there is a larger potential market.
- ◆ Contraceptive prevalence: Contraceptive prevalence is the percentage of married women of reproductive age (15–49 years old) who use family planning. Given its goal of shifting consumers from the public to private sector, PROFIT targeted countries with contraceptive prevalence rates that indicated there was a sufficiently large demand for family planning. It is helpful to examine the prevalence rates for modern rather than traditional family planning methods because private providers are most likely to offer only modern methods.
- ◆ Public sector provision of family planning: Given its goal of shifting consumers from the public to the private sector, PROFIT sought information on where consumers go for family planning products and services. The project relied on Demographic and Health Surveys, which typically indicate what proportion of family planner users obtain services from the public and private sectors.
- ◆ Level of economic development: To succeed in shifting family planning consumers to the private sector, they must have sufficient disposable income to pay for the products and services. PROFIT used per capita GNP as a basic measure of economic development, and considered countries with per capita GNPs below \$500 to be unlikely candidates for a private sector intervention.

Although these criteria are relatively simple, they do provide sufficient preliminary information to determine whether a country might be appropriate for a private sector intervention and to assess the likely impact of such a program. If it is determined that a given country has the potential for increased private provision of family planning, the project team typically makes a field visit to gather additional information, including through locally available data and reports and interviews with representatives of the public sector, nonprofit organizations, and commercial entities.

Figure 1 ranks some of the countries PROFIT assessed according to their suitability for potential private sector interventions.

## Conducting a Private Sector Family Planning Country Assessment

<b>Figure 1</b>				
<b>Suitability for Commercial Sector Family Planning Intervention, Selected Countries</b>				
Country (Year of contraceptive information)	Population (millions)	Contraceptive Prevalence Rate*	Reliance on Public Sector Family Planning (% of total users)	Per Capita GNP (US dollars)
<b>Highly Suitable</b>				
Indonesia (1994)	Large (190)	High (52)	Medium (62)	Medium (\$880)
<b>Moderately Suitable</b>				
Bangladesh (1993)	Large (118)	Medium (36)	High (79)	Low (\$220)
<b>Less Suitable</b>				
Nigeria (1990)	Large (108)	Low (4)	Low (41)	Low (\$280)
*Percent of married women of reproductive age (15–49 years) currently using modern contraceptive methods.				
Sources: Population and GNP: World Bank, <i>World Development Report 1996</i> (Washington, DC: World Bank, 1996); Contraceptive Prevalence and Reliance on Public Sector Family Planning: Demographic and Health Surveys, various years (Columbia, MD: Macro International Inc.).				

For example, Indonesia is a country with a high potential for a commercial family planning intervention. It has a large population, which means a large potential market for family planning services. The relatively high contraceptive prevalence rate and the moderately high dependence on public sector family planning services means that there is a proven demand for family planning and large numbers of consumers who may be shifted to the private sector. Finally, the per capita GNP is high, which suggests that a significant number of people can afford to pay for private family planning services.

Bangladesh is only moderately suitable for an intervention. Although it has a large population, a medium contraceptive prevalence rate, and a high reliance on public sector services, Bangladesh is not sufficiently developed economically to enable a significant percentage of the population to afford private family planning services.

Nigeria is unsuitable for a commercial sector intervention because of its low contraceptive prevalence rate, low public provision of family planning, and low per capita GNP. A more appropriate intervention may be one that sought to increase contraceptive prevalence, for example, by expanding government provision of family planning, increasing the number of low-cost or subsidized services, subsidizing distribution of contraceptives through social marketing.

## Conducting a Private Sector Family Planning Country Assessment

### Step 2. Analyze Market Demand

The next step in the assessment process is to determine the existing and potential market in countries that appear to be suitable for commercial sector family planning interventions. This involves examining the demand for private family planning services, the supply of private providers (e.g., physicians, pharmacies, nurses, midwives), and the policy and regulatory environment.

It is not easy to determine the size of the market for private family planning services because there are a number of factors that affect a person's willingness to obtain and pay for such services. One fast and inexpensive method is to use data available from DHS studies on the total size of the population, the percentage of women of reproductive age (WRA), contraceptive prevalence, and source of supply for family planning services. Figure 2 show how this data can be used to estimate the number of WRA who currently rely on the public sector to meet their family planning needs.

Population (1990 census)	179.4 million
Married Women of Reproductive Age (1995)	25 percent of population = 52.7 million
Contraceptive Prevalence	58 percent all methods; 52 percent modern methods
Sources of Supply (percent of current users of modern contraceptive methods)	Commercial sector: 28 percent Semi-public sources:* 23 percent Public sector: 49 percent Total, non-commercial sector: 72 percent
Market Demand (number of women using public sector family planning services)	$MWRA \times \text{Contraceptive Users} \times \text{Non-commercial sources} = 52.7 \text{ million} \times .52 \times .72 = 19.7 \text{ million}$
*Village delivery posts ( <i>polindes</i> ), health posts ( <i>posyandus</i> ), and family planning posts are considered "semi-public" because they receive government subsidies.	
Source: Demographic and Health Survey, Indonesia (Columbia, MD: Macro International, Inc., 1994).	

Income surveys, when available, can be used to take the analysis a step further by assessing the ability to pay (effective demand). For example, in Indonesia, PROFIT was able to obtain a study conducted by the Futures Group that segmented the market for family planning. The paper reveals that more than 50 percent of family planning users in the two upper-income quartiles obtained their family planning services from the public and/or semi-public sectors. This suggests that a large percentage of those who use public sector sources could afford to pay for services and/or products from the private sector. Figure 3 outlines the step-by-step process for analyzing market demand.

## Conducting a Private Sector Family Planning Country Assessment

**Figure 3**  
**Step-by-Step Analysis of Market Demand**

Step	Data Needed	Source	Function	Example
1	Women of Reproductive Age (WRA)	Demographic studies; Population Reference Bureau	Actual or estimated	52.7 million
2	Percent of WRA using modern contraceptives	Demographic and Health Surveys	multiply	52 percent
3	Number of women using contraceptives	N/A	equals	$52.7 \text{ million} \times .52 = 27.4 \text{ million}$
4	Percent who obtain family planning from public sector sources	Demographic and Health Surveys	multiply	72 percent
5	Theoretical potential increase in the market for family planning in the private sector	N/A	equals	$27.4 \text{ million} \times .72 = 19.7 \text{ million}$
6	Percent of upper- and middle-income consumers who obtain family planning from public sector sources	Income studies	multiply	50 percent of the two upper-income quartiles = 25 percent of total
7	Number of WRA using modern contraceptives obtained from public sources who could theoretically afford to pay for services and/or products	N/A	equals	$19.7 \text{ million} \times .25 = 4.8 \text{ million}$

### ***Looking Beyond the Numbers***

The market demand analysis can help to determine the existing demand for family planning and the current sources of supply. However, given PROFIT's goal of shifting demand from public to private sources, it was critical to understand other factors that could affect the potential success of a commercial family planning intervention. Figure 4 outlines some of the factors that were relevant in the Philippines.

## Conducting a Private Sector Family Planning Country Assessment

**Figure 4**  
**Looking Deeper to Assess Market Demand: Philippines**

When PROFIT conducted its Country Assessment of the Philippines in 1993, it looked at first blush like a good potential market for private provision of family planning because the market was relatively large, there was potential for market growth, and there was a high reliance on the public sector for family planning services.

Existing DHS data showed a large population (62 million) and a medium contraceptive prevalence rate (39 percent of women of reproductive age). It also indicated that 38 percent of women of reproductive age had an unmet need for family planning services (defined as the percentage of currently married women who either do not want any more children or want to wait before having their next child but are not using any method of family planning). Although abortion is illegal, abortion rates were considered to be high — a good indication of potential demand for family planning services. Moreover, a large percentage of family planning services (72 percent) were provided by the public sector.

However, a closer look at the numbers pointed to some potential problems. Contraceptive use was heavily dominated by traditional methods (14 percent), and the second leading method was tubal ligation (11 percent). Users of tubal ligation (or female sterilization) are difficult to shift to private sector sources because the procedure involves a substantial outlay of money and requires a relatively sophisticated setting.

Another potential obstacle was the strong and vocal opposition of the Catholic Church to family planning and, in particular, to modern methods.

Finally, economic growth in the Philippines had been slow, and an estimated 50 percent of the population lived below the poverty line. In other words, the potential market of consumers able to pay the full cost of their services was likely to be only a small percentage of the total population.

In some cases the DHS or other studies provide information on consumers' motivations for using a given source of supply for family planning services. For example, in the 1994 DHS for Indonesia, the most important reason for choosing a source of supply was convenience (closer to home, 52 percent of respondents). Other factors such as lower costs were cited far less frequently. This was important to learn because price is often assumed to be the key factor in people's decisions to seek services at public versus private facilities.

The DHS can sometimes provide insight into factors that can affect actual demand, but it is sometimes necessary to conduct primary research to determine people's willingness to switch to and pay for private sector services (see Figure 5). Such research may examine:

- ◆ How satisfied are consumers with their existing sources of supply?
- ◆ What factors satisfy and dissatisfy consumers about their existing sources of supply?
- ◆ What attributes are associated with a given source of supply (e.g., convenience, price, quality), and how important are those attributes?
- ◆ To what extent are people willing to pay for those attributes?
- ◆ What would be the key motivation for people to shift to private sources of supply?

## Conducting a Private Sector Family Planning Country Assessment

**Figure 5**  
**Analyzing Consumer Motivations: Philippines**

PROFIT conducted a quantitative survey among consumers in the Philippines to look at factors that affected their decisions to utilize public versus private sources for family planning. The survey found that price was the most important factor in determining source of supply for family planning, unlike in Indonesia, where convenience was the most important determinant.

The study showed that more than half of consumers (54 percent) preferred to obtain their family planning services from public health facilities (versus only 25 percent for private sources), and 70 percent of respondents cited price as the reason. In addition, 87 percent of those surveyed indicated that the perceived expense discouraged them from using private sector sources for their family planning needs.

These findings suggested that, unless the prices of services in the public sector were increased or the prices in the private sector reduced, consumers would be unlikely to shift from public to private sources of supply. This points out the importance of examining consumers' willingness and ability to pay for private services and exploring alternative means of financing the provision of services.

### Step 3. Analyze Market Supply

The next step in the assessment process is to analyze the supply of family planning products and services. This involves determining what providers currently supply family planning products and services and to whom, as well as which products and services are available and at what price. This market supply analysis helps point out opportunities and obstacles to expanding the private provision of family planning products and services. It therefore helps identify initial areas to be targeted by project interventions.

There are several key questions that must be answered:

- ◆ What contraceptive methods are currently available, and is there a large unmet need for a specific method?

A country may depend primarily on resupply methods (i.e., pills and condoms), and longer-term methods such as IUDs may be unavailable or available only in limited quantities or from a small number of providers. Such a situation may present an opportunity to introduce or expand the variety of methods available, particularly through private outlets.

In Brazil PROFIT found that IUDs were primarily available through nongovernmental organization (NGOs) that served a relatively small portion of the family planning users in the country. Few private doctors had been trained in IUD

## Conducting a Private Sector Family Planning Country Assessment

insertion, and the IUD was available to them only at high prices. PROFIT developed a subproject to train private doctors in IUD insertion and to sell them a high-quality, lower-cost product.

- ◆ Where do consumers obtain their products and services? What is the relative role of the nonprofit private sector, the for-profit, private (commercial) sector, and the public sector?

The goal of this analysis is to determine the main competitors to private sources of supply. In many cases, the main competition to commercial suppliers is the public sector. This may be because the public sector's products and/or services are free or highly subsidized or because the government is the only source of supply for a given method. In countries that have relatively high contraceptive prevalence rates and where the government is not actively providing family planning services, the main competitors to commercial suppliers may be private, nonprofit clinics. These clinics typically charge a fee for family planning services, but the fees are often subsidized.

In Zimbabwe, PROFIT found that private pharmacies played a relatively small role, because the methods that pharmacies could provide — condoms and pills — were widely available at subsidized prices through the public sector. This made it clear that efforts to increase the role of pharmacists in providing family planning products and services would require the collaboration of the government.

- ◆ How do the prices of contraceptive products and services vary among public sector, NGO, and commercial suppliers?

In many countries, contraceptives available from the public sector are free or below cost. Private practitioners may have only limited access to high-priced contraceptives. In such cases, it is difficult for private distributors and private providers to compete, unless the low-cost and subsidized products offered by the government are targeted to those who can least afford to pay for them.

Figure 6 shows the relative prices and use of certain contraceptives in Indonesia by source of supply. This figure indicates that the price advantage of the public sector for Norplant®, pills, sterilization, and IUDs, has crowded out private sector alternatives. It also suggests that, unless the prices of public sector services change, commercial suppliers may be limited to supplying injectables and condoms — those products that the public sector does not distribute free or widely and for which consumers prefer private sector sources.

## Conducting a Private Sector Family Planning Country Assessment

<b>Figure 6</b>					
<b>Relative Prices and Use of Various Contraceptive Methods in Indonesia</b>					
Method	Public Sector Supply* (% of total)	Available Free (% of total from all suppliers)	Mean Cost for Public Supplies (rupiah)	Mean Cost for Private Supplies (rupiah)	Current Users (% of total)
Norplant®	89.6	43.9	5,878	7,780	9.4
Injectables	49.2	5.8	2,765	4,367	19.7
Condoms	33.6	20.9	N/A	2,250	1.7
Pills	74.1	18.8	621	1,532	32.8
Female sterilization	70.9	30.5	103,736	337,496	5.9
Male sterilization	77.3	N/A	N/A	N/A	1.3
IUD	72.8	57.2	8,489	34,051	19.7
<p>* includes semi-public suppliers (i.e., those that receive government funding)</p> <p>** does not include semi-public suppliers</p> <p>US\$1.00 = 2,200 rupiah</p> <p>Source: Demographic and Health Survey, Indonesia (Columbia, MD: Macro International, Inc., 1994).</p>					

- ◆ What is the profile of health care practitioners in the country, including doctors, OB/GYNs, general practitioners, nurses, midwives, pharmacists, and others? For example, how many work in private practice, full-time and/or part-time? What is the licensing structure? Are there active professional associations?

In Indonesia, doctors can provide the full range of contraceptive methods. Midwives are trained and permitted to provide all methods except sterilization. The role of pharmacists is limited to selling condoms and pills, the latter of which can be sold only with a doctor's prescription. Private midwives are by far the most important component of the commercial family planning sector, providing 57 percent of all private family planning services. From discussions with the Indonesian Midwives Association and with other donors, PROFIT learned that there are a large number of midwives in Indonesia and that they are permitted to provide a wide range of contraceptives. Their services are much more affordable than those of private doctors, and midwives can be found in both rural and urban settings. Many midwives run private practices, but most are employed by the government and run their own practices after hours. The Indonesian Midwives Association, founded in 1951, oversees the accreditation of midwives and provides continuing education classes, peer reviews, and other services to improve midwives' skills. The number of midwives has increased rapidly in recent years, largely as a result of a government program to train an additional 60,000 midwives.

## Conducting a Private Sector Family Planning Country Assessment

As a result of this profile, PROFIT sought to work with midwives and established a loan fund to help them establish and expand their private practices.

- ◆ What obstacles do private practitioners encounter to providing family planning products and services?

In Zimbabwe doctors indicated that they lacked training and supplies, and midwives indicated that they were permitted to provide family planning only under a doctor's supervision.

### Step 4. Explore Opportunities for Alternative Financing

The final step in the assessment process is particularly important in countries where a large proportion of consumers cannot afford to pay for private family planning services. In these countries, there may be opportunities to finance the provision of care through alternative means, in particular, through establishment and expansion of health insurance coverage for family planning and of employer-based family planning services.

#### *Health Insurance*

- ◆ What is the relative importance of private health insurance? Do insurance providers offer family planning benefits?

One possible intervention is to encourage private health insurers to include family planning as a benefit, but determining the potential impact of such an intervention requires knowing the current extent and nature of private health insurance. It is helpful to understand what percentage of the population is covered by health insurance, whether those covered by insurance are using contraceptives, and where they obtain their family planning services.

If the covered population either does not use family planning or uses public sector sources of supply, then the next task is to demonstrate to insurer(s) the merits of including family planning benefits and encouraging plan members to use them. For example, the insurer may be able to reduce outlays for delivery costs and pre- and post-natal care.

#### *Employer-Based Projects*

- ◆ What is the percentage of large companies that run health clinics for their employees? Do these employers offer family planning services? Does the government have any programs or laws regarding employer provision of health and/or family planning?

## Conducting a Private Sector Family Planning Country Assessment

In some countries, the government requires companies over a certain size to have a clinic. In others, some companies find they must offer health services to stay productive, particularly those in rural areas or in plantation settings. Companies that currently run clinics are much easier targets for employer-based family planning programs than those without. In Zimbabwe, PROFIT conducted a survey of the 210 largest work sites to determine how many had clinics, whether they offered family planning, and, if so, which methods. Of the 168 companies that responded, 135 had clinics on-site. Of those, 70 percent (95) offered at least one method of family planning. However, a majority of those companies only offered condoms and pills and few offered clinical methods.<sup>1</sup> PROFIT worked with these companies to broaden the method mix available at the clinics and to promote utilization of the family planning benefits by employees.

### Step 5. Assess the Policy and Regulatory Environment

The purpose of this step is to assess whether the policy and regulatory environment is conducive to or, at a minimum, would not obstruct a private sector family planning initiative. (Figures 7, 8, and 9 provide examples of a facilitating environment for the commercial sector, a neutral environment, and an inhibiting environment.) It will also help determine whether it is feasible to attempt to change those policies that would constrain such an initiative. There are four areas to examine.

#### ***Family Planning Policy***

Even if market conditions indicate that there is an opportunity to expand private provision of family planning products and services, exploiting the opportunity will require that government policies support such an effort or, at a minimum, do not provide an obstacle. The following questions can help answer that question:

- ◆ What types of family planning programs does the government support?

This can help identify opportunities for a project intervention. For example, if the government exhibits a bias against a given method, there might be an opportunity for private providers to supply that method. Also, if the government is conducting a successful IEC campaign about family planning in general or to promote a particular method, there might be an opportunity to use the campaign to promote the use of private providers. Finally, if the government is running an

---

<sup>1</sup>Premila Bartlett, *A Study of Employer-Based Family Planning Services in Zimbabwe* (Arlington, VA: PROFIT Project, October 1996).

## Conducting a Private Sector Family Planning Country Assessment

untargeted distribution program for condoms or pills, private providers might be crowded out of the market.

- ◆ Does the government target its services?

The government may represent the main competition for private providers, and any private sector initiative would need the cooperation of the government. A first step is for the government to recognize the importance of promoting utilization of alternative sources of supply. This recognition often, although not always, comes about as a result of budget constraints that force the government to encourage private sector provision of services. The next step is for the government to set policies that make private provision viable, for example, by targeting government services to those who can least afford to pay for private sector services.

- ◆ Which donors are active in population programs, and to what extent do they support private sector provision?

Donors can also undermine efforts to promote the use of private providers, for example, by distributing commodities without targeting them to those who cannot pay. Therefore, it is important to coordinate not only with the local government but also with large donors.

**Figure 7**

### **A Facilitating Environment for the Commercial Sector: Indonesia**

The government of Indonesia recognizes that achieving further increases in contraceptive prevalence will require significant resources. Therefore, the government has set a goal of increasing private provision of family planning services to comprise 50 percent of users, which will free up government resources to help reach new acceptors.

While the public sector does compete with private providers in provision of certain methods, the government recognizes and tracks pricing and market segmentation and is working to better target its services. In addition, the government publicly encourages those who can pay for family planning services to use private providers as part of *K.B. Mandiri* (self-sufficiency) program.

## Conducting a Private Sector Family Planning Country Assessment

**Figure 8**

**A Neutral Environment for the Commercial Sector: Romania**

The Romanian government's inaction provides an opportunity to increase the private provision of family planning. Family planning only became legal in Romania in 1989, and although fertility rates have been low, primarily through utilization of abortions (illegal before 1989 and legal thereafter), the government has no family planning policy. The World Bank has provided the government a loan to establish public sector reproductive health services, but the government has been slow to implement the project. Romanian people desire to have small families, as evidenced by the low fertility rates, but they have few sources for information on modern contraception. In addition, family planning products, particularly the pill and condom, are widely available without a prescription in the large number of newly privatized pharmacies.

By working directly with private pharmacies and by providing women with information on modern contraceptives through largely private media channels, PROFIT was able to have an impact, without government political commitment.

**Figure 9**

**An Inhibiting Policy Environment: Philippines**

In the Philippines, the policy environment inhibits the role of the commercial sector in providing family planning. Although both the president and the minister of health of the Philippines support the provision of family planning by the public sector, the Catholic Church, a popular and powerful voice in the Philippines, is constantly challenging the government's efforts to provide the public with correct information about family planning.

The government has indicated that, due to budget constraints, it would like to see the role of the private sector increase, but it has not taken action to target public sector services to those least able to pay. PROFIT's research indicates that price is the key determinant of where people obtain their family planning. Therefore, the failure to adequately target free and low-cost public services inhibits the private sector's ability to compete.

## Conducting a Private Sector Family Planning Country Assessment

### ***Level of Commercial Activity***

The second area to be examined in assessing the policy and regulatory environment is the overall climate for private investment.

- ◆ What is the political structure?

Indonesia has been an authoritarian regime dominated by a single individual since 1965. This high level of government control can hinder private industry, particularly because there is “controlled” competition and the government owns shares in many major industries including pharmaceuticals. On the other hand, the government maintains accurate and up-to-date health statistics, including exceptionally detailed information on family planning attitudes and contraceptive usage. This information is helpful to commercial entities interested in entering the family planning market.

- ◆ What is the investment climate? Is private investment rising? Are trade laws being liberalized? What factors do commercial entities cite as hindrances to growth?

Indonesia has experienced rapid economic growth since the 1990s, which has led to widespread improvements in education and family income. In addition, Indonesia took measures to streamline the investment process including deregulating investment in the pharmaceuticals industry, strengthening the capital markets, reducing subsidies, and removing credit ceilings. Private investment has increased significantly as a result. Nonetheless, an inefficient bureaucracy, corruption, the lack of competition in certain monopoly sectors, rising wages, and tight credit continue to be cited by commercial firms as constraints to private sector development/investment.

- ◆ Is credit available? What are prevailing rates?

In Indonesia, commercial interest rates are very high, in excess of 25 percent, although credit is widely available in both urban and rural areas through private banks, government banks, and credit programs. Although Indonesia has a generally positive economic climate, high interest rates may be a limitation on private sector expansion and therefore might be a target of a project intervention.

- ◆ Are there exchange controls? If so, what are their effects on private industry?

For example, Indonesia’s currency is fully convertible, and there are few restrictions on the repatriation of income. In Romania, however, limited access to foreign exchange has slowed industrial growth. In particular, the health industry relies heavily on foreign imports (all contraceptives are imported, none are locally manufactured), and importers indicate it can take three to six months to obtain the

## Conducting a Private Sector Family Planning Country Assessment

foreign exchange necessary to pay for imported products. (Recently, Romania has undertaken economic reform, including exchange rate liberalization, which have greatly improved the situation.)

### ***Regulation of the Delivery of Health Products and Services***

The third area to be examined in assessing the policy and regulatory environment is the regulations governing the private health sector.

- ◆ Are there plans to privatize the health sector?

In Indonesia, recent government policies support privatization of health services, with the most ambitious being the end of guaranteed employment in the public sector for graduates of medical school and midwifery school. In addition, in 1991, the government launched a program to train 60,000 new midwives over a five-year period, which quadrupled the number of trained midwives in service of the government's objective of placing a midwife in every village in Indonesia. However, this program did not include assistance for graduates who sought to set up private practices, an area PROFIT sought to address with its Revolving Loan Fund for Midwives.

- ◆ Are regulations on the establishment of private practices overly burdensome? Do they prevent any private practitioners from establishing practices?

In Zimbabwe, for example, the process for doctors and pharmacists to establish private practices appears to be relatively straightforward, but there is considerable bias within the regulatory agencies against private midwifery practices and a limited knowledge among midwives about the regulations governing the establishment of private practices. As a result, a large number of nurses and midwives work in private doctors' offices rather than establish independent practices. This may limit the private provision of family planning services because the number of doctors in Zimbabwe is limited, and access to doctors is limited by the concentration of these doctors around the two largest cities.

- ◆ Is the sale or distribution of pharmaceutical products regulated?

In Indonesia, pharmaceutical distributors cite leakage of contraceptives from the public sector into the private market as one factor hampering the growth of private services. They also cite the Indonesian law that prohibits the operation of foreign distribution companies in the pharmaceuticals industry. Pharmacists in Indonesia feel their profitability is limited by regulations that permit them to sell only drugs (over-the-counter and prescription) and not other products.

- ◆ Are there import and/or price controls on pharmaceutical products?

## **Conducting a Private Sector Family Planning Country Assessment**

In Zimbabwe, import controls and regulations on foreign exchange adversely affect the pharmaceuticals industry: many imported pharmaceuticals face a 15 percent import tax, a 20 percent surtax, and a 10 percent customs duty. Other goods and raw materials fall under the Open General Import License, which has a less stringent duty structure (general surcharge of 10 percent and a minimum import tariff of 10 percent).

- ◆ Are there regulations that might induce or coerce employers to offer health and/or family planning benefits, such as a requirement to provide employees with health insurance or to run a health clinic on company premises?

In the Philippines, companies with more than 200 employees are required by law to provide on-site family planning, although the regulation is not enforced.

### ***Regulation of the Delivery of Family Planning Products and Services***

The fourth and final area to examine in assessing the general policy and regulatory environment is the regulation of family planning products and services.

- ◆ Are there restrictions or biases against particular contraceptive methods?

In Indonesia, although all contraceptive methods are available, the government does not promote sterilization because of religious opposition (although sterilizations are provided in public health facilities).

- ◆ Are certain health care providers restricted as to which methods they can offer?

PROFIT found that pharmacists in Zimbabwe were allowed to start women on the contraceptive pill but that, because they lacked training, they were unwilling to do so without a doctor's prescription. PROFIT trained private pharmacists, developed a reference guide that was distributed to pharmacists nationwide, and conducted an information, education, and communications (IEC) campaign to inform consumers that they could obtain contraceptive pills through their pharmacists.

- ◆ What training is required to provide a given family planning method?

In Indonesia, no additional training beyond medical or midwifery school is required to provide family planning services, with the exception of Norplant® (both doctors and midwives must go through a special training program before they are certified to insert and remove Norplant®). On the other hand, in Romania, OB/GYNs who want to provide family planning in the private sector must complete a six-week training course provided by the government, and the requirements for general practitioners are even stricter.

## Conducting a Private Sector Family Planning Country Assessment

- ◆ Is advertising of family planning permitted?

In Indonesia, advertising of family planning is permitted, although it must be coordinated through the Government Family Planning Coordinating Committee. In other cases, the regulations are more restrictive.

### Conclusions

One of the mandates of the PROFIT Project was to identify countries and sectors appropriate for interventions to expand private family planning services, with a specific focus on the for-profit (commercial) sector and an emphasis on shifting users of family planning from government sources to self-financing, private sector alternatives. PROFIT conducted feasibility assessments in potential target countries to determine what, if any, project interventions would be appropriate to fulfill that mandate. The assessment process involves five steps, as summarized in Figure 10.

## Conducting a Private Sector Family Planning Country Assessment

<b>Figure 10</b> <b>The Process for Conducting a Feasibility Assessment</b>	
1. Assess General Suitability for an Intervention	<ul style="list-style-type: none"> <li>◆ Review available secondary data to make a preliminary determination of whether a country is appropriate for a commercial sector intervention. Indicators include: population size, contraceptive prevalence, extent of public provision of family planning, and per capita GNP.</li> <li>◆ Conduct a field visit to gather additional data, for example, by collecting locally available data and reports and conducting interviews with representatives of the public sector, nonprofit organizations, and commercial entities.</li> </ul>
2. Analyze Market Demand	<ul style="list-style-type: none"> <li>◆ Determine the existing and potential market in countries that appear to be suitable for commercial sector family planning intervention by examining the demand for private family planning services, the supply of private providers (e.g., physicians, pharmacies, nurses, midwives), and the policy and regulatory environment.</li> <li>◆ Look behind the numbers to understand other factors that could affect the potential success of a commercial family planning intervention, including people's motivations for using certain sources for family planning.</li> </ul>
3. Analyze Market Supply	<ul style="list-style-type: none"> <li>◆ Analyze the supply of family planning products and services to help uncover opportunities and obstacles to expanding the private sector role.</li> <li>◆ Determine the types of providers that currently supply family planning products and services and to whom, as well as which products and services are available and at what price.</li> </ul>
4. Explore Opportunities for Alternative Financing	<ul style="list-style-type: none"> <li>◆ Examine opportunities to finance the provision of care through alternative means.</li> <li>◆ In particular, examine the potential to establish and expand health insurance coverage for family planning and employer-based family planning services, especially in countries where a large proportion of consumers cannot afford to pay for private family planning services.</li> </ul>
Step 5. Assess the Policy and Regulatory Environment	<ul style="list-style-type: none"> <li>◆ Determine whether the policy and regulatory environment is conducive to or, at a minimum, would not obstruct a private sector family planning initiative by examining four areas:                             <ul style="list-style-type: none"> <li>◇ Family Planning Policy: Expanding private provision of family planning will require that government policies support such an effort or, at least, do not present barriers.</li> <li>◇ Level of Commercial Activity: Assess the overall climate for private investment.</li> <li>◇ Regulation of the Delivery of Health Products and Services: Assess the regulations governing the private health sector, particularly whether there are plans to privatize the health sector, overly burdensome regulations on private practices, and what products are regulated.</li> <li>◇ Regulation of the Delivery of Family Planning Products and Services: Examine the regulation of family planning products and services, looking in particular for bias against certain methods and restrictions on provision of services by particular providers.</li> </ul> </li> </ul>

## **Appendix: Information Sources**

### ***Demand Analysis and Demographic Statistics***

Demographic and Health Surveys provide a considerable amount of valuable information for conducting a market analysis. They have been conducted for 47 countries and always include information on contraceptive prevalence, awareness rates, unmet need, and sources of supply. The newer studies also include questions about motivations for using particular sources of supply for family planning and pricing information.

### ***Motivating Factors***

There are not many studies that directly examine the rationale for utilizing public or private sector sources for family planning services, but there are many such studies for the general health sector. It is also worthwhile to survey other organizations working in the country to determine if they have conducted related research.

### ***Income Data***

International organizations (such as the United Nations and the Organization for Economic Cooperation and Development) and international financial institutions (such as the World Bank, International Monetary Fund, and the regional development banks) often collect and publish data on national and personal income. (In fact, much of these data are now available online.)

Advertising agencies also track socioeconomic data to determine people's ability to pay for a given product or service. They use a variety of variables, including educational level, occupation, ownership of selected consumer goods, living situation, expenditures, and income. Local advertising agencies are often willing to share this information.

### ***Supply of Practitioners***

Professional medical associations (e.g., of doctors, OB/GYNs, midwives, pharmacists) can provide information on the number of practitioners in a given country and sometimes on the percentage of practitioners in the public and private sectors. They are also often willing to help set up focus group discussions with their members or a survey, for example, to determine the range of current family planning services or obstacles faced by private practitioners.

## Conducting a Private Sector Family Planning Country Assessment

### ***Level of Commercial Activity***

The major accounting firms typically publish reports on the business climate in a given country. For example, Deloitte, Touche, Tohmatsu International publishes a report entitled, *The International Tax and Business Guide Series*, which is currently available for 48 countries or regions. The Economist Intelligence Unit (based in London) also produces reports on the business climate in selected countries.

### ***Regulatory Environment for the Health and Family Planning Sectors***

Secondary reports occasionally provide an overview of the regulatory environment for the health or family planning sectors. For example, USAID supports projects that conduct regulatory reviews, and reports from the World Bank's Health Sector often include regulatory information.

In other instances, it is necessary to conduct a regulatory review firsthand. Two guides can help:

- ◆ Genevieve Kenney, *Assessing Legal and Regulatory Reform in Family Planning* (Washington, DC: OPTIONS for Population Policy, The Futures Group International).
- ◆ Frank Feeley, *Practical Pointers for Conducting Commercial Sector Family Planning Assessments* (Arlington, VA: PROFIT Project).

## **6. The PROFIT Model for Implementing Partnerships**

**This section reviews PROFIT's experiences in initiating, negotiating, and managing partnerships with commercial entities, including the particular approaches used and practical considerations that arose.**

## The PROFIT Model for Implementing Partnerships

Since the mid-1970s, USAID has sought to create partnerships with private sector entities to expand family planning activities in developing countries. USAID traditionally had regarded the “private sector” to include both nonprofit and for-profit organizations. Faced with growing worldwide demand for family planning services and decreased donor and host government funding to pay for these services, USAID turned to the for-profit, or commercial, private sector to help reduce this “resource gap.” This strategy was based on the recognition that commercial organizations had well-established networks and infrastructures to serve consumers in developing countries, as well as financial resources and management skills that could be mobilized to support family planning initiatives. With the creation of the PROFIT Project in 1991, USAID began an ambitious and innovative program to forge partnerships with commercial organizations in order to expand family planning services (see also Section 3, “The Design and Evolution of the PROFIT Project”).

PROFIT had several features that made it unique from prior population projects. First, PROFIT was given financial resources to use as “seed” capital for commercial subprojects. The availability of this capital permitted PROFIT to approach commercial organizations as partners, to share in subproject development and implementation costs. Second, the PROFIT staff included a number of individuals who had extensive experience in investment and finance and in the field in developing countries. In addition, the project consortium had technical resources in the areas of family planning, contraceptive technology, and health finance.

PROFIT organized itself as an investment fund which sought to identify, structure, finance, and help implement commercial subprojects involving family planning services and products. In other words, PROFIT saw its role to include both mobilizing commercial organizations to become engaged in family planning and being an active partner in the operational aspects of the subprojects it financed. PROFIT sought a close working relationship with its commercial sector partners in all aspects of the subprojects’ preparation and implementation.

Another key aspect of PROFIT’s approach to partnering was a “business-driven” orientation that meant that PROFIT and its partners would share the financial burdens and rewards from commercial family planning activities. The expectation was that PROFIT’s

## The PROFIT Model for Implementing Partnerships

funding would be repaid from the proceeds generated by the activities financed. Although PROFIT was willing to provide technical assistance to facilitate the technical implementation of a given subproject, the emphasis was on developing subprojects that could achieve financial sustainability over the long term.

PROFIT's emphasis on financial sustainability, repayment, and a business-oriented approach represents a new model for creating partnerships with commercial organizations for social objectives. This new model is examined in detail below, in particular, how it was developed through PROFIT's assessment of over 80 partnership opportunities, of which 28 were developed and 15 were implemented. (See Section 3 for profiles of the subprojects implemented.)

## PROFIT's Approach to Partnerships

### *Strategic Assumptions*

#### The Profitability of Family Planning

PROFIT's approach to partnering with the commercial sector was based on several project design assumptions, the most fundamental of which was that commercial organizations in developing countries would regard family planning as an important, profit-making business activity. Some of the presumptions about the motivations of potential commercial partners included:

- ◆ Private health care providers in many countries already provided family planning services on a fee-for service basis to consumers and would have an interest in expanding their markets or client bases.
- ◆ Insurance companies and health maintenance organizations (HMOs) might derive savings by covering family planning services for their clients, for example, by averting maternity expenses and other related costs.
- ◆ Private employers could derive cost savings by providing family planning benefits to their employees, for example, by decreasing staff turnover and maternity costs — benefits that would also be considered a competitive advantage in attracting or retaining employees.
- ◆ Manufacturers and private distributors could produce and/or market contraceptive products on a commercial basis at affordable prices to a growing number of consumers who had previously used public sector sources for contraceptive products.

## The PROFIT Model for Implementing Partnerships

### Access to Capital and Cost-Sharing

The approach for mobilizing commercial organizations was to provide capital and thereby to share the costs and risks of new commercial ventures and programs and to provide technical assistance and training in family planning service provision. In return, the partners were expected to share the costs of developing and implementing subprojects.

### Family Planning Objectives

Originally, PROFIT was to support subprojects that could achieve financial sustainability and, over time, contribute to broader family planning objectives, such as increased contraceptive prevalence. Implicit in PROFIT's design was a recognition that the general policy environment would need to be supportive of private sector involvement in family planning and that service delivery objectives would only be achieved after such involvement became accepted and replicated.

PROFIT was not intended to meet the family planning needs of the poorest members of the population, but to shift those who could afford to pay for services to commercial sector providers, freeing up donor and public sector resources to meet the family planning needs of poorer population segments. The implication was that partnerships would not be built on philanthropic motives but would be profitable and financially self-sustaining by targeting clients who could pay for services.

### ***Operational Approaches***

These design parameters greatly influenced PROFIT's operational approaches for pursuing and creating partnerships.

### The Role of Investments

In order to attract or mobilize commercial sector partners, PROFIT modeled itself as an investment fund. PROFIT offered financial support in the form of direct loans or equity capital in joint ventures. Although PROFIT offered preferential terms, partners were required to repay the funds after a reasonable period of time (usually 3-7 years). The primary motives for this approach were to:

- ◆ preserve PROFIT's investment funds from erosion due to losses or inflation
- ◆ promote a "business-driven" orientation with partners that would foster the financial sustainability of subproject operations and impose a certain rigor and discipline
- ◆ exercise proper "due diligence" in analyzing potential subprojects to be submitted to USAID for funding approval.

## The PROFIT Model for Implementing Partnerships

Thus, PROFIT initially viewed partnerships as [risk-sharing] undertakings, and not as grants or donations. Although the commercial orientation was modified over time to include soft loans and grants for highly innovative or pilot subprojects, the pursuit of business-driven partnerships was the basis for most investments supported by PROFIT.

As noted, PROFIT's approach was facilitated by its staff members' expertise in investment banking, corporate finance, and commercial marketing, as well as their experience working overseas and on development-oriented projects. They were supported by technical staff members who had backgrounds in family planning and evaluation.

PROFIT established a nonprofit entity, The Summa Foundation, to legally hold all investment assets and to receive repayments or investment income from its partners. Because The Summa Foundation was legally independent, it was designed to survive beyond the end of the PROFIT Project and to continue to oversee PROFIT's investments.

### Project Development Processes

PROFIT initially pursued partnerships through a formal subproject development process that utilized financial and business assessments. The process had several stages:

- 1) Country assessments: These were used to assess the business environment and the status of health and family planning service delivery in each target country. The country assessments were critical in focusing on the specific segments (such as manufacturing, insurance, or service provision) in which PROFIT could seek commercial partnerships. (See Section 5 for a review of PROFIT's five-step process for conducting country assessments.)
- 2) Identification of potential partners: PROFIT spent considerable time and effort identifying potential partners. These included established health care providers, insurance companies, associations of medical practitioners (physicians, midwives, pharmacists), contraceptive manufacturers and distributors, family planning NGOs, and social marketing companies. In most instances, these partners had not previously collaborated with public sector or donor-funded activities. Potential partners were invited to submit concepts and plans for subprojects or new ventures, which PROFIT evaluated in terms of financial and family planning merits in order to select those to be developed.
- 3) Development of subprojects: The technical feasibility of potential subprojects was determined using market studies, family planning appraisals, and financial evaluations.
- 4) Negotiations with partners: PROFIT negotiated with potential partners to develop subprojects to be submitted to USAID for approval and funding. The negotiations included clarification of the need for technical assistance, definition of the subproject structures, funding arrangements, the conditions of PROFIT's participation, and plans for PROFIT's eventual withdrawal from the partnerships.

## The PROFIT Model for Implementing Partnerships

- 5) Implementation: After USAID approved a subproject, the activity was carried out according to the contractual and legal agreements negotiated with the partners. Implementation often involved extensive monitoring and evaluation activities, which were conducted in coordination with partners.
- 6) Exit: The last stage in the process is PROFIT's exit from the partnerships, a process that involves divesting from any commercial agreements entered into through its nonprofit foundation and transiting monitoring responsibilities to other local organizations. The PROFIT model is allowing some partnerships to continue beyond the contractual end of the PROFIT Project (September 30, 1997), which will help ensure that these partnerships achieve their longer-term objectives.

## Identifying and Selecting Partners

### *Partner Attributes*

PROFIT selected 28 subprojects to develop out of approximately 80 opportunities submitted by commercial organizations and a limited number of NGOs (See Appendix A in Section 9). Certain key attributes characterized those organizations PROFIT selected as partners:

- ◆ Well-established organizations with track records in commercial activities: Most of the organizations selected had been in business for many years and had credible records in operating and managing commercial operations in their countries. A majority of those organizations had business operations in health service delivery, health insurance, or product manufacturing or distribution. By contrast, most of the partners whose subprojects were not developed either had been in business only a limited time or had no established record in pursuing health-related or family planning activities. In the NGOs selected, PROFIT looked for a commitment to commercializing activities, a well-managed organization, and staff member(s) with private sector experience who would be in charge of the proposed commercial activity.
- ◆ Management support: The organizations with which PROFIT pursued partnerships demonstrated senior management commitment to the initiatives being proposed. PROFIT looked for key senior managers who championed commercializing or integrating new health services or family planning activities into their business operations. PROFIT did not pursue opportunities unless such commitment was evident.
- ◆ Infrastructure and resources: The partners selected had the organizational infrastructures and resources to pursue, develop, and implement commercial

## The PROFIT Model for Implementing Partnerships

activities. Although some partners were small entrepreneurs, they made a strong case that they would devote substantial resources to their subprojects. Notably, PROFIT did not prominently consider organizational ties to multinational corporations as a contributing factor; a more decisive attribute was whether the partner had *local* resources, experience, and infrastructure to pursue the investment.

### ***Financial and Technical Factors***

The partnerships PROFIT developed generally had positive financial and family planning prospects. It is difficult to generalize about the subprojects that were approved, but there are consistent patterns in the 12 subprojects and potential partnerships that were not approved or were dropped after being developed, as shown in Table 1.

The majority of the subprojects dropped did not meet PROFIT's criteria for financial sustainability or did not show adequate market or business potential. Likewise, some partners abandoned subprojects because of financial considerations or concerns. In only a few cases (3) were family planning issues a reason for dropping a subproject, including USAID's prohibition on supporting products that have not been approved by the U.S. Food and Drug Administration (FDA) such as Cyclofem®.

This subset of subprojects that were dropped offer some important lessons about the development and structuring of commercial partnerships:

- ◆ Financial risks: Because PROFIT expected its investment to be repaid, its potential partners weighed the financial risks of the proposed subprojects very seriously. Some partners reconsidered subprojects when the financial risks seemed too high, either because of the potential for losses or because of foreign exchange risks. This was particularly true of NGOs, which had previously obtained donor funding through grants and had not incurred repayment obligations. As a result of this aversion to risk, PROFIT was forced to reconsider its terms and conditions for financing subprojects. In some cases, PROFIT began to offer loans denominated in local currency in order to remove the foreign exchange risks. It also extended preferential terms to NGOs to facilitate repayment.

## The PROFIT Model for Implementing Partnerships

<b>Table 1. Reasons Potential Partnerships Were Dropped</b>	
Odebrecht	Technically complex; large financial requirements
Superior Medical Center	Insufficient family planning potential
JIEP Industrial Estates	Partner (estate) unwilling to make the staffing and management changes necessary for implementation
Blue Cross of Jamaica	Partner unable to devote resources to subproject
Jamaica Insurance Companies	Financially unsustainable
AAR/Sulmac	Partner perceived lack of cost savings; recruitment disadvantages; family planning quality might decline
Profam	Partner decided to sell company
FEMAP/Community Doctors	Partner feared loan default risk by borrowers
FEMAP/Affiliate Labs	Partner unwilling to assume foreign currency risk
AF/Carnot Laboratory	USAID policy against financing non-FDA approved products
Nigeria Bankers Hospital	Technically unfeasible: low demand for services
Nigeria Depo-Provera®	Insufficient market demand; financial returns uncertain

- ◆ **Market factors:** Some subprojects were dropped because market conditions were unfavorable. For example, in Nigeria, PROFIT had to abandon an opportunity to market Depo-Provera® because price levels could not be dropped low enough to be competitive with other products — the market was distorted by the prevalence of heavily subsidized contraceptives — and simultaneously yield adequate financial returns for PROFIT’s partner, a local distributor.
- ◆ **Development efforts:** Most subprojects required an average of six to nine months to develop for USAID approval. This level of effort would generally occupy one or two staff people nearly full-time in data-gathering and analysis, conducting discussions and negotiations with partners, overseeing research or studies, financial and technical reviews, and drafting investment documents for USAID review. Every potential subproject, regardless of the financial requirements, required senior-level staff input for family planning and technical review, as well as for investment “due diligence,” such as reviewing the partner’s background and financial statements and conducting legal research.

## The PROFIT Model for Implementing Partnerships

- ◆ Broader health initiatives: PROFIT found that most commercial organizations were interested in pursuing broader health service delivery activities and had only limited interest in subprojects focused solely on family planning. Even family planning NGOs sought to enter into commercial delivery of other health services, such as maternal and child health and laboratory services, in order to broaden their income potential. PROFIT therefore had to consider subprojects that went beyond family planning. For example, PROFIT funded the establishment of a low-cost health program that included integrated family planning services. This meant that family planning components were not the primary focus of most subprojects and that PROFIT had to be diligent to ensure that its partners gave the family planning components appropriate funding and attention during the development phases.
- ◆ Selling ideas: PROFIT's task in developing subprojects consisted largely of selling the notion to its partners that family planning could be successfully integrated into their commercial operations and that it could produce positive business results for the larger operations. The potential benefits would include greater profits, an enhanced image in the community, increased sales and market share (particularly among new population segments), access to technical assistance, and the potential to conduct business with public sector agencies or donors. To sell these concepts, it was critical that PROFIT understand the motivations of its partners and to relate the potential benefits in terms that the partners could understand. PROFIT staff had to speak the language of business and finance and be able to communicate with top management and decision makers on their terms.

## Factors for Success

The implementation of PROFIT's partnerships was influenced by a variety of factors that affected the ability of PROFIT and its partners to achieve their objectives. Many of the factors were external, but some reflected the strengths and attributes of the partners themselves.

### *Partners' Characteristics*

- ◆ Management Support: Whether or not a partnership succeeds depends in large part on the commitment of the management. During the development phase, PROFIT had to secure partners' commitment in specific and contractually binding terms. However, once implementation began, PROFIT had to rely on the commitment and support of top managers for the partnership to thrive. For example, in the Kenya AAR Project and the Philippines Low-Cost Health Plan implemented by PhilamCare, senior managers in the commercial firms provided leadership in moving the subprojects forward and in maintaining their commitment to its social objectives.

## The PROFIT Model for Implementing Partnerships

- ◆ **Entrepreneurship:** In most developing countries, those willing to take the risk of launching new initiatives tend to have an entrepreneurial spirit. However, working with entrepreneurs can be risky. For example, they may have autocratic management styles which makes it difficult for them to accept oversight and involvement from other parties, such as donors.

In Indonesia, PROFIT implemented a subproject with PT Bonnys, a chain of vaccination clinics owned by an entrepreneur with extensive experience in the pharmaceutical industry. Although the proprietor was committed to the partnership, he also wanted to run the subproject his own way. His style often interfered with the efforts of subordinates, and he disregarded the technical assistance PROFIT provided to improve his marketing efforts. Eventually, he ran into severe financial difficulties which forced him to close down much of his operations, and PROFIT had to end the subproject and recover the funds it had lent to him.

In Kenya, PROFIT established a partnership with an entrepreneurial company, AAR Health Services, to launch a pre-paid package of health care and family planning services to be marketed to industrial employers. AAR, a small company, had a highly entrepreneurial style and wanted to expand its clientele and introduce managed health care concepts to its clinics' operations. Unlike PT Bonnys, AAR's management was willing to accept the necessary technical assistance from PROFIT and to work with PROFIT on technical and programmatic issues, both of which benefited the partnership.

- ◆ **Start-up companies:** PROFIT's experience indicates that working with start-up companies requires unusually high levels of technical assistance and management oversight from all parties. PROFIT launched two commodity-distribution companies, one in Russia and another in Brazil. In both cases, PROFIT had been unable to find local or foreign partners to participate and decided to proceed with the subproject and to identify partners at a later stage. Although PROFIT was able to recruit local managers to run the companies it established, they required considerable assistance and oversight, which normally would have been provided by a partner organization.

In Russia, the company was established and negotiated agreements with suppliers, but it was unable to begin operations due to USAID's preference to support alternative commodity subprojects. In Brazil, the commodity company was successful in importing and distributing large volumes of IUDs and marketing them to NGOs, public sector agencies, and private physicians. The Brazilian company was sold to the management staff and will operate independently after 1997.

In both cases, the implementation would have been easier if a local partner had been secured at the outset. In addition, a project like PROFIT, with a relatively brief life span, is unlikely to be able to build all the necessary competencies in a

## The PROFIT Model for Implementing Partnerships

local organization it creates from scratch. Using existing commercial infrastructures is more efficient and increases the chances that the partnership can be sustained.

- ◆ Associations/cooperatives: Organizations that have complex management structures or are subject to periodic changes in management can be less effective as partners. In Brazil, PROFIT was unable to fully implement its subproject with UNIMED/Maceio, a physicians' cooperative, because the management was elected by member physicians and changed regularly. These leadership changes led to implementation delays and a reluctance to adhere to prior agreements. In spite of extensive efforts, PROFIT was unable to motivate UNIMED's new managers to extend services beyond existing clients to low-income individuals and had to divest from the subproject. However, the commercial nature of the partnership allowed PROFIT to negotiate a financially attractive divestment, thus averting a loss of USAID funds.

Medical associations, particularly those of physicians, provide an excellent forum for reaching large numbers of providers. However, it is unrealistic to expect a voluntary organization to become actively involved in a subproject, particularly if there is no financial compensation or if a manager is not hired specifically to manage the day-to-day subproject activities. This was the case in the Philippines, where PROFIT established a Loan Fund for Physicians, with the initial endorsement of the Philippines Medical Association. The organization's volunteer structure made it unable to support the subproject or to market the loan fund to its members.

- ◆ Nongovernmental organizations: NGOs appear to be appropriate partners for family planning subprojects because of their commitment to social objectives and to serving lower-income populations. However, these organizations are also extremely risk-averse and are generally unwilling to enter into partnerships on commercial terms. For example, PROFIT was unable to develop subprojects in Mexico with FEMAP because of its reluctance to assume commercial obligations for PROFIT funds. In India, PROFIT offered Parivar Sevar Sanstha (PSS), a family planning NGO, a loan to purchase its own building and avoid escalating rent payments. However, PSS did not avail itself of the loan because it could not identify a proper building. After considerable delays, PSS received a grant from other donors for this purpose. Commercial efforts should be targeted at organizations with a true track record of competing in the marketplace.
- ◆ Financial intermediaries: PROFIT found the use of financial intermediaries useful in a number of subprojects. Two examples are Bank Rakyat Indonesia (BRI), which implemented the PROFIT Loan Fund for Midwives in Indonesia, and Bankers' Association of the Philippines Credit Guaranty Corporation (BCGC), which implemented the Physicians Loan Fund in the Philippines. Both institutions facilitated the administration and processing of loans to private providers, a class of borrowers that have not been traditionally well served by lending institutions. PROFIT offered the intermediaries appropriate financial incentives to lend to these

## The PROFIT Model for Implementing Partnerships

targeted borrowers. In addition, BRI contributed \$500,000 to the midwives fund, through the efforts of the Indonesian government's Family Planning Board.

Despite their usefulness, both of these financial intermediaries had to be assisted by other partners. The process of reaching midwives was facilitated by the Indonesian Midwives Association (IBI), which informed its member midwives about the availability of the loans and assisted midwives in the completing the formal loan application process. In addition, IBI personnel helped create among borrowers the expectation that the loans had to be repaid in order for other borrowers to gain access to the fund. In the case of BCGC, the marketing and outreach effort was made difficult by the fact that one partner, the Philippines Medical Association, did not actively market the program to its members because its leaders were opposed to family planning on religious grounds. This lack of support made it difficult to reach potential borrowers and forced PROFIT to discontinue the subproject after a year.

### ***Environmental and Design Factors***

PROFIT's subprojects were also affected by environmental factors specific to the country or the nature of the activities.

- ◆ Country environments: A pervasive influence on all of PROFIT's efforts were the public sector policies toward family planning, the role of the private sector, and the general economic conditions. For example, in Indonesia, PROFIT encountered a supportive public sector which favored engagement of the private sector in family planning activities. In Mexico, the preponderance of public sector activities limited commercial organizations' opportunities in family planning. In Russia, PROFIT had to deal with a chaotic and nascent private sector, which inhibited foreign investment and commercial operations. While PROFIT pursued activities in all these countries, its success in developing and implementing subprojects was directly tied to these basic policy and macroeconomic conditions.
- ◆ USAID's role: USAID played both a facilitating and constraining role in the implementation of PROFIT's partnerships. In many cases, USAID missions were eager to build alliances with the commercial sector to implement their programs and saw PROFIT as a "bridge" to the commercial sector. Other missions were less receptive to PROFIT's efforts, often because they had little or no experience with such organizations and did not entirely trust the commercial sector's motivations. Similarly, some missions felt that commercial partnerships did not provide them with adequate control over the eventual implementation of programs, particularly in contrast with programs managed through NGOs or traditional family planning projects.

Because the missions had oversight over PROFIT's activities, mission personnel made the ultimate choices of subprojects and partners. In certain cases,

## The PROFIT Model for Implementing Partnerships

the mission played an influential role in defining the direction of PROFIT's subprojects, such as focusing on health insurance issues or assisting NGOs. Periodic changes in USAID mission staff sometimes resulted in different "marching orders" for PROFIT. Thus, PROFIT's collaboration with the commercial sector in certain countries reflected the predisposition of mission staff members more than an overall strategy for the mission's family planning portfolio.

USAID missions often felt under pressure to show concrete results in terms of family planning impact. Because many of PROFIT's subprojects did not achieve immediate gains in service delivery statistics, they were often targeted for scrutiny or termination, even in cases when the missions were not funding the activity. Thus, there was incompatibility between the missions' need to achieve tangible outputs and the longer-term approaches typical of commercial sector interventions.

USAID contractual regulations also impeded implementation efforts on a number of fronts. First, commercial partners were required to adhere to USAID procurement procedures, which required purchase of U.S.-manufactured equipment and/or vehicles and thereby raised the subproject's implementation costs. On distribution subprojects, PROFIT partners were required to market U.S.-made contraceptives, ostensibly for quality reasons. However, PROFIT was precluded from directly financing the procurement of contraceptives because of USAID's policy for central procurement of all family planning commodities. Therefore, PROFIT had to use other means to obtain contraceptives, including obtaining external financing and or negotiating consignment arrangements with manufacturers. These arrangements entailed delays and high costs for PROFIT distribution subprojects in Brazil and Russia.

- ◆ Commitment to subproject strategies: PROFIT's efforts were enhanced when the partners themselves were responsible for designing and implementing the strategies for their subprojects. In Zimbabwe, PROFIT utilized a participatory approach to enable private providers and employers to identify constraints to their participation in provision of family planning services. They formulated specific technical assistance needs and programs to address their need for training, financial resources, and equipment. By taking responsibility for defining and addressing their own needs, the beneficiaries became the owners of the partnerships, rather than passive recipients of external assistance.

Commitment to partnerships also involves building consensus among multiple parties in both the private sector and the public sector. In Indonesia, the success of PROFIT's loan fund was dependent on the positive involvement of all three partners: the Indonesia Midwives Association, BRI, and the Indonesia Family Planning Board. The process of building consensus among these partners was time-consuming, but it was essential to the subproject's success. It also facilitated a transition of the management of the loan fund to the partners, which will enable the fund to continue after the end of the PROFIT Project in September 1997.

## The PROFIT Model for Implementing Partnerships

- ◆ Technical assistance: The majority of PROFIT's partnerships benefited from technical assistance, particularly training on technical issues, such as family planning service delivery, contraceptive technology, communications skills, business management, and managed health care concepts. Without this technical assistance, which was generally provided at no cost to the partners, the subproject's family planning components would not have received adequate attention and emphasis. PROFIT had access to other USAID projects and consultants, which provided accurate and useful training that enabled PROFIT's partners to effectively implement the family planning components of the subprojects.

## IMPLICATIONS FOR FUTURE EFFORTS

PROFIT's experience in establishing and implementing partnerships with commercial organizations points to a number of broad issues that need to be addressed.

### 1) *Clear Objectives*

PROFIT pursued partnerships with commercial sector organizations largely to take advantage of profit-making opportunities or business-enhancing activities, as perceived by its partners. In only a few instances did PROFIT or its partners pursue activities that had limited prospects for commercial sustainability purely for philanthropic reasons or as a social investment. Indeed, partners dropped potential subprojects when their business interests were not being served or when they perceived the business risks to be too high.

Successful partnerships with the commercial sector in the area of family planning require that the profit or business motivations be paramount. This fundamental requirement may pose difficulties for donors, such as USAID, that look to such partnerships to achieve social objectives. Satisfying both business and social objectives is made more difficult when the partnership seeks to serve the poor who do lack the means to pay for family planning through private providers or suppliers — population segments that USAID regularly targets. Although the commercial sector can and does serve the needs of middle-class and even lower-middle-class clients in the absence of market imperfections or distortions, commercial firms will be unlikely to enter into partnerships that target poorer clientele because these are not normally financially feasible.

The interim objective of shifting middle-class or lower-middle-class clients from public sector sources to the commercial sector can work, over time, but it requires that public sector cooperation to ensure that the commercial sector is not undercut. When the commercial sector faces no barriers to providing services and can recover its costs and make a reasonable profit, it will serve those clients who can afford to pay. The real challenge for donors and public sector agencies is to facilitate the commercial sector's ability to do so.

## The PROFIT Model for Implementing Partnerships

Partnerships that involve commercial sector subsidies for programs or services previously supported by the public sector will not succeed. The private sector will not play this role, other than for philanthropic or charitable reasons. Over the long-term, a commercial firm will only enter into partnerships that offer a reasonable prospect of enhancing its business interests and making a profit. Efforts to shift the costs of public sector programs to the commercial sector do not provide a sustainable basis for building public-private partnerships.

### 2) *Support for Partnerships*

Donors must support their commercial sector partners and, to do so, must understand their business needs. PROFIT's experience showed that commercial partners require the following types of support:

- ◆ Financial resources when subprojects carry higher-than-average risks: Partners expect financing to be made available through preferential terms, since commercial sources of financing might not normally underwrite risky activities. Partners can and do provide their share of resources (financial and in-kind), but the donor contribution is often the key to their participation in innovative subprojects.
- ◆ Technical support to facilitate implementation of innovative subprojects: This is critical, particularly to enhance family planning activities through technical training, communications skills, business management, and information systems. Partners consider technical support to be essential when the business motives are apparent but may resist technical support that they perceive to be donor-driven, especially if it offers only minimal business value. For example, physicians resist general family planning training because they perceive it to have limited benefits for attracting clients. Donors should fund such technical support because it is essential for attaining their overall program objectives, although some partners are willing to share the costs (particularly if they help select and design the training).
- ◆ Flexible use of financial resources, especially for equipment or commodity purchases: In many cases, the funding is to be repaid by the partners, and they want to make purchasing decisions based on economic justifications rather than restrictions imposed by USAID.
- ◆ Assistance in developing subprojects, particularly to ensure the financial viability of the activity: Partners understand the need for feasibility studies, market research, and other studies, and they have an interest in determining how these studies are carried out and how they are utilized or interpreted. In many cases, partners are not as risk-averse as donors once they have such market research, which they often view as a tool for fine-tuning a subproject rather than the basis for making a decision to proceed or halt a subproject.

## The PROFIT Model for Implementing Partnerships

- ◆ Ongoing involvement and interest by the donor or its implementing agency without micro-management of business decisions: Delineating donors' and partners' spheres of influence is difficult, but partners generally view the donor's role to be facilitation rather than hands-on control. Donors cannot assume this role without sacrificing one of their main objectives for partnering with commercial organizations — namely, that commercial firms are managed to achieve financial results. Donors can play a positive role by ensuring that their partners receive management or technical support they need and allowing the partners to manage their business affairs with maximum leeway.
- ◆ Appropriate measures for assessing the progress of donor-driven initiatives or components, such as the status of family planning services: Partners realize that donors have specific social objectives that need to be measured or monitored. Donors must assist partners to expand or improve their systems for collecting such data. Such processes should have a business-driven rationale in addition to meeting the donor's information needs in order to facilitate the partner's participation in and support of data collection efforts.

### **3) Appropriate Roles**

In addition to the financial and technical support that USAID and its implementing agencies can provide to partners, all parties have broader roles to play in formulating and implementing commercial partnerships.

#### USAID's Role

USAID should continue to champion the involvement of the commercial sector in social services, such as family planning, despite traditional attitudes that these services are the responsibility of public agencies or NGOs. Many commercial organizations undertake philanthropic activities or social investments, but commercial activities will be sustainable over time only if they are based on business motivations and are supported by donors on this basis.

USAID must continue to view its support for commercial activities to be in the service of those who are able and willing to pay for private services and products. By meeting the needs of such people through the commercial sector, donors and public sector agencies will be better able to serve those who must rely on free or largely subsidized services and products.

To support this effort, USAID must educate its personnel about the positive contributions the commercial sector can make play in social areas and must reinforce this point by ensuring that public programs do not "crowd out" the participation of the commercial sector.

Finally, USAID and other donors must take a longer-term perspective regarding the achievement of development or social objectives through commercial sector initiatives. Some

## The PROFIT Model for Implementing Partnerships

initiatives may fail, either financially or technically. It may take longer to realize the social objectives because of a lack of consumer interest or an willingness to pay for services or products that can be obtained elsewhere for free. Or the partners may be unable to implement the social components because they lack the resources or commitment. Only a consistent effort to support commercial initiatives will yield success.

### Implementing Agencies

Implementing agencies bear responsibility for enhancing the participation of commercial sector entities in their projects. Even when projects have no “private sector component,” implementing agencies should inform themselves about the commercial sector’s role in the activities they are supporting — which may directly compete with the activities of private providers or commercial organizations. Familiarity with commercial sector organizations can lead to collaboration (even on a nonprofit basis) and, over time, to fully commercial delivery of some services or products.

Implementing agencies often mistrust commercial organizations because they fear that their profit-led motivations may lead them to give less attention to social objectives. Such fears underscore the need for commercial partnerships to be formed around the delivery of services and products that serve the compatible objectives of both partners.

Beyond this, implementing agencies must have the technical and business acumen to enter into partnerships with commercial organizations. A great deal of the work involved in forming partnerships centers on assessing potential partners — examining their financial positions and requirements, their track records and level of commitment, and their ability to manage new or innovative subprojects. Too often, implementing agencies rely on technical specialists (in health or other social disciplines) who have insufficient business experience.

### Commercial Organizations

As partners, commercial organizations must understand that they are part of a relatively new type of collaborative relationship with donors and implementing agencies. This relationship makes them more than a vendor or subcontractor and requires them to share the risks, costs, and responsibility for success or failure. To make this type of collaborative arrangement work, commercial organizations must be frank about what they are prepared to do to advance social objectives and must assess whether their proposed activities meet the needs of donors over time. This requires that they realistically assess their internal resources, staff capabilities, and corporate commitments. PROFIT often had to enhance the management skills of its partners in order to implement subprojects or had to push them to implement their subprojects when they concluded that they no longer served their corporate priorities.

Partners also must be prepared to take risks and to expand the reach of their services and activities in order to serve the populations that donors target. This requires forward thinking on the part of management and a willingness to work in ways that may be new to the

## The PROFIT Model for Implementing Partnerships

organization. Collaboration with donors also means adopting new reporting requirements and meeting the expectations of stakeholders other than senior managers or owners. For such initiatives to succeed, commercial organizations must devote sufficient staff time and resources and must be willing to educate their partners (donors, implementing agencies) about the progress of the subprojects and how social objectives are being met.

## **7. Selected PROFIT Research and Studies In Brief**

**This section includes briefs on selected PROFIT  
research and activities.**

## Perspectives on Commercial Sector Involvement in Family Planning Services

A Summary of: Linda Griffin Kean. *Summary Proceedings: Invitational Meeting of Experts on Opportunities for Commercial Sector Involvement in Developing Country Family Planning Services.* (Arlington, VA: PROFIT, October 1996).

*In October 1996, PROFIT sponsored a small meeting of experts to exchange ideas and information on commercial sector involvement in delivering family planning services in developing countries. The meeting centered on sharing ideas, advice, lessons, and strategies, not on building consensus. The focus was on the commercial sector, not on nongovernmental organizations (NGOs), and the discussion was meant to be relevant to the delivery of family planning services, not commodities. The participants identified three compelling reasons for involving the commercial sector in family planning: to help private providers gain market share in order to transfer those patients who can pay for services to the private sector from the public sector; to improve the quality of services; and to motivate private providers to provide preventive as well as curative services. To be feasible, a donor program that involves the commercial sector should pass a "dual litmus test": the program must serve the interests of the private sector in order to be profitable, and the program must serve the public good in order for the donor to be involved.*

PROFIT convened a small meeting of experts in October 1996 to facilitate an exchange of ideas and information on commercial sector involvement in delivering family planning services in developing countries. The purpose of the meeting was twofold: to facilitate an exchange of ideas and information on working with the commercial sector in delivering family planning services in developing countries, and to distill recommendations about which, if any, strategies warrant pursuit in the future by the U.S. Agency for International Development (USAID) and other donors. What follows are excerpts from the discussion about several key questions addressed by the meeting participants.

**Deloitte Touche  
Tohmatsu**



The key questions about commercial sector involvement in delivering family planning services in developing countries addressed were:

- What are the most compelling reasons for involving the commercial sector in family planning services?
- What is the range of expectations for commercial sector involvement?
- What are the requisites for success for programs seeking to involve the commercial sector in family planning services?
- What approaches have been tried?
- What are the pros and cons of each approach?
- What promising approaches have yet to be tried?

## **Compelling Reasons for Commercial Sector Involvement**

Historically, there have been three compelling reasons for involving the commercial sector, and they all relate to public goods:

- to help private providers gain market share in order to transfer those patients who can pay for services to private sector providers and away from government
- to improve the quality of services offered by private providers — some of the least effective efforts to do this have involved direct government intervention; some of the most effective have addressed barriers to quality
- to motivate private providers who offer the whole range of curative services to provide preventive services, which they can often add easily and cheaply.

In areas where the private commercial sector can and is serving the market, the most important thing for the public sector to do, including the donor community, is to get out of the way. Where there are regulatory and other obstacles that impede the commercial sector, the donors can study and attempt to eliminate them.

By engaging the commercial sector, donors can enlarge choices for consumers, offer them better-quality services in many cases, and lessen their reliance on constrained public sector resources.

## **Expectations for Commercial Sector Involvement**

Donors tend to overlook commercial firms' expectations of the public sector. Donors need to find out what the hook is for them to participate in donor programs.

Delivering family planning services within the context of health sector reform means including family planning within an essential package of health services and working to improve access to high-quality, cost-effective health care in general.

There is a need to move toward sector-wide approaches, away from targeted interventions. In health, the key sectoral issues include financial sustainability, cost-effectiveness, and the link between what donors are doing in a specific sector and the macroeconomic environment.

There are four components involved in examining the appropriate role for the public sector: public provision of care, public financing, regulation, and information.

Commercial banks look upon private health enterprises as risky, and donors may be able to do more to build networks of private enterprises and to assist these enterprises in dealing with the public sector.

The role of the public sector should be to guarantee universal access to a basic package of essential health services.

Having the public sector guarantee an essential package of health services does not necessarily mean that the public sector must provide those services. In fact, the most effective way to guarantee an essential package of services may be for the public sector to use regulatory, financial, and informational mechanisms to help the private sector provide those services.

For the most part, the public sector should not be providing care.

Provision of services to the poorest of the poor is one of the most corruptible areas of public provision. However, if the public sector is to move away from providing care to the poor, subsidies must be shifted from the supply side to the demand side.

If you accept that serving the poorest of the poor is never going to be financially sustainable and that the public sector is going to pay for care for the poor, then the objective is to minimize costs. Donors could set the capitation rates, set quality standards, and either pay for services directly or give the money to governments and let them contract for services.

In countries that are changing rapidly, the lines between the commercial, nonprofit, and public sectors are becoming very blurred. In fact, it's becoming increasingly common for commercial firms to measure ventures not just by the profit motive, but also by the benefits to their stakeholders, which include employees, clients, and communities. NGOs are shifting to become "social enterprises" — organizations that make a profit but don't distribute it the way that commercial sector firms do.

There are two issues of sustainability: the sustainability of service delivery, and the sustainability of inputs to keep private practitioners in business — e.g., training or the supply of commodities.

## Requisites for Success

To be feasible, a program should pass the “dual litmus test”:

- The program must serve the interests of the private sector in order to be profitable.
- The program must serve the public good in order for donors to be involved.

Family planning must be integrated into general maternal and child health services — certainly into preventive and perhaps also into curative services — if they're going to be more viable and more interesting to the private sector.

Private sector firms can compete with public sector services, but they must have the capacity to build the market — to do the consumer research, to understand the market, to develop the marketing plan, all of which is very expensive.

One requisite for successful commercial sector involvement is for the public sector to share information about the existence of a market (e.g., public procurement plans for a particular product) with commercial companies.

Donors could make a useful contribution by picking up the brand-name marketing costs of delivering family planning, in order to bring products and services to the attention of the public and to increase demand.

Firms are always divesting themselves of products that are not central to their markets, even if they are profitable. If family planning is central to serving the market, providers will continue to deliver it.

There is an inherent logic to the idea of integrating family planning into broad maternal and child health services, but focusing services may be much more important to profitability, because of the amount of time involved in trying to develop markets on a number of different fronts.

Linda Griffin Kean. *Summary Proceedings: Invitational Meeting of Experts on Opportunities for Commercial Sector Involvement in Developing Country Family Planning Services*. (Arlington, VA: PROFIT, October 1996).

# PROFIT

Promoting Financial Investments and Transfers  
to Involve the Commercial Sector in Family Planning

1925 N. Lynn Street  
Arlington, Virginia 22209

Telephone: (703) 276-0220  
Facsimile: (703) 276-8213

# IN BRIEF

## Mobilizing the Resources of the For-Profit Sector for Family Planning

A Summary of: David Logan, Matthew Friedman, and Marianne Lown, *Mobilizing the Resources of the For-Profit Sector to Support the Expansion of Family Planning Services in the Developing World*. (Arlington, VA: Population and Technical Assistance Project (POPTECH), December 1989).

*Efforts to enlist the for-profit sector in programs to increase access to family planning services in the developing world and to transfer the costs of such services from the public to the private sector should target three groups. First, the organized employment sector should be encouraged to provide family planning services to their employees. Second, service providers — including insurance companies, health maintenance organizations, medical personnel, and microbusiness initiatives — should be encouraged to include family planning in the mix of health services they provide. In addition, the market for these services should be expanded and the quality improved. Finally, the resources of for-profit commercial entities should be leveraged to expand and supply the market for family planning. These resources include corporations' ability to use political and public advocacy, sponsor educational events, generate media coverage, make cash and in-kind contributions, and leverage their financial assets. (PROFIT has re-issued this paper because of its strong influence on the early design of the project.)*

Starting in the mid-1970s, the U.S. Agency for International Development (USAID) and other donors sought to create new alliances with private businesses to increase access to family planning. This was done primarily through social marketing projects such as the Enterprise Project (1985-1990) and the Technical Information on Population for the Private Sector (TIPPS) Project (1985-1990). This paper draws on the experiences of these projects to outline a plan to enlist the resources of the for-profit sector to increase access to family planning services and to transfer more of the costs of those services from the public to the private sector. This paper provided the framework for the early design of PROFIT.

**Deloitte Touche  
Tohmatsu**



Deloitte Touche Tohmatsu International  
in association with:

Boston University Center for International Health Multinational Strategies, Inc. Development Associates, Inc. Family Health International

108

The paper divides for-profit businesses into three broad categories:

- **Companies as Employers:** Some types of companies can realize significant cost savings by providing family planning services as a benefit to their employees, even when the full costs are met by the company. However, many more companies are concerned about the health of their employees, even without the potential for cost savings.
- **Family Planning Service Providers:** Insurance companies, health maintenance organizations, medical personnel, and microbusiness entities provide health and family planning services to the public on a commercial basis. These providers seek to increase their markets, gain a competitive advantage, and boost their profitability.
- **Companies as Corporate Citizens:** The for-profit sector has the resources to voluntarily contribute to the growth of family planning services as part of a country's overall development — ranging from political lobbying, to cash and in-kind donations, to sponsorship of events and activities that promote family planning.

## **Lessons Learned**

### **External Factors**

- The success of a for-profit project can be significantly affected by external factors such as the existence of macroeconomic conditions favorable to private business, the host government's support for family planning, cultural and religious barriers to family planning, policies that facilitate program activities, and the lack of restrictive regulations, among others.

### **Project Design**

- When working to incorporate family planning into various for-profit settings, a significant amount of time must be allocated to brokering, negotiating, and consulting with the companies and service providers involved and with the governmental agencies that regulate them.
- If cost-efficiency is not stressed in a project's design, there will be little incentive for project managers to place a high priority on managing resources cost-effectively.

### **Market Segmentation**

- Programs must carefully "map" the for-profit sector into different areas of activity.
- Project staff must learn the for-profit sector's motives, methods, and styles of operation.

### **Building Partnerships**

- Success in working with the for-profit sector requires a business-like style that mirrors the operating styles and procedures of private businesses.
- Private sector partners can be most successfully approached from a business perspective: a project should make financial sense for them, and cost-benefit analysis is an effective tool for showing them the potential benefits of participating.
- Senior company managers are often just as impressed by the prospect of potential health benefits to their employees as they are by demonstrated cost savings.
- Initiating and sustaining employee-based family planning programs requires participation at all corporate levels.
- Knowledge, attitudes, and practice (KAP) surveys are essential for showing corporate leaders the advantages of providing family planning services.

### **Service Delivery**

- Once a company has been convinced to provide family planning services for its employees, the resources and skills must be made available for swift service delivery.
- Private service providers (for-profit and nonprofit) often require extensive technical support to develop and implement family planning activities and to manage their organizations.

### **Staffing/Management**

- People with a blend of for-profit and public sector experience should be in key management positions and should comprise a major portion of a project's staff.
- The ability of staff to be flexible and to make rapid site decisions is crucial to building effective working relationships and to a project's success.

### **Sustainability**

- For-profit programs do not address the needs of the poorest groups, but they do help institutionalize programs that can free resources to address more urgent needs.
- Private sector participants can support a project by paying for training, marketing, materials, or other costs.

## Goals and Objectives of Future Work with the For-Profit Sector

The primary goal of USAID's efforts in the for-profit sector should be to achieve the greatest for-profit sector contribution to the support and funding of family planning services in developing countries. USAID must also strive to transfer to host countries the concepts, technologies, and experience necessary to mobilize the for-profit sector in support of family planning. Each intervention should be cost-efficient, and efforts should be made to achieve quantifiable resource and service delivery gains.

The key objectives for mobilizing the for-profit sector can be grouped under three headings, which should normally be undertaken in this order:

- **Policy/Behavior Change:** No real progress can be made in for-profit family planning activities unless, by argument and example, policy and attitudinal changes can be made that create a commitment to action to expand family planning among private enterprises, private voluntary organizations, and governments and their agencies.
- **Financing:** New resources must be enlisted from for-profit and comparable public sector entities to support family planning programs, in particular, through transferring the cost of services from the public to private sector, ensuring that family planning programs are financially sustainable, and capitalizing on success to leverage more resources.
- **Service Delivery:** Tangible improvements in the provision of family planning services are a high priority, particularly to increase public awareness and acceptance, increase access, improve the quality of services, and increase contraceptive prevalence.

These objectives should be sought by concentrating on the three target groups identified above: companies as employers, family planning service providers, and companies as corporate citizens. It is important to identify which measures of success relate to which activities. Lessons about what works should be incorporated into future program decision-making and design. Even those efforts that fail can provide valuable knowledge about working with the for-profit sector.

David Logan, Matthew Friedman, and Marianne Lown, *Mobilizing the Resources of the For-Profit Sector to Support the Expansion of Family Planning Services in the Developing World*. Occasional Paper No. 3. Arlington, VA: Population Technical Assistance Project (POPTECH), December 1989. Re-issued by the PROFIT Project, Arlington, VA.

111

# PROFIT

Promoting Financial Investments and Transfers  
to Involve the Commercial Sector in Family Planning

1925 N. Lynn Street  
Arlington, Virginia 22209

Telephone: (703) 276-0220  
Facsimile: (703) 276-8213

# IN BRIEF

## Leveraging Mechanisms

A Summary of: *Leveraging Mechanisms*. (Arlington, VA: PROFIT Project, September 1997).

*Reductions in donor funding for international development activities have made leveraging a key objective for both donors and implementing organizations. Among the strategies that have been used are loans, guarantees, equity financing, debt conversions, co-financing, and cost-sharing. These mechanisms are viable and important means to help increase the funding available to achieve key development objectives, but they should not be pursued solely to create financial leverage. Donors and implementing organizations should continue to focus their attention and resources on achieving their overall programmatic objectives and should employ these leveraging mechanisms only when they clearly contribute to those objectives.*

Over the past twenty years, official development assistance has not kept pace with increasing worldwide demand. To respond to this challenge, donors have used a variety of financial mechanisms to leverage their limited resources. Leveraging mechanisms allow donors and other organizations involved in international development to supplement donor funding with inputs from other project participants and partners, such as commercial banks or entrepreneurs, and thereby to expand the total funding available for development activities. This paper examines the most common leveraging mechanisms: loans, guarantees, equity financing, debt conversion, co-financing, and cost-sharing.

### Loan Programs

Loan programs are employed to provide funding to a given sector of the economy that may not have access to formal financing sources, typically to expand commercial or economic activity among certain target sectors such as small businesses. Loan programs are particularly effective because they target funding to a particular beneficiary group and because they can leverage donor resources. The leveraging occurs when the funds that are lent are subsequently repaid and relented to new borrowers. Each time the original funds are

**Deloitte Touche  
Tohmatsu**



Deloitte Touche Tohmatsu International  
in association with:

Boston University Center for International Health Multinational Strategies, Inc. Development Associates, Inc. Family Health International

112

recycled, the donor has effectively leveraged the reach of its funds by 100 percent. In some cases, the funds are lent in conjunction with other technical or business training, which often increases the borrowers' ability to use the capital efficiently. Two types of loan programs are often used by donors:

- **On-Lending Programs:** On-lending is when a donor lends to one or more institutions that then pass the funds on by lending to target borrowers. On-lending programs achieve leverage in two ways. First, participating institutions are usually required to lend their own funds as well as donor funds, thereby increasing the overall pool of funding to borrowers. Second, funds are recycled through repayments. Donors generally make a loan or grant to a management or "apex" entity (usually within a host government ministry or the central bank), which subsequently lends the funds through the formal banking system.
- **Loan Funds:** Loan funds function much like on-lending programs in that they normally target particular sectors of the economy (e.g., agro-businesses) or classes of borrowers (e.g., private physicians). However, loan funds tend to be administered by only one lending institution rather than by multiple organizations or through an apex arrangement.

## **Guarantees and Guarantee Funds**

Loan guarantees are credit instruments that are issued by a donor or financial institution to guarantee payment of a loan on behalf of its customers to a beneficiary, normally a third party, for a stated period of time and under certain conditions. Donors use guarantees to increase credit flows through normal commercial banking channels to groups or individuals who are considered high credit risks and who therefore lack access to capital. In addition, guarantees are used to mobilize funding from local sources for a particular project by providing local investors with some cushion against potential risks. Usually, the guarantor agrees to cover a percentage of the principal, although some guarantees cover a percentage of principal and interest.

## **Equity Financing**

Equity financing represents a more complex way to provide funding to development projects. In essence, equity financing is the provision of capital through a direct ownership stake in a company or project. Equity financing can leverage donor funds by attracting other funding, such as commercial bank loans and guarantees, as well as financial resources from entrepreneurs who are setting up new projects or companies. Leveraging can also occur if the projects are successful and the equity share yields large dividends or a sizable payoff for the organization.

## **Debt Conversions**

When developing countries became unable in the 1980s to service their outstanding debt to commercial banks (primarily in Western Europe and the United States), the debt was

sold at a discount to other banks or organizations. These groups then negotiated favorable terms with developing countries to convert the debt instruments into local currency or assets in the debtor countries. One of the most popular conversion techniques was debt-for-equity conversions or swaps, which subsequently led to debt-for-development transactions involving nongovernmental organizations (NGOs). The NGO purchased debt on the secondary market and exchanged the debt with central bank authorities in a particular developing country at a prearranged exchange rate. The central bank paid the NGO in local currency, and the NGO used the proceeds to finance development projects, particularly in environmental conservation, health, or education. Debt conversion programs of all types have declined in recent years, and many debt traders and analysts currently view the opportunities for debt-for-development to be quite limited as a result of rapid changes in the emerging markets. These limitations, coupled with the high transaction costs, long negotiation periods, and large amounts of paperwork, make such transactions much less attractive to most NGOs than in the past.

## Co-Financing

Co-financing involves joint or parallel funding of specific projects by a number of donors. The financing takes the form of loans, guarantees, or grants. Co-financing arrangements are usually structured either as joint financing (i.e., financing in agreed portions) or as parallel financing (i.e., financing of different components or different goods and services). The leveraging effect from co-financing is limited unless it can be shown to entice other donors to support a given project.

## Cost-Sharing

Cost-sharing occurs when an organization, such as an NGO, is able to encourage other donors or private sector organizations to donate in-kind contributions of commodities or services to a project. Cost-sharing falls outside the strict definition of financial leveraging, but it can be used to leverage commodities, equipment, the use of assets such as buildings, lobbying support, human resources, and services. Cost-sharing provides greater exposure for a project within the community and may thereby attract more support, new funding, or in-kind resources. This type of leveraging also has been employed by organizations that face decreased support from traditional donors.

## Factors for Success

There are several key factors that affect the success of leveraging mechanisms:

- **Partners:** The institutions and organizations involved in developing and implementing the mechanism are critical to the success of any financial leveraging activity. An institution's track record, management capabilities, and commitment to a particular development objective must be considered.

114

- **Leveraging Potential:** The potential for financial gain must be weighed against the risk of losses to the beneficiaries, donors, lenders, or other partners.
- **Control:** The use of leveraging mechanisms affects donors' control over a particular project, particularly the use of donor funds and the ability to reach the intended beneficiaries. Donors should carefully consider the potential that their control may be limited and should develop appropriate monitoring mechanisms.
- **Costs:** The costs to donors, lenders, or other financial partners include the transaction costs (including the cost of assessing and developing the program), the implementation costs, and the costs of technical assistance or training. These should be realistically estimated and weighed against the potential gains.
- **Timing:** The time needed to launch a leveraging program and the time that will elapse before any gains are realized will differ considerably for each mechanism.
- **Limitations:** Certain mechanisms are appropriate and effective only under certain conditions. Donors should carefully assess whether the necessary preconditions are met and whether the overall environment is conducive to success.

## Strategies for the Future

Leveraging mechanisms should be viewed primarily as tools to achieve broader development objectives. Although their use may be an appropriate and effective means to augment diminishing development funds, they should be used only if they further the overall development objectives of an organization or program. Donors and implementing agencies that consider options for leveraging their limited funds must assess whether a particular leveraging mechanism is appropriate, whether the potential financial gains outweigh the costs, and whether the effort stands a reasonable chance of success. Fundamentally, however, they must determine whether the use of such mechanisms is the most effective and efficient means to pursue their broader goals and objectives.

# PROFIT

Promoting Financial Investments and Transfers  
to Involve the Commercial Sector in Family Planning

1925 N. Lynn Street  
Arlington, Virginia 22209

Telephone: (703) 276-0220  
Facsimile: (703) 276-8213

# IN BRIEF

## Debt Conversion Transactions: An Update

A Summary of: Debt Conversion Transaction Update. (Arlington, VA: PROFIT Project, June 1997).

*When the PROFIT Project was developed in 1989, debt conversion was seen as a new way to leverage resources in highly indebted countries, and its use was incorporated into PROFIT's mandate to help leverage the resources provided to its subprojects. The use of such debt conversion techniques as debt-for-equity, debt-for-nature, or debt-for-development swaps peaked in 1990 and has fallen sharply since 1992, due largely to changing market conditions. In particular, the international response to the debt crisis — including the Brady Plan and the continual Paris Club restructurings — has reduced the indebtedness of many developing countries. This has raised the price (by lowering the discounts) on debt available in the secondary market and therefore has limited the potential gains from conversion transactions. Furthermore, the fact that many developing countries have reduced their debt to sustainable levels means they have fewer incentives to seek debt conversion.*

The use of such debt conversion techniques as debt-for-equity, debt-for-nature, or debt-for-development swaps increased rapidly after the first debt-for-equity program was initiated by Chile in 1985. Debt-for-development activities peaked in 1990 at \$27 billion and have declined since 1992, mainly due to changes in market conditions. In particular, the price of the debt on the secondary markets has risen (i.e., the discount has decreased), reducing the potential gains that can be captured through conversion transactions. Also, a large proportion of debt conversion activity was linked to privatization programs in the developing countries, and these activities are being wrapped up. In fact, several countries have swapped their collateralized Brady Bonds for uncollateralized debt in recent years. Finally, the debt relief operations undertaken as part of the Brady Plan in the late 1980s and early 1990s have helped many indebted countries to improve their relations with commercial bank creditors, giving these countries more flexibility in managing their debt and reducing the incentives to seek debt conversion.

**Deloitte Touche  
Tohmatsu**



Deloitte Touche Tohmatsu International  
in association with:

Boston University Center for International Health Multinational Strategies, Inc. Development Associates, Inc. Family Health International

116

Under a debt conversion, an investor buys a country's outstanding debt on the secondary market at a discount off its face value. The investor then sells the debt instrument to the central bank of the debtor country for local currency at a negotiated price. The local currency is then invested in the debtor country, for example, to purchase assets or to fund development-related programs. The benefits of debt conversion are associated with two elements of the transaction: the *discount* on the debt available in the secondary market (compared to the face value) and the *premium* offered on the swap by the debtor country (compared to a simple foreign exchange transaction).

Debt conversions have been used by nongovernmental organizations (NGOs) to leverage the funds available for development projects in the debtor countries. However, conversion operations involve significant investments of time and resources on the part of the banks, NGOs, and other entities involved. There are now fewer opportunities for debt conversion due to rapid changes in emerging capital markets, and the profitability of such deals has been squeezed by high inflation and smaller discounts on debt in secondary markets. These factors, along with the high transaction costs, the lengthy negotiation periods involved, and the significant amounts of paperwork required, have made debt conversions much less attractive to most NGOs in recent years.

Nonetheless, some NGOs remain active in debt-for-development swaps. Three organizations in particular have been dominant: Finance for Development (FFD), New York Bay Company (which now owns FFD), and the United Nations Children's Fund (UNICEF). FFD and New York Bay conducted swap transactions involving \$391 million in debt, including \$29.7 million in 1996. The funds generated through these operations have been invested in health, population, agriculture, ecotourism, and low-income housing projects.

UNICEF has continued the debt-for-child-development programs it pioneered. By 1996, UNICEF had completed 22 transactions that led to debt reduction of \$199 million and generated local currency funds worth \$53 million. These funds were invested in programs to support primary education, women in development, improvements in primary health and sanitation, and aid for children in special need.

Debt conversion specialists generally recommend that, to be worthwhile, a transaction should carry a potential premium of at least 25–30 percent. In countries where the transaction costs are particularly high and the procedures for debt conversion are not well established, the potential premiums must be even higher to make the transactions worthwhile. As noted above, changes in the secondary market for debt have made it increasingly difficult to find opportunities that promise returns sufficient to cover the transaction costs. For this reason, debt-for-development swaps are now undertaken by the few organizations that have significant expertise in this area.

# PROFIT

Promoting Financial Investments and Transfers  
to Involve the Commercial Sector in Family Planning

1925 N. Lynn Street  
Arlington, Virginia 22209

Telephone: (703) 276-0220  
Facsimile: (703) 276-8213

# IN BRIEF

## Using Endowments for Financial Sustainability

A Summary of: *Endowments as a Tool for Financial Sustainability: A Manual for NGOs.* (Arlington, VA: PROFIT Project, 1993).

*Creating endowment funds is one of the financing mechanisms PROFIT has used to promote private sector involvement in family planning. An endowment is a sum of money that is invested to generate income. Endowments may provide nongovernmental organizations (NGOs) with a new source of reliable income, offer them greater flexibility in spending (particularly in dealing with emergencies), and improve their image among donors. However, having an endowment can lead some organizations to reduce the attention paid to planning and to raising other funds. Moreover, there is the risk that the principal will be devalued or that the income will be insufficient to offset the costs of establishing and managing the endowment. The first part of this manual outlines how NGOs — both for-profit and nonprofit — can determine whether creating an endowment will serve their financial needs. The second part of this manual offers practical guidelines for those organizations that decide to proceed. The guidelines cover four stages: First Steps, Developing the Implementation Plan, Putting the Plan into Action, and Helping the Endowment Grow.*

One of the objectives of the USAID-funded Promoting Financial Investments and Transfers (PROFIT) Project is to promote private sector family planning ventures through innovative financing mechanisms and investments. One mechanism PROFIT has used is creation of endowment funds. The first part of this manual assists nongovernmental organizations (NGOs) — both for-profit and nonprofit — in determining whether an endowment can help them meet their financial needs. The second part of the manual provides general guidelines for establishing, managing, and growing an endowment.

**Deloitte Touche  
Tohatsu**



Deloitte Touche Tohatsu International  
in association with:

Boston University Center for International Health Multinational Strategies, Inc. Development Associates, Inc. Family Health International

118

## What Is an Endowment?

An endowment is a sum of money that is invested to generate income. Usually, the principal must remain invested, while the income is spent or reinvested. The endowment may be restricted, meaning that the proceeds may be used only for specific purposes, or unrestricted, meaning that the proceeds may be used for any legitimate purpose.

Endowments can provide NGOs with a new source of reliable income, a means to increase principal, greater spending flexibility, and an enhanced ability to handle financial emergencies. They may also help improve an NGO's image among donors.

On the other hand, endowments may leave NGOs with less incentive to plan ahead or to raise other funds. In addition, the invested principal may produce low returns, the returns may not cover the costs of managing the endowment, or the principal may be devalued.

Organizations that assess whether to start an endowment should consider a number of factors that may affect their prospects for success. These factors fall into three categories:

- **Organizational Factors:** Several key characteristics of an organization will affect its ability to successfully use an endowment, including its long-range plans, reputation, staff composition (especially skills and experience), current financial resources and funding sources, and access to donors.
- **External Factors:** The general climate in which an NGO operates will have a significant impact on the advisability and feasibility of creating an endowment. This includes the laws, policies, and regulations that govern the organization's operations; the availability of donor funds and the conditions imposed on such funding; competition for funding by other, similar organizations; and the costs of establishing and managing an endowment.
- **Costs and Benefits:** The amount of work involved in starting and maintaining an endowment is substantial and may not be worthwhile for some organizations.

## Deciding to Create an Endowment

To decide whether to create an endowment, an organization must collect and analyze some basic information about its operating environment:

- the laws, policies, and regulations governing endowment structures and management
- which donors have given endowment funding to other NGOs or have policies that permit them to grant endowment funds
- the experiences and perspectives of donors and other NGOs
- the likely costs of acquiring the skills needed to establish and maintain an endowment.

This information will be used to answer two main questions:

1. What are the chances that the NGO can raise endowment funds?
2. Will the benefits be worth the costs?

The people who analyze the information gathered to answer these questions must possess a variety of skills, experience, and perspectives, and they must be able to devote sufficient time to the decision-making process. If they decide that the NGO should *not* create an endowment, they should identify the factors that were critical to their decision and determine whether these factors are within the NGO's control. If the determining factors are within the NGO's control, a strategy may be developed to improve the environment for an endowment in the future. If the determining factors are outside the NGO's control, a plan may be developed to revisit the issue when certain conditions change.

## **Establishing and Maintaining an Endowment**

The second part of the manual offers guidelines for those organizations that decide to create an endowment, organized into four stages: First Steps, Developing the Implementation Plan, Putting the Plan into Action, and Helping the Endowment Grow.

### **First Steps**

The NGO must first determine what type of endowment fund it will establish. This decision will reflect local and national laws, policies, and regulations, including those that govern permissible activities, investment options, management and reporting requirements, taxes, liability, and insurance. It must also reflect the interests, preferences, and policies of potential donors.

The organization must also determine how much money needs to be raised. This requires answering two questions:

1. What will be the cost of the activities to be supported by the endowment?
2. How large must the endowment be to generate enough income to cover those costs?

These calculations must be based on realistic and conservative projections about the costs of program activities, the expected rate of return on investments, and the rate of inflation. Unrealistic assumptions will lead to disappointment and may be taken by potential donors as a sign of financial irresponsibility.

There is no rule about how much income an endowment must generate to be worthwhile. Many NGOs consider the threshold to be a net return (after inflation and administrative costs) of 4–5 percent — or, annual income of \$40,000 to \$50,000 on a \$1 million fund.

### **Developing the Implementation Plan**

Outlining a plan for creating an endowment requires intensive work by people with

expertise and experience in several critical areas, including fundraising, establishing relationships with potential donors, strategic planning, marketing, public relations, communications, and general organizational management. The implementation plan should include the following components:

- general strategy
- investment policies
- legal and procedural requirements
- key informational documents and materials
- list of potential donors
- task list and assignments.

### **Implementing the Plan**

The NGO must assemble the people and resources needed to implement the plan and to monitor its progress. One member of the endowment planning group should be charged with tracking and reporting on completion of tasks and activities.

Monitoring progress is important for two reasons. First, if the overall strategy is not working or the informational materials are not clear and persuasive, they will need to be revised. Second, keeping donors informed may help leverage additional funding.

### **Helping the Endowment Grow**

After the endowment has been established, the NGO must turn its attention to maximizing the investment income, monitoring the costs of managing the endowment, tracking expenditures, and attracting additional funds or sources of funds. The implementation plan will have laid out basic guidelines about the role of the endowment managers and the acceptable levels of costs and risk. These guidelines should periodically be reviewed against performance to ensure that they continue to serve the NGO's best interests. Monitoring the expenditure of endowment income helps ensure compliance with the original endowment proposal, with subsequent funding agreements, and with the NGO's overall priorities. Disseminating information to donors about the organization's achievements helps to raise the NGO's visibility and reputation among donors.

*Endowments as a Tool for Financial Sustainability: A Manual for NGOs.* Arlington, VA: PROFIT Project, 1993.

## Conducting Regulatory Assessments for Commercial Sector Family Planning

A Summary of: Frank Feeley, *Practical Pointers for Conducting Commercial Sector Family Planning Regulatory Assessments..* (Arlington, VA: PROFIT Project, March 1997).

*Regulatory reform can be a critical component of efforts to increase the commercial sector's role in delivering family planning services, but no single strategy will work in every country. A thorough regulatory assessment will help identify which strategies will be most appropriate. Such an assessment should examine five areas: regulations that constrain contraceptive options; tax and import policies; advertising and promotion regulations; other regulations that affect the commercial sector; and restrictions on nonprofit organizations. PROFIT's experience provides three lessons for conducting a regulatory assessment. First, develop a clear understanding of what existing regulations say and what they do not say. Second, look beyond the written laws and regulations to understand how they are actually implemented and practiced. Finally, determine whether regulatory reform can have a meaningful effect on the commercial sector role in family planning by carefully studying existing patterns of contraceptive provision and use and relating them to the existing regulatory structure.*

As part of its efforts to expand commercial sector provision of family planning services in developing countries, the PROFIT Project has assessed the feasibility of a wide variety of potential subprojects. Part of this assessment process is a review of the regulatory environment in each potential host country.

Regulatory reform is an important component of efforts to increase the commercial sector's role in delivering family planning services, but no single strategy will work in every country. A thorough regulatory assessment will help to determine which

**Deloitte Touche  
Tohmatsu**



strategies will be most appropriate. For example, one strategy may be to open a dialogue among representatives of the commercial family planning sector and public health officials in order to identify barriers to increased commercial sector involvement in family planning and to attempt to reduce or eliminate them. Another strategy may be to aggressively lobby the government to eliminate regulatory barriers to effective delivery of family planning, such as import taxes on contraceptive commodities or regulations that restrict the ability of health care professionals to provide services. A third strategy may be to creatively work around the regulatory barriers in a particular environment.

Regulatory assessments should include five components:

- regulations that constrain contraceptive options
- tax and import policies
- advertising and promotion regulations
- other regulations that affect the commercial sector
- restrictions on nonprofit organizations

### **Practical Tips**

- Whenever your analysis points to a relevant regulation, get a copy and have it translated independently. Careful study of the text may suggest that the laws and regulations provide more or less flexibility than is exercised administratively.
- Use consistent questions with flexible follow-up across all the sources interviewed. Interviews must be designed to get consistent information, but the interviewer must respond promptly to statements that suggest inconsistencies or identify previously unrecognized requirements. Start with a list of questions, and try to cover all of them in the interview.
- Promptly document your interview notes. When your team splits up to interview different parties, the notes provide a way to share experiences. The notes also become the most important source for assembling recommendations and preparing a final report.
- Assess the impact of regulatory reform on providers based on the number and type of providers who would be affected. The importance of a particular regulation depends on the number of providers subject to it. However, it is difficult to get accurate estimates of the number of private providers within a particular category broken down by geographic location, and you may need to use two or three estimating techniques.
- Determine the licensing standards used for nonprofit and nongovernmental organization clinics. Regulatory policies can constrain the ability of nonprofit organizations to

provide family planning services, because these organizations are generally held to the same licensing standards as for-profit clinics or pharmacies. Explore with the regulators whether there is a possibility of granting exceptions to well-funded and well-managed nonprofit clinics. It is also important to determine if nonprofit organizations are treated differently under the laws governing corporate formation or taxation.

- Search for and understand the ramifications of unwritten, informal regulations. It is important to learn as much as possible about the standards actually used in inspections. If possible, accompany an inspector, or look at reports citing regulatory violations. It may be helpful to encourage the country to analyze the costs and benefits of such de facto standards and to explore whether a more lenient, alternative standard would provide an acceptable level of quality. If, as in some countries, the discretion left to inspectors is an invitation to corruption, then it may be necessary to consider including a revised and reasonable standard in written regulations.
- Consider the commercial needs of the private sector as you analyze regulations. It is important to understand the economic forces that drive the commercial sector and to suggest reforms that are consistent with these economic forces. Attempts to craft regulations that respect the economic realities facing commercial practices can improve providers' willingness to expand family planning services.
- Understand the ramifications of tax and trade barriers at the retail level. Importers and distributors are usually well-versed in current tax and trade issues. Determine the existing, as well as the historic effect of such barriers, including price controls and the effect of foreign exchange.
- Identify hidden advertising and promotion regulations related to family planning. Advertising and promotion regulations are often not well documented or stipulated. Even private media outlets may have unwritten policies about sensitive subjects such as contraception that reflect the opinions of the owners, advertisers, or readers. The best way to identify these unwritten policies is to talk to advertisers and advertising agencies about the problems they have faced in placing advertisements or public relations materials.
- Seek information from multiple perspectives. Laws may be written, but the implementing regulations may never be issued or may be enforced unevenly. Even where regulatory language appears explicit, there is often substantial room for administrative interpretation. It is important to understand the real regulatory climate faced by individuals or companies in the commodity production/distribution chain and in the provision of family planning services.
- Factor family planning survey data into the regulatory analysis. Review the most recent surveys of family planning practices, including the DHS (Demographic and Health Survey). These data should not only show the level of contraceptive knowledge and prevalence, but the current sources of supply for contraceptive users.

## CONCLUSIONS

Regulatory reform is an important component of efforts to increase the commercial sector's role in delivering family planning services, but no single strategy will work in every country. A thorough regulatory assessment will help to determine which strategies will be most appropriate. PROFIT's experience provides three lessons for conducting this type of assessment:

- Develop a clear understanding of what existing regulations do and do not say.
- Look beyond the written laws and regulations to understand how they are actually implemented and practiced.
- Determine whether regulatory reform can have a meaningful effect on the commercial sector role in family planning by carefully studying existing patterns of contraceptive provision and use and relating them to the existing regulatory structure.

Frank Feeley, Practical Pointers for Conducting Commercial Sector Family Planning Regulatory Assessments. (Arlington, VA: PROFIT Project, March 1997).

# PROFIT

Promoting Financial Investments and Transfers  
to Involve the Commercial Sector in Family Planning

1925 N. Lynn Street  
Arlington, Virginia 22209

Telephone: (703) 276-0220  
Facsimile: (703) 276-8213

# IN BRIEF

## Employer-Based Family Planning Projects

A Summary of: Eve E. Epstein, *Employer-Based Family Planning Projects: Past Guidance and Future Implications*. (Arlington, VA: PROFIT Project, June 1996).

*The U.S. Agency for International Development (USAID) has sought over the past decade to initiate and expand employer-based programs for delivering family planning services in selected countries. USAID initiatives have involved five basic intervention strategies, ranging from direct support (i.e., providing direct assistance and subsidies to employers) to indirect support (i.e., working through business and professional associations). This experience does not provide enough evidence to draw conclusions about which approaches are most effective for achieving donors' key objectives in this area, such as increasing contraceptive prevalence, averting births, reducing public expenditures, improving the method mix, or reaching underserved populations. However, recent experience suggests that future programs should focus on several key goals, including minimizing the provision of direct financial subsidies to employers, providing adequate and appropriate technical assistance, working through umbrella business organizations, and investing in long-term follow-up.*

The U.S. Agency for International Development (USAID) and other donors have encouraged and financed commercial family planning activities throughout the developing world, including initiatives designed to stimulate employer-based family planning service delivery. The Promoting Financial Investments and Transfers (PROFIT) Project (1991–1997) followed two other USAID projects that also sought to promote employer-based family planning projects — the Enterprise Project (1985–1990) and the Technical Information on Population for the Private Sector (TIPPS) Project (1985–1990).

**Deloitte Touche  
Tohmatsu**



Deloitte Touche Tohmatsu International  
in association with:

Boston University Center for International Health Multinational Strategies, Inc. Development Associates, Inc. Family Health International

126

These programs relied on five basic intervention strategies:

- providing direct technical and financial subsidies to employers
- conducting analyses of costs and benefits to employers
- linking private providers and employers
- mainstreaming family planning and/or maternal and child health (FP/MCH) services into managed health care systems
- working through business and professional associations.

These interventions also involved a variety of inputs and objectives, which makes it impossible to draw conclusions about which strategies were most effective. Nonetheless, the experiences of these projects provide a number of lessons about how employer-based programs operate and suggest some key principles for the design, implementation, and evaluation of similar programs in the future.

### **About Employers**

- Employer-based programming involves a significant corporate investment, with or without a subsidy, which requires that the program serves the interests of the employer.
- Introducing and/or expanding FP/MCH services requires a stable economic and business environment and the commitment of top and middle management.

### **About Health Insurance Providers and Managed Care Arrangements**

- Insurance companies are generally conservative and risk-averse and are not primarily motivated by social concerns, and therefore the opportunities for insurers and donors to collaborate — that is, areas where their interests intersect — are extremely limited.

### **About Linking Providers and Employers**

- Employers generally need specialized technical assistance to establish and maintain FP/MCH programs, even where company health clinics and services exist. Formal linkages between employers, nongovernmental organizations (NGOs), and hospitals can serve this need.

## **About Working through Umbrella Organizations**

- Working through umbrella business and professional organizations can help donors achieve economies of scale in costs and facilitate collaboration with employers.

## **About Program Design and Implementation**

- Most employer-based programs integrate family planning into other existing primary health and maternal and child health services.
- The typical three- to five-year duration of projects places real limitations on what can be achieved.
- An opportunistic, ad hoc approach to choosing employer-partners may be as good as or better than trying to use a rigid, framework-based approach.
- Technical assistance is virtually always a prerequisite to establishing employer-based services. It is less clear whether financial subsidies make a substantial contribution to the sustainability or replication of projects in the long run.
- Commercial insurers clearly need technical assistance and financial subsidies to minimize their financial risks.

## **About Evaluation**

- Definitive, scientific evaluation of the impact of employer-based programs is neither possible nor cost-effective at this time.
- Investment in long-term follow-up may be very beneficial in assessing programs' sustainability and replication.

## **Future Directions**

The idiosyncrasies of the business environment in various countries and the uniqueness of each employer's situation mean that flexibility and experimentation must be critical elements of employer-based family planning programs. Experience suggests that future frameworks should incorporate the following key goals:

- Broaden the area in which partners' and donors' objectives intersect.
- Minimize direct financial subsidies in light of the uncertain long-term results unless there is an overriding reason for subsidies, as in the case of reducing financial risks within the managed care arena.
- Carefully identify the partner's needs for technical assistance and help meet them.
- Facilitate provider-employer networks by brokering linkages among employers, other for-profit organizations, NGOs, and health care or managed care providers, focusing on those providers that require minimal technical or financial assistance.
- Enlist the cooperation of umbrella business and professional organizations that have the ability to stimulate participation among their members with relatively little support.
- Disseminate and explore the effectiveness of self-help tools to help employers initiate delivery of family planning and other health care services for employees.
- Engage private sector partners in activities that go beyond simple cost-sharing, which helps to weed out potential partners who are unwilling to risk their own funds.
- Broaden the types of partnership arrangements and help enable partners to carry out all responsibilities (e.g., start-up financing, quality service delivery, sales, outreach to new populations, etc.) through the use of creative subprojects, technical assistance, and brokered linkages with supportive organizations.
- Continue to integrate family planning into other employer-provided health services.
- Set feasible and appropriate objectives given the three- to five-year duration of most projects, and refrain from making comparisons among projects based on incomparable measurements.
- Gather only the data that is most appropriate and useful information for managing and assessing a project.
- Invest in long-term follow-up, particularly if the project is meant to be sustained or replicated.

Epstein, Eve E. *Employer-Based Family Planning Projects: Past Guidance and Future Implications*. Arlington, VA: PROFIT Project, June 1996.

# PROFIT

Promoting Financial Investments and Transfers  
to Involve the Commercial Sector in Family Planning

1925 N. Lynn Street  
Arlington, Virginia 22209

Telephone: (703) 276-0220  
Facsimile: (703) 276-8213

# IN BRIEF

## Perspectives on the Local Manufacture of Contraceptives

A Summary of: John Stanback, *Perspectives on Local Manufacture of Contraceptives in Developing Countries*. (Arlington, VA: PROFIT Project, June 1997).

*This report examines the issue of donors' support for the local manufacture of contraceptives in developing countries. Decisions about the feasibility and advisability of local manufacturing must be made on the basis of the factors specific to the particular project and location. Donors and manufacturers should assess not only the economic and technical feasibility of potential projects but also the social and political factors that may affect the success of the venture. These include the interests, motivations, actions, and interactions of those involved, including multinational and local pharmaceutical firms, donors, government officials, and consumers. An appendix includes a checklist of questions and issues to be considered.*

This report examines the issue of donor involvement in and financial support of local manufacture of contraceptives in developing countries, based on a literature review and a survey among those involved in such ventures. Typically, donors assess the potential of a local manufacturing project by conducting a series of feasibility studies. They examine the potential demand for the product(s) to be manufactured, the capabilities and capacities of the local partner(s), and financial projections about start-up costs, operating costs, and sales revenue. However, in addition to these market-based considerations, the eventual success of the enterprise will also depend on social and political factors — specifically, the interests, motivations, actions, and interactions of the people and organizations that influence and are affected by its operations. Decision makers should seek a more complete understanding of these social and political factors when assessing the feasibility and advisability of any potential local manufacturing project.

**Deloitte Touche  
Tohmatsu**



Deloitte Touche Tohmatsu International  
in association with:

Boston University Center for International Health Multinational Strategies, Inc. Development Associates, Inc. Family Health International

130

This report draws on a literature review of technical and economic information produced by the Program for Appropriate Technology in Health (PATH), the United Nations Population Fund (UNFPA), and PROFIT. In addition, the author interviewed dozens of people knowledgeable about and involved in local manufacturing operations, including family planning experts and representatives of contraceptive manufacturers, donor agencies and partners, and a private U.S. foundation. The perspectives and opinions in the paper are those of the interviewees.

The interviews revealed that, as may be expected, those people who are affected by decisions about local production of contraceptives work to serve their own interests. When the interests of these people or groups coincide, they form coalitions. When their interests conflict, they struggle for influence. The result is that decisions about local manufacturing may reflect not only the economic or technical feasibility of the projects, but also the interests of people or groups that wield money and power.

### **Factors that Affect Local Manufacturing**

Donors assessing potential local manufacturing operations should consider the full range of market-based and political and social factors that will affect the success of the enterprise:

- **Demand for contraception:** The method mix varies by region and country, as well as by age, marital status, reproductive intentions, and other social and demographic factors. Demand for the product(s) will be affected by these and other demographic, cultural, and behavioral factors.
- **Profitability:** The production of contraceptives is capital-intensive and enjoys significant and increasing returns to scale — that is, unit production costs decrease as the volume of production increases. Production volume must be sufficient to keep the costs, and thereby the price to consumers, low enough to be competitive in the market. The ability of the new facility to sustain a profitable production volume will be affected by the current and future availability of relevant products from imports, local production, and/or government and donor distribution.
- **Trade restrictions:** The import of contraceptive products and/or the export of locally manufactured contraceptives may be restricted or regulated by the government. For example, imports may be limited by type, volume, or time period. The ability of companies to repatriate their profits may be circumscribed. Or imports and exports may be subject to tariffs, inspections, or local-content restrictions. The ability of the local manufacturing operation to import, license, or export contraceptive products may be limited by such laws and regulations.
- **Potential public-private partnerships:** There may be an opportunity to establish or promote a partnership among donors, government agencies, multinational or local companies, and/or local investors. Partnerships can improve the viability of the local manufacturing operation by tapping and leveraging the partners' resources and

capacities, including financial and human resources, market research and intelligence, sales and distribution networks, and publicity and public information capabilities.

- Intellectual property protection: Local laws concerning the protection of patents, trademarks, and other intellectual property may affect the willingness of major multinational companies to establish local manufacturing facilities or to license their brands for local production.
- Donated commodities: Public sector programs that provide free or low-cost contraceptive products to low-income consumers will affect the overall demand for these products. Despite efforts to make donated commodities less appealing to consumers who are willing to pay for contraceptives, there is usually some “leakage” of donated contraceptive supplies into the marketplace.
- Corruption: Corruption among business people or government officials can be a severe market distortion. Many multinational companies are unwilling to enter markets where they cannot adhere to their own codes of ethics.
- Government and donor policies to promote local production: Some governments — and the donors that work with them — implement explicit policies to promote local production of contraceptives even when the venture does not meet strict profitability criteria. These policies may reflect a desire to utilize available local inputs or production capacity; to develop local infrastructure, skills, or employment opportunities; to make contraceptive products more culturally acceptable; or to boost national pride.
- Quality assurance: The ability of some local manufacturers to produce high-quality products may be compromised by insufficient capital, a desire to lower production costs (e.g., to compete with donated supplies), outmoded production facilities, lax regulatory and inspection systems, poor management, and a lack of skills. Poor quality assurance can make multinational firms unwilling to license their product(s) or to participate in partnership arrangements. Poor quality also limits demand for the product(s) and therefore compromises the long-term viability of the manufacturing operation.

## The Role of Donors

Donors influence the local manufacture of contraceptives in several ways. The most important may be to limit the ability of local firms to profitably produce contraceptive products: unless they produce for donors, these firms are forced to compete with donated commodities that are available in the public sector for free or at subsidized prices.

Even when local firms seek to produce for donors, their ability to compete may be affected by the effect on prevailing prices for contraceptives of donor procurement. For example, by being able to purchase huge quantities of commodities, donors can often negotiate prices that are too low to be profitable for local producers. In addition, the procurement practices of some donors are restricted by law. For example, USAID must

procure only from U.S. producers and has only limited ability to buy local products.

The quality of contraceptive products can be directly and indirectly affected by donor programs to support local manufacture. Donors naturally insist on adherence to Good Manufacturing Practices (GMP) and have helped to develop quality standards for certain products. Nonetheless, limited technical expertise or inadequate regulatory and inspection mechanisms in some countries may mean that donors are unwitting accomplices in the manufacture of poorer-quality products.

Finally, the policies and programs of donors may reflect other motivations that distort the market for local products. For example, in addition to their relief and development mandates, national aid agencies may be required to further national security interests, accommodate domestic or international political realities, or conform to certain ideological objectives. The programs and priorities of multinational donor agencies often reflect their broad missions and their funding sources. For example, the World Bank has traditionally assessed potential loans for local contraceptive manufacture on strict profitability criteria, whereas the United Nations Population Fund (UNFPA) has traditionally used a number of family planning-related criteria.

## **The Future of Local Manufacturing**

Donors will no doubt continue to be involved in the local manufacture of contraceptive products in developing countries. However, the most successful ventures are likely to be those initiated in collaboration and partnership with the private sector. Global trends toward economic liberalization will continue to limit the role of government-owned production facilities and will increase competition among private firms.

The local manufacturing projects funded by donors in the future therefore should adhere to stricter economic criteria. The producers should be subject to market incentives that reward high-quality, efficient production. Given the general decrease in commodity donations, the role of donors may revolve around helping developing countries to:

- more accurately assess the feasibility of local production operations
- support economically viable local manufacturing facilities
- efficiently procure commodities on the international market when local production proves impractical.

Stanback, John. *Perspectives on Local Manufacture of Contraceptives in Developing Countries*. Arlington, VA: PROFIT Project, June 1997.

# PROFIT

Promoting Financial Investments and Transfers  
to Involve the Commercial Sector in Family Planning

1925 N. Lynn Street  
Arlington, Virginia 22209

Telephone: (703) 276-0220  
Facsimile: (703) 276-8213

# IN BRIEF

## Family Planning and Health Insurance

A Summary of: Frank Feeley and Vaira Harik, *Family Planning and Health Insurance in Developing Countries*. (Arlington, VA: PROFIT Project, 1997).

*Expanding the availability of insurance benefits for family planning services was one strategy investigated by the PROFIT Project as part of its effort to encourage private financing of such services. Most insurance providers are reluctant to add benefits that are not accident- or illness-related to their indemnity plans — the most common plans in developing countries. Adding family planning benefits does not produce significant cost savings for most providers because they rarely provide maternity benefits. Furthermore, the beneficiaries of such policies are in the highest income and educational groups and are most likely to already use family planning and to buy their services from the private sector. Therefore, efforts to expand the private provision of family planning through insurance initiatives should be focused on integrating family planning benefits into managed care plans. These plans already cover a range of preventive services, and they have more control over the extent to which the insured utilize covered benefits. Efforts to include family planning in managed care programs are particularly appropriate in areas where contraceptive prevalence is reasonably high but where family planning users depend largely on public sector providers, such as in Asia.*

Private health insurance is available in most every country in the world, commonly in the form of indemnity insurance. Under an indemnity plan, the provider agrees to reimburse the insured for medical expenses incurred in the event of an accident or illness. Some indemnity insurers offer health plans only as a vehicle for expanding sales of their primary products, such as life and disability insurance.

The insurance companies that provide indemnity plans are in the business of insuring against risks that are statistically predictable among large groups of people, or “risk pools.” These providers are reluctant to add benefits that would make the people covered by their plans more likely to receive benefits. This is called “moral hazard”: when the existence of an insurance benefit causes the insured to take actions or risks that s/he

**Deloitte Touche  
Tohmatsu**



Deloitte Touche Tohmatsu International  
in association with:

Boston University Center for International Health Multinational Strategies, Inc. Development Associates, Inc. Family Health International

134

would not otherwise take, increasing the total cost of the benefits paid. Moral hazard makes indemnity insurers reluctant to include family planning as a benefit. In addition, adding family planning benefits does not produce any costs savings for insurers that do not provide maternity benefits. Nonprofit insurers are an exception. They are less concerned with moral hazard and are more willing to include benefits they consider social goods.

Unlike indemnity health insurers, which cover only expenses incurred as the result of accident or illness, managed care organizations assume responsibility for the covered individuals' total health care. This makes managed care organizations more willing to include a range of preventive services, because the organizations themselves stand to gain from providing services that can avert other medical costs down the road.

Managed care organizations also have some control over the extent to which beneficiaries utilize covered services, which can allow them to successfully promote use of the family planning benefit. For example, unlike traditional indemnity insurers, managed care organizations may control which health care practitioners patients see and which services those practitioners provide. In many cases, managed care organizations directly employ the health practitioners.

In some countries, the very success of the government in providing family planning services may discourage health insurers or managed care organizations from providing family planning benefits. Specifically, having such benefits does not necessarily lead people to switch their sources for family planning, and many continue to use their existing government clinics for services and supplies.

Working with managed care organizations offers a better opportunity to shift clients away from government family planning programs than working with indemnity providers. This is because managed care providers are more likely to offer integrated services, including preventive care, and because managed care organizations have more control over their provider networks and therefore can more easily encourage their providers to promote the use of the family planning benefit.

In sum, efforts to expand the private provision of family planning through insurance are most likely to have a favorable impact when they are:

- not directed toward providers of traditional indemnity plans unless they are nonprofit;
- focused on integrating family planning services into managed care plans
- targeted to countries where contraceptive prevalence is relatively high but where family planning services are provided primarily by the government, such as in Asia.

Frank Feeley and Vaira Harik, *Family Planning and Health Insurance in Developing Countries*. Arlington, VA: PROFIT Project, September 1997.

135

# PROFIT

Promoting Financial Investments and Transfers  
to Involve the Commercial Sector in Family Planning

1925 N. Lynn Street  
Arlington, Virginia 22209

Telephone: (703) 276-0220  
Facsimile: (703) 276-8213

# IN BRIEF

## Providers and Consumers of Commercial Sector Family Planning Services

A Summary of: Paul Hopstock, Ann Sherpick, and Carla Briceno, *Providers and Consumers of Commercial Sector Family Planning Services in Developing Countries*. (Arlington, VA: PROFIT Project, September 1997).

*Efforts to increase the involvement of the commercial sector in providing family planning services are fueled by the realization that donor and public sector funds cannot fully address the growing need for family planning services and by an increasing appreciation of the strengths and advantages of commercial sector health providers. The commercial sector currently plays a significant role, providing contraceptives to about 20 percent of women who use modern methods. Pharmacies are the leading commercial providers of family planning services. Commercial providers are more likely than public sector providers to offer supply methods (i.e., condoms, pills, and vaginals) and less likely to offer clinical methods (i.e., male and female sterilization). They tend to serve people of higher socioeconomic status, although their client base includes people from all socioeconomic groups. Consumers who use commercial providers do so because of the quality, convenience, and privacy of services. Those who prefer public providers do so because of lower prices, although many may be willing to pay more for higher-quality services.*

For over a decade, international donors and government leaders in developing countries have attempted to increase the involvement of the commercial sector in providing family planning services. This effort has been fueled by the realization that funds from donors and the public sector cannot fully address the growing need for family planning services and by an increasing appreciation of the strengths and advantages of commercial sector health providers.

**Deloitte Touche  
Tohmatsu**



Deloitte Touche Tohmatsu International  
in association with:

Boston University Center for International Health Multinational Strategies, Inc. Development Associates, Inc. Family Health International

136

This report provides a profile of who provides commercial family planning services in developing countries, who uses the services of those commercial providers, and the motivations that influence both providers and consumers. The authors reviewed more than fifty recent Demographic and Health Surveys (DHSs) and a range of qualitative and quantitative studies.

The commercial sector services about 20 percent of women who use modern methods of contraception in developing countries. This translates into 7 percent of the total number of married women of reproductive age (15–49 years) — more than served by the nonprofit sector (5 percent) but considerably less than the public sector (23 percent).

Supply-based methods dominate the mix of contraceptive methods provided by commercial providers. Pills and condoms comprise 69 percent of the methods obtained from the commercial sector; injectables and IUDs, 25 percent; sterilization, 5 percent, and other methods, 2 percent.

Pharmacies are the leading commercial provider of contraceptive methods in developing countries, reaching 4 percent of married women of reproductive age. Commercial doctors serve 1.4 percent, midwives reach 0.7 percent, and shops or markets serve 0.6 percent.

Commercial family planning clients have a higher socioeconomic status than those who use public sector family planning services. However, some people in even the lowest socioeconomic groups use commercial providers. Urban residents are more likely to use commercial sources of family planning services than rural residents. Women with more children and/or more children than they would prefer are less likely to use private or commercial sources for family planning services.

The key motivation for health care providers who offer commercial family planning services is the revenue potential. The nonmonetary motivations include independence, flexibility, lighter workloads, opportunities for growth (i.e., experience and training), concern for their patients, and concern over rapid population growth.

Providers' interest in and ability to offer commercial family planning services are constrained by a lack of training and by the policy and regulatory environment. Providers cite governmental restrictions on services, distribution of contraceptives, and advertising, as well as taxes, price controls, and import/export restrictions. The profitability of commercial family planning services is constrained by:

- the availability of subsidized family planning services and methods
- limited access to capital and cash flow problems
- weak commercial distribution channels.

Consumers choose commercial providers primarily because of their perceptions about:

- competence and friendliness of staff
- quality and extent of the consultation
- quality of the waiting conditions
- trustworthiness of the service provider
- shorter waiting times
- longer hours of operation
- privacy of services.

Those who choose public providers cite lower prices for services, the availability of other services at the same location, and a lack of knowledge of alternative sources. There is evidence that many consumers in developing countries may be willing to pay more for family planning services in order to receive higher quality services.

## Conclusions

- The commercial sector currently plays a significant role in the provision of family planning in developing countries, serving approximately 20 percent of all women in developing countries who use modern contraceptive methods.
- Pharmacies are the leading commercial providers of family planning services, although doctors, midwives, and other shops or markets also play a meaningful role.
- Commercial providers are more likely than public providers to offer supply methods (i.e., condoms, pills, and vaginals) and less likely to offer clinical methods (i.e., male and female sterilization).
- The clients of commercial providers are more likely to be in higher socioeconomic groups, although people from all socioeconomic categories use commercial providers when they are able.
- Providers are motivated to provide family planning services in the commercial sector by a range of factors, including profit potential, independence, flexibility of practice, and a desire to have a positive social impact. They are constrained by government regulations, fiscal constraints and concerns about profitability, and lack of training.

- Consumers choose commercial providers based on their perceptions about the quality of service, convenience, and privacy. Consumers who use public providers cite the lower price. There is evidence, however, that many consumers in developing countries may be willing to pay more to receive higher quality family planning services.

Paul Hopstock, Ann Sherpick, and Carla Briceno. *Providers and Consumers of Commercial Family Planning Services in Developing Countries*. Arlington, VA: PROFIT Project, September 1997.

# PROFIT

Promoting Financial Investments and Transfers  
to Involve the Commercial Sector in Family Planning

1925 N. Lynn Street  
Arlington, Virginia 22209

Telephone: (703) 276-0220  
Facsimile: (703) 276-8213

# IN BRIEF

## PROFIT Revolving Loan Fund for Midwives: A Profile of Borrowers

A Summary of: Ann R. Sherpick and Paul J. Hopstock, *Baseline and Follow-Up Data on Participants in the PROFIT Revolving Loan Fund for Midwives (Indonesia)*. (Arlington, VA: PROFIT Project, March 1997).

*To assess the effectiveness of its \$1 million Revolving Loan Fund for Midwives in Indonesia, the PROFIT Project conducted baseline and follow-up surveys among the midwife borrowers. The borrowers used their loans to improve the range and quality of the family planning and non-family planning services they provided. About 15 percent of the 500 borrowers during the first two years of the Loan Fund used the funds to establish new clinics. Those with existing practices used the loans to improve and/or refurbish their clinics; buy contraceptives, medicines, and other supplies; and buy medical equipment. About 5 percent of the borrowers were bidan di desa (village midwives), who are younger and less experienced than other midwife borrowers. Over three-quarters of the borrowers' new clients previously had no source for family planning services, and 12 percent had previously obtained such services from public sector sources. Overall, however, the midwife borrowers experienced only slight increases in the total number of family planning clients.*

In April 1995, PROFIT established a \$1 million Revolving Loan Fund for Midwives to help midwives establish or expand private practices that include the delivery of family planning and reproductive health services. PROFIT's partners in this subproject are the Indonesian Midwives Association (IBI), Bank Rakyat Indonesia (BRI), and Indonesia's National Family Planning Coordination Board (BKKBN). To assess the effectiveness of the Loan Fund, PROFIT conducted baseline and follow-up surveys among participants. This report summarizes the findings from these surveys.

**Deloitte Touche  
Tohmatsu**



Most borrowers reported that their purpose in securing a loan was to improve the range and quality of services offered rather than to increase the number of clients served. This was reflected in the ways they spent the funds and the fact that overall client volumes did not increase significantly as a result of the loans.

About 15 percent of the 500 borrowers during the first two years of the Loan Fund used the funds to establish new clinics. Those with existing practices used the loans to improve and/or refurbish their clinics; buy contraceptives, medicines, and other supplies; and buy medical equipment.

About 5 percent of the borrowers were *bidan di desa* (village midwives), who are younger and less experienced than other midwife borrowers.

The slight increase in the number of continuing contraceptive users seen by borrowers may be a reflection of improvements in the services provided by the borrowers, which was one of the midwives' main objectives in securing their loans.

The majority of midwives reported providing collateral in order to secure their loans, but the collateral was often not of direct cash value (e.g., license to practice, letter of appointment), which meant that the financial burden of obtaining the loans was minimized.

A relatively large proportion of the borrowers were (or had been) board members of IBI, the midwives' professional association and a partner in the Loan Fund. This may have been because:

- Experienced midwives, many of whom are board members, were those most comfortable applying for loans.
- IBI boards consciously chose experienced midwives to recommend for loan approval because they were perceived to be least likely to default on payments, and IBI wished to prove the creditworthiness of midwives to the bank and to set an example for other midwives.

Fewer village midwives (*bidan di desa*) received loans than projected. This may be because:

- The village midwives were younger and had been in practice for fewer years than other midwives.
- IBI board members were less familiar with the village midwives and their abilities to repay loans and therefore were less likely to recommend them for loan approval.
- Midwives who did not have a close affiliation with a network of supportive, encouraging midwives were less inclined to apply for loans.
- Living in rural areas may have made it more logistically difficult for village midwives to apply for the loans.

The village midwives had lower client volumes compared to other midwives, which may be attributable to the fact that they had been in practice for fewer years. In fact, a group of other midwives who had been in practice for a comparable number of years reported similar client volumes.

Sherpick, Ann R., and Paul J. Hopstock, *Baseline and Follow-Up Data on Participants in the PROFIT Revolving Loan Fund for Midwives (Indonesia)*. Arlington, VA: PROFIT Project, March 1997.

# PROFIT

Promoting Financial Investments and Transfers  
to Involve the Commercial Sector in Family Planning

1925 N. Lynn Street  
Arlington, Virginia 22209

Telephone: (703) 276-0220  
Facsimile: (703) 276-8213

# IN BRIEF

## The Potential of Pharmacists to Promote Family Planning in Romania

A Summary of: Ann R. Sherpick and Paul J. Hopstock, *Study of Romanian Private Pharmacists*. (Arlington, VA: PROFIT Project, November 1996).

*In 1995, the PROFIT Project surveyed the knowledge, attitudes, and practices (KAP) of private pharmacists in Romania concerning family planning to help design a subproject to encourage pharmacists to promote family planning and to help private pharmacies become a major source for contraceptives. The pharmacists appear to be an effective and willing means of expanding the use of modern contraceptive methods in Romania, particularly given their professional orientation, generally positive attitudes toward contraception, and willingness to discuss contraception with customers. However, the sale of contraceptives is not likely to be a major source of revenue for private pharmacies. Therefore, efforts to encourage private pharmacists to sell and provide information on contraceptives should emphasize the social and health benefits rather than the potential economic benefits to them. The pharmacists suffer severe cash flow problems and may need mechanisms for increasing their contraceptive stocks under positive credit terms. Because consumers of contraceptives are sensitive to both price and quality, efforts to train pharmacists and educate consumers might emphasize price and/or quality considerations.*

In 1995, USAID/Romania requested that PROFIT develop a subproject to promote the use of modern contraceptives through the commercial sector. A major focus of the subproject was to involve private pharmacists in efforts to promote family planning. In April 1996, PROFIT contracted with the Institute of Marketing and Survey (IMAS) to undertake a study of private pharmacists' business skills and their knowledge, attitudes, and practices (KAP) about family planning and their level of interest in receiving training and promotional materials. The study included one-on-one interviews with 597 pharmacists who managed private pharmacies in five geographic areas of Romania, as well as six focus groups with a total of 49 pharmacists from three cities (Bucharest, Cluj, and Iasi).

**Deloitte Touche  
Tohmatsu**



Deloitte Touche Tohmatsu International  
in association with:

Boston University Center for International Health Multinational Strategies, Inc. Development Associates, Inc. Family Health International

143

## Findings

- Virtually all of the pharmacists in the interview sample (92.3 percent) were female. The average age was 45, and 56.1 percent were between ages 41 and 50. Respondents had been in the pharmacy field for an average of 21 years.
- Most of the pharmacies managed by respondents (67.4 percent) had been privatized or newly established between 1991 and 1993. Respondents set up private pharmacies primarily from a desire to work on their own (71.9 percent) or because of government-led privatization programs (51.8 percent). Fewer than half of the facilities (42.8 percent) were previously state-owned pharmacies, and only 38.3 percent included staff members held over from previous state ownership. When asked to describe their typical customers, most respondents described older or retired clients (69.0 percent of respondents).
- Most private pharmacies employ three people, two of whom are involved in selling medications. However, 26.6 percent of private pharmacies had six or more workers, and 14.4 percent had only one worker. Virtually all of the pharmacies (92.1 percent) employed fully educated, experienced pharmacists; 6.2 percent had a resident pharmacist; and 69.8 percent had a pharmacy assistant. Nearly all of the pharmacies (90.5 percent) used the services of an accountant, who, in most cases, was employed on a part-time basis.
- Revenues from contraceptive sales represented a very small proportion of total revenues. In fact, more than half of respondents (52.3 percent) indicated that revenues from contraceptive sales were insignificant.
- Cash flow and financial issues were the most common problems reported by private pharmacists (71.3 percent). Almost half (41.4 percent) reported that slow reimbursement by the government for subsidized prescriptions was a major factor in cash flow management.
- Competition among pharmacies is not a major concern in Romania. Many pharmacists (38.7 percent) reported feeling no competition. Focus group members commented that there is a shortage of pharmacists, particularly in rural areas, and that the government controls the number and location of pharmacies.
- Most private pharmacies stock and sell contraceptive products. Condoms and oral contraceptives are very widely available, but IUDs and diaphragms are less available. The factors that most influence whether specific brands of contraceptives are carried are price (48.7 percent of respondents), knowledge of and trust in the product (16.1 percent), quality (9.4 percent), and effectiveness (8.4 percent).
- Pharmacists reported being comfortable selling contraceptives and confident in answering questions from customers. However, pharmacists reported that they are not regularly asked for advice on contraceptives, although they are regularly asked for advice about

other medicines they sell. Pharmacists were asked three questions that tested their knowledge about the use of oral contraceptives. On average, the pharmacists provided two correct answers and one incorrect answer.

- Nearly all respondents (91.2 percent) indicated that they were willing to display promotional materials about contraceptives in their pharmacies, and they indicated a willingness to learn more about new products. When asked about topics for future training, the most common responses related to new producers and new products.

## Conclusions

- Although most private pharmacies stock and sell contraceptives, contraceptive sales represent an insignificant percentage of total revenues. The typical customer at most pharmacies is an older, retired person, who is not a potential user of contraceptives.
- Cash flow is a major problem for private pharmacies. Most pharmacies use loans from banks and/or friends to pay for supplies or buy on credit from suppliers. A major factor contributing to cash flow problems is delayed government reimbursement for discounted prescriptions sold to patients who are unable to pay full price.
- Pharmacists working in private pharmacies view themselves as health care professionals rather than as business people. Government controls on sales margins limit the potential profits of private pharmacies. Pharmacists do not consider themselves to be in competition with each other.
- Most pharmacists expressed confidence in their ability to provide accurate information about contraceptive methods. However, the survey pointed out gaps in their knowledge about oral contraceptives.
- Pharmacists expressed an interest in and willingness to pay for training about new products and suppliers. Most respondents also expressed a willingness to display promotional materials for contraceptive products. They were less interested in training in such business areas as marketing, finance, human resources, advertising, and inventory management. (They were not asked about training in contraceptive methods.)

## Implications for Project Design

- Private pharmacists appear to be an effective and willing means of expanding the use of modern contraceptive methods in Romania, particularly given their professional orientation, generally positive attitudes toward contraception, and willingness to discuss contraception with customers.

145

- The sale of contraceptives is not likely to be a major source of revenue for private pharmacies. Therefore, efforts to encourage private pharmacists to sell and provide information on contraceptives should emphasize the social and health benefits of contraceptive use rather than the potential economic benefits to them.
- Given the cash flow problems faced by private pharmacies, attention should be given to finding ways of providing additional contraceptive stocks under positive credit terms. This might be accomplished through agreements with manufacturers and suppliers or alternative sources of credit.
- Consumers of contraceptives are sensitive to both price and quality. Price seems to be the most important factor for oral contraceptives, while perceived quality is most important for condoms. Pharmacist training and consumer education efforts might emphasize price and/or quality considerations.
- Pharmacists are quite interested in what is new and effective in the area of contraception. Training pharmacists about contraceptive methods should focus on new products.
- Only a minority of private pharmacists are interested in classic business training. Any business training should focus on the unique business conditions facing private pharmacies in Romania (limited profit margins, noncompetitive environment, etc.).

Sherpick, Ann R., and Paul J. Hopstock. *Study of Romanian Private Pharmacists*.  
Arlington, VA: PROFIT Project, November 1996.

# PROFIT

Promoting Financial Investments and Transfers  
to Involve the Commercial Sector in Family Planning

1925 N. Lynn Street  
Arlington, Virginia 22209

Telephone: (703) 276-0220  
Facsimile: (703) 276-8213

# IN BRIEF

## Training Private Providers to Improve Access to Quality Contraceptive Services

*PROFIT has been working in Romania and Zimbabwe to maximize consumers' access to quality contraceptive services from private physicians, pharmacists, and nurse/midwives. As part of this effort, PROFIT has trained private providers in the safe and effective use of contraceptives, interpersonal communication skills to allow them to educate their clients about modern contraceptives, and basic inventory and cash management skills to help ensure adequate supplies of a variety of appropriately priced contraceptives. The training programs have been developed and conducted in partnership with associations of health professionals, universities, and private businesses. PROFIT has trained a total of about 100 physicians, 300 pharmacists, and 50 nurse/midwives in the two countries and has developed guides for pharmacists on contraceptive technology and quality client services.*

PROFIT has been working in Romania and Zimbabwe to maximize access to quality contraceptive services through private health care providers. To achieve this goal, PROFIT has developed training programs for physicians, pharmacists, and nurse/midwives. The training focuses on three main areas:

- contraceptive technology, to help ensure safe and effective contraceptive use, to allow providers to educate their clients about methods, and to effectively manage clients' side effects if they arise
- interpersonal communication skills, to help providers effectively communicate with their clients to educate them about contraceptives and to help them make informed choices

**Deloitte Touche  
Tohmatsu**



Deloitte Touche Tohmatsu International  
in association with:

Boston University Center for International Health Multinational Strategies, Inc. Development Associates, Inc. Family Health International

147

- business skills, such as basic inventory and cash management, to help ensure adequate supplies of a wide variety of contraceptives at appropriate prices.

## The “BASICS” of the PROFIT Training Program

The participants in the PROFIT training programs in Romania and Zimbabwe have found them effective and relevant. The program’s success is due to six key elements that comprise the core — or “BASICS” — of the training program:

### **B Best Practices**

Best practices have been included in the three main training areas: contraceptive education, interpersonal communication skills, and basic business skills. By learning and following the best practices in these fields, providers are capable of delivering safe, effective, and efficient contraceptive services.

### **A Assessment**

PROFIT determined the training’s content by assessing participants’ needs using surveys, focus groups, and other research methods and then developing training courses to address those needs. Conducting training that was relevant increased its effectiveness in changing the knowledge, attitudes, and practices of the private providers who participated.

### **S Selection**

PROFIT selected the participants in the training workshops after reviewing applications to maximize the effect of the courses on consumers’ access to quality contraceptive services. The criteria included geographic location, facility size, and client demand.

### **I Interaction**

The program has encouraged interaction among trainers and participants, during and after the training sessions, particularly through the use of participatory training methods and trainers from the same geographic areas as the participants. This has helped create professional networks that can facilitate a sharing of skills and experiences as well as provide support over time.

### **C Competence**

The participants’ competence was augmented and reinforced during the training by role modeling, practicing new skills, conducting self-assessments, receiving feedback from other participants, and using checklists to assess their skill level in clinical procedures, interpersonal communication, and business practices. The

participants leave the training course feeling confident in their ability to provide quality services.

## **S Sustainability**

The training courses have been designed to incorporate elements that increase the likelihood that they will continue after the end of PROFIT in September 1997. For example, PROFIT ran a training of trainers (T-O-T) workshop in Romania and, in Zimbabwe, recruited trainees from the national pharmacists' association, pharmaceutical distributors, and university departments, and organized a coordinating council with representatives from the public and private sectors to oversee the project.

## **Lessons Learned**

- Private sector physicians, pharmacists, and nurse/midwives are more likely to use effective communication with and counsel their clients after they are trained in the principles, concepts, and techniques of providing quality services. The PROFIT training course included this reminder to practitioners:

What you provide (complete and accurate information) + How you provide it (communication skills, polite and caring manner) = QUALITY SERVICE! You can ensure safe, effective, continued contraceptive use by providing complete and accurate information in a polite and caring manner!

- Private providers need business skills to run their practices efficiently. Since they do not make a living solely by selling contraceptives or providing contraceptive services, they need training in the skills that will improve the quality of their full range of services or products.
- Business skills are best taught using an integrated, applied approach. Most previous training programs have focused on either contraceptive technology or business skills. Integrating both technical and business-management skills in a single training course can help providers understand how each set of skills contributes to improving the quality of their services. This can be done, for example, through a training exercise that involves developing a marketing plan for a particular service or contraceptive product.
- The selection of appropriate trainers and participants using defined criteria is essential. Having trainers who are representative of the participants and/or who come from the geographic areas where the training takes place can facilitate dialogue, encourage its continuance, and ensure informal follow-up. Including respected professionals and opinion leaders in the training sessions lends credibility to the program and stimulates participation.

- In the private sector, time is money. Training programs for private practitioners should be held at convenient times and locations. Providers are able and willing to participate fully in training sessions that fit into their schedules (i.e., held on the weekend).
- A modular curriculum design breaks training into separate and distinct topics. This allows for flexibility in the training schedule and adaptation of participants' needs for more or less information, depending on their knowledge and skill levels.
- Quantitative checklists should be used to assess competency. Such checklists establish a minimum standard of performance and can legitimize the content of a training program, in part, by setting objective standards for evaluating the results. Moreover, private providers are comfortable using such checklists and may use them in their own facilities to assess their performance and skills or those of their colleagues and subordinates. However, quantitative checklists should complement, not replace, the use of qualitative measures or indicators of quality such as providers' mannerisms, body language, tone, or attitude toward patients/clients.

150

# PROFIT

Promoting Financial Investments and Transfers  
to Involve the Commercial Sector in Family Planning

1925 N. Lynn Street  
Arlington, Virginia 22209

Telephone: (703) 276-0220  
Facsimile: (703) 276-8213

# IN BRIEF

## Manual for Corporate Initiatives in Family Health Care in India

A Summary of: *CII Manual for Corporate Initiatives in Family Health Care*. (New Delhi: Confederation of Indian Industry, with PROFIT, Arlington, VA, 1996).

*The Confederation of Indian Industry (CII), a leading industrial association in India, encourages industry involvement in activities that contribute to the social infrastructure of the country. In 1995, to commemorate its centenary, CII formed a special council on Corporate Citizenship to address issues related to health and family welfare, AIDS, education, and literacy, among other issues. Health and family welfare was one area accorded special attention. In cooperation with PROFIT, CII produced this manual to equip middle-level managers with information on how to: define the family planning needs of the employees and their families; identify the resources needed to run a successful program; choose an appropriate model in tune with the company's size and budget; identify a task force comprising all persons whose support is necessary; produce a program document with a mission statement, goals, and strategies; set up a proper reporting and documentation system to establish cost/benefit figures and other parameters for assessment and monitoring; and finally, identify areas of support at all stages of the program.*

In 1995, the Confederation of Indian Industry (CII) formed a special council on Corporate Citizenship to address issues relating to health and family welfare, AIDS control, education, rural development, and more. Among the selected areas of social development adopted by CII, health and family welfare was accorded special importance. In cooperation with PROFIT, CII produced the *Manual for Corporate Initiatives in Family Health Care*, with guidelines on family health care initiatives for Indian industry.

This manual was designed for organizations that want to introduce family health care services to benefit their companies in the long term and the short term. Such programs should help the company extend benefits to a large number of eligible persons, be cost-

**Deloitte Touche  
Tohmatsu**



Deloitte Touche Tohmatsu International  
in association with:

Boston University Center for International Health Multinational Strategies, Inc. Development Associates, Inc. Family Health International

151

effective, and be of high quality. The manual is designed to be used by middle-level managers.

The manual offers guidelines for deciding how to go about introducing family health care programs, whom to approach for help, how to justify expending additional resources, and how to evaluate the program. Family health care programs improve the lifestyles of employees, raise productivity, improve labor-management relations, reduce absenteeism and turnover, and enhance the company's image by contributing significantly to the community.

Family health care refers to planned and responsible parenthood. It includes all aspects of mother and child health, reproductive health, and planned parenthood. For family health care to be successful, family planning is an important (though not the only) prerequisite. In practical terms, family planning translates into delaying pregnancy, avoiding very late pregnancy, spacing children, and limiting the number of births.

There are approximately 25 million workers in the organized (formal) workforce in India, who can be used to reach approximately 18 percent of the people of reproductive age through employer-provided services. The benefits to employees of providing family health care include accessibility to services by employees, a safer workplace, better quality services, healthier mothers, healthier children, protection from unsafe abortions, better male participation, and higher employee morale. The benefits to employers include healthier workforce and their families, lower expenditures on maternity benefits, better labor-management relations, retention of good people, reduced health care and other social costs, good return on investment, and better corporate image.

The organized sector is uniquely placed for successful family health care because:

- It has tremendous direct reach.
- Employment-based services are effective because concentrations of eligible people are available at one location.
- There are fewer opportunities for waste.
- The organized sector is concerned with getting results.
- The organized sector is well organized with a good administrative system. It has professional, goal-oriented managers and financial resources. Moreover, it has an established practice of providing benefits, including health care, to employees and their dependents.
- The organized sector is in direct contact with government, unions, employees, labor contractors, and private voluntary organizations and nongovernmental organizations (PVOs and NGOs) that are capable of providing professional help.

This manual includes a section on how to gauge signs of commitment to family health care programs by top management, middle management, unions, and employees. It also

152

helps define the target group. It offers nine steps for middle managers who seek to convert commitment into action, including drawing up an action plan, deciding on an appropriate model, leveraging the resources of others to launch a program, and effectively communicating with all parties concerned.

The manual also lays out procedures for planning and estimating resource requirements in terms of finance, assets, human resources, and service provision. It illustrates how to develop a document that clearly states the mission and objectives, coverage, budget, strategy, expected outcomes, collaborating individuals and associations, and evaluation.

Another section of the manual helps managers define what services will be provided. Included are instructions for doing a needs assessment, outlining and budgeting services to be provided, identifying the sources for services, and practical hints for adding value to the program.

This manual also discusses how to implement and manage family health care services, including staffing, training, and supervision needs, and how networking can increase efficiency while reducing costs. It sets out parameters for cost-control, monitoring, and evaluation, including establishing a good documentation system and measurable objectives. Finally, the manual provides useful checklists for reviewing the final design of the family health care program and for sharing information on the program both internally and externally.

A bibliography and a directory of professionals in the fields of surveys, research, evaluation, training, reproductive health services, and counseling are included as appendices.

Confederation of Indian Industry, *Manual for Corporate Initiatives in Family Health Care*. (New Delhi: CII, and Arlington, VA: PROFIT, 1996).

# PROFIT

Promoting Financial Investments and Transfers  
to Involve the Commercial Sector in Family Planning

1925 N. Lynn Street  
Arlington, Virginia 22209

Telephone: (703) 276-0220  
Facsimile: (703) 276-8213

# IN BRIEF

## Employer-Based Family Planning Services in Zimbabwe

A Summary of: Premila Bartlett, *A Study of Employer-Based Family Planning Services in Zimbabwe*. (Arlington, VA: PROFIT Project, October 1996).

*Zimbabwe's family planning program is considered to be one of the most successful in Africa, with 48 percent of married women using family planning and 42 percent using modern methods of contraception. Much of this success can be attributed to the government's strong family planning program, which provides services to 85 percent of female contraceptive users. The level of unmet need remains high, however, and the government is encouraging the private sector to play a more active role by providing services to those who can afford to pay for them. One way to expand private provision of service is through employer-based programs. PROFIT conducted a survey to gather information about the health services that companies provide to their employees and to assess their interest in and expectations for introducing or expanding the provision of family planning services. The results suggest that efforts to promote the introduction or expansion of family planning services at worksite health clinics should focus on those companies that have a large proportion of female workers or that provide health services to workers' dependents. In addition, providing clinic managers with detailed cost-benefit analyses may help them convince senior management of the value of providing family planning services.*

Zimbabwe's family planning program is considered to be one of the most successful in Africa, with 48 percent of married women using family planning and 42 percent using modern methods of contraception. Much of this success can be attributed to the strong government family planning program, which provides services to 85 percent of female contraceptive users. The level of unmet need remains high, however, and the government's budget continues to be reduced even as the cost of providing more family planning services and information escalates. The Zimbabwe National Family Planning Council (ZNFPC) recognizes the need to direct its resources to those clients who cannot afford to pay for services. It therefore encourages the private sector to play a more active role by providing services to those who *can* afford to pay for them.

**Deloitte Touche  
Tohmatsu**



Deloitte Touche Tohmatsu International  
in association with:

Boston University Center for International Health Multinational Strategies, Inc. Development Associates, Inc. Family Health International

154

The private sector contributes to family planning in two ways. First, the private sector provides family planning services through private clinics, including company-owned facilities, private practitioners (i.e., doctors), and private pharmacies. Second, the private sector pays for family planning services through medical aid (insurance) programs. Nonetheless, only 14 percent of users obtain their contraceptive services and supplies from private sources.

The PROFIT Project was given funding by USAID/Zimbabwe to increase the provision and use of private sector family planning services in Zimbabwe. One component of PROFIT's program was to expand employer-based family planning services. Previous USAID-funded projects, including the Enterprise Project and the Family Planning Service Expansion and Technical Support (SEATS) Project, had provided technical, material, and logistical support to several companies to introduce or expand contraceptive services.

Through two brief surveys carried out in 1995, as part of its assessment of the private medical sector in Zimbabwe, PROFIT found that about 70 companies provided some family planning services. Of these, all provided condoms, 57 percent provided oral contraceptives, and 25 percent provided injectables. These surveys also indicated that there were opportunities to introduce family planning services at companies that did not currently offer such services and to expand the contraceptive method mix offered by some companies that did.

In order to refine its strategy for taking advantage of those opportunities, PROFIT conducted this study to gather more comprehensive data on the services being offered by individual companies and on their interest in and expectations for expanding such services. PROFIT worked closely with the Zimbabwe Occupational Health Nurses Association (ZOHNA) to conduct this study.

## Findings

- Of the 170 company worksites responded to the PROFIT survey, 135 have on-site health facilities. Almost half (45.9 percent) are in manufacturing; 17 percent are in mining; and the remaining 50 companies (37 percent of the total) are split about equally among agriculture, food processing, services, and other sectors (including finance).
- Most of the worksites have between 500 and 5,000 workers, with about half having fewer than 1,000 workers and half having more than 1,000.
- About two-thirds of the worksites are urban, and about a quarter are rural.
- Women represent less than 10 percent of workers at most of these worksites (80.8 percent). However, women comprise more than half of the workers at four worksites, including two sites where they comprise more than 75 percent of workers.

155

- About 80 percent of the worksites provide medical aid (insurance) coverage to some or all employees and their dependents; 17 percent do not provide coverage for dependents.
- Many of the companies provide free, comprehensive, on-site health services (including drugs) to lower-grade employees and contractors. Most also contribute to a medical aid scheme for higher-grade employees, who are encouraged to seek private health services elsewhere. Lower-grade employees who seek medical aid coverage must usually pay the full premiums themselves.
- The National Association of Medical Aid Societies (NAMAS) is an association of all medical aid societies. NAMAS sets the payment schedules for drugs and treatment after negotiating with representatives of the medical profession. Companies that either run their own medical aid societies or are members of other medical aid societies register with NAMAS in order to submit claims for services provided at on-site health facilities.
- Most worksite clinics focus on curative and emergency care, including first aid. About 70 percent offer family planning, and over half (57.5 percent) offer preventive care (e.g., immunizations). Some clinics require employees to pay for treatment of sexually transmitted diseases (STDs).
- Company employees, rather than dependents, are the main users of worksite health facilities.
- Most on-site clinics provide regular health education sessions, at which the most popular topic is STDs, including HIV/AIDS. About 70 percent of on-site clinics hold educational sessions on family planning. Most sessions involve the use of posters, pamphlets, and videos.
- Only about 16 percent of worksites have community outreach workers. About half of the outreach workers are volunteers, and half are paid employees.
- Of the 70 percent of clinics that offer family planning, all provide condoms, 65 percent offer oral contraceptives, 44 percent provide injectables, 11 percent insert IUDs, 4 percent perform voluntary surgical contraception (mainly tubal ligation), and 5 percent offer other methods (e.g., spermicides and diaphragms). Only one provides Norplant®.
- Most of the clinics that provide family planning also provide counseling (77 percent), and over half (57 percent) conduct male motivation programs.
- Companies' primary motivation for providing family planning services is to help workers to improve their economic well-being by controlling their fertility. Some companies also cite a desire to ensure a healthy workforce.
- Many clinics (65 percent) obtain contraceptive supplies from the Zimbabwe National Family Planning Council (ZNFPC). About 11 percent of the clinics obtain supplies from pharmaceutical distributors. Many clinics provide condoms free of charge, and many of these obtain free supplies from AIDS prevention programs.

## Conclusions

- Many company worksites that do not provide family planning services may not be aware of what is involved in doing so.
- Many companies are unaware that the ZNFPC has a Private Sector Coordinator who can help them introduce or expand family planning services.
- The managers of many worksite clinics are unaware that they can submit claims for family planning services to their medical aid societies.
- A significant number of the worksite clinics that responded to the PROFIT survey offer condoms and orals but not injectables, in part because many clinic managers are unaware that Depo Provera® has been reintroduced into the Zimbabwean market (it had been removed from the market amid some controversy).
- Companies that have a large proportion of female workers or that provide health services to workers' dependents are the most suitable targets for efforts to promote the introduction or expansion of on-site family planning services.
- Clinic managers may find detailed cost-benefit analyses helpful in their efforts to persuade senior management to provide family planning services.

Bartlett, Premila. *A Study of Employer-Based Family Planning Services in Zimbabwe*.  
Arlington, VA: PROFIT Project. October 1996.

137

# PROFIT

Promoting Financial Investments and Transfers  
to Involve the Commercial Sector in Family Planning

1925 N. Lynn Street  
Arlington, Virginia 22209

Telephone: (703) 276-0220  
Facsimile: (703) 276-8213

# IN BRIEF

## Moving an NGO Toward Financial Sustainability: The Family Planning Association of Kenya (FPAK)

The Family Planning Association of Kenya (FPAK) is the International Planned Parenthood Federation (IPPF) affiliate in Kenya. FPAK is the largest nongovernmental organization (NGO) provider of family planning in Kenya, responsible for approximately 5 percent of modern contraceptive usage, according to the 1993 Demographic and Health Survey.

FPAK provides all modern contraceptive methods through 14 clinics throughout the country. It also operates a community-based distribution (CBD) program with over 1,000 CBD agents. It runs other programs that focus on youth education and family life education, male involvement in family planning, improving the status of women, and information, education, and communications (IEC) campaigns.

The U.S. Agency for International Development, which has supported FPAK with financial and technical assistance for many years, planned to end its funding. In addition, FPAK's funding from the IPPF was also diminishing. In September 1995, the USAID mission in Nairobi requested that the PROFIT Project conduct a comprehensive assessment to determine what strategies FPAK should pursue to increase its financial sustainability. USAID/Nairobi planned to use the findings and recommendations from PROFIT's assessment to assist FPAK in making short-term operational decisions, as well as to define FPAK's long-term role in Kenya's health and population sector. The findings of this study were also meant to assist USAID/Nairobi in prioritizing its assistance to FPAK.

FPAK's management had come to an internal consensus that five organizational and management strategies held promise for improving FPAK's ability to independently provide quality reproductive health services:

- Introducing cost recovery mechanisms to collect fees from clients to cover the cost of family planning services as well as from other family planning NGOs for training and other activities

**Deloitte Touche  
Tohmatsu**



Deloitte Touche Tohmatsu International  
in association with:

Boston University Center for International Health Multinational Strategies, Inc. Development Associates, Inc. Family Health International

8/97

- Improving the cost-effectiveness of delivering clinic and community-based services (called “cost rationalization” by FPAK)
- Introducing new services to increase and diversify FPAK’s revenue and client base
- Developing FPAK’s marketing strategy and capacity to better identify and meet clients’ needs and preferences and to investigate alternative sources of revenue such as the private sector or civic organizations
- Developing a capacity to sell commodities and/or services previously provided at no cost to FPAK clients.

## **PROFIT’S Approach**

PROFIT conducted its assessment from a commercial perspective, which was unfamiliar to FPAK. Despite the fact that FPAK had undergone other management and organizational reviews, PROFIT sought to bring FPAK toward a more commercial level of management accountability and efficiency. PROFIT worked with the management consulting division of Deloitte & Touche/Kenya, which had assisted a variety of private sector companies to improve their profitability. Deloitte’s commercial experience was supplemented by the involvement of a consultant with extensive knowledge of healthcare operations in Kenya.

The assessment involved a rigorous financial and management review to uncover the reasons for FPAK’s financial weakness and to examine the potential impact of the five strategies under consideration by FPAK’s management. The assessment was to focus on making strategic decisions based on financial analysis, and the process involved four steps.

- 1) Information Gathering: Working closely with the financial staff and senior management, PROFIT conducted a thorough financial and management review, including a full review of FPAK’s
  - institutional mission, operations, and products and services
  - funding sources (donor funds, membership fees, etc.)
  - current market position, competitive environment, and market outlook
  - the ability of management information systems (MIS) to be used to implement new strategies
  - accounting systems, including the quality and reliability of data, linkages between facility-level data and the central office, adequacy in tracking program costs and the financial strategy

- financial performance, including unit cost analyses of both static clinics and community-based activities
  - assessment of management and organizational structure and personnel functions
- 2) Field Visits: After a thorough orientation to FPAK, the assessment team visited 10 of FPAK's 14 clinics, 6 of its 8 area offices, and 6 of its 21 CBD sites. The topics covered during the site visits included:
- differences in the ability to pay of client groups served by different clinics
  - the logistical feasibility of adding new services to existing facilities
  - efficiency issues related to staffing and clinical procedures
  - utilization rates of various clinics
  - the steps required to track the profitability of each clinic
  - the capacity of each clinic to conduct local marketing and fundraising activities
- 3) Feasibility Analysis and Financial Modelling of Various Strategies: Based on the findings of the field visits and other information-gathering activities, the PROFIT team prepared a feasibility analysis of various probable outcomes of the five different strategies. The analyses projected the potential financial impact by incorporating the administrative, management, and technical inputs required, as well as projections of the costs of initiating new strategies. Here are some examples of the analyses that were conducted:
- the costs of implementing systems to allow each clinic to track its own income and costs
  - potential cost savings of different measures to improve efficiency
  - estimated financial return of introducing new services, using sensitivity analysis to calculate the potential risk
  - sensitivity analysis to calculate the financial impact to FPAK of cost-reduction measures, service expansion, and fee increases
- 4) Management Workshop: PROFIT prepared an initial report of its findings and recommendations and distributed it to FPAK, USAID, IPPF, and other donors. The assessment team then conducted a two-day workshop with representatives from all these organizations to seek a consensus on the most appropriate strategies for FPAK to pursue. The critical objective for the workshop was to ensure that all parties participated in the decision-making process and supported the final recommendations. The final recommendations reflected input from this workshop.

## **Findings**

In 1994, 96 percent of FPAK's income came from donors' grants, and the remaining 4 percent was generated through local fundraising efforts and client fees. FPAK's total expenses were \$3.7 million. Over the past four years, FPAK's total expenditures have increased at a compounded rate of 43 percent annually. During this same period, the clinic workload (the number of clients seen) declined by 14 percent, and the CBD program workload was flat. If FPAK were to remain a leader in its field, it would have to reverse these trends. Of the five strategies reviewed, three proved critical to the organization's financial sustainability: cost recovery, cost-effectiveness, and introducing new products.

### **Cost Recovery**

Cost recovery is the collection of fees from clients to recoup the costs of providing family planning services. PROFIT's assessment found that FPAK's systems did not adequately track cost centers or reconcile financial and service data. Shortfalls in the financial accounting system and procedures would make it extremely difficult to determine the full costs of operating a clinic or a CBD site. For example, the costs of contraceptives were not allocated to specific clinics but were charged to the central office, and these costs were not considered in determining the prices charged to clients. Overall, there were significant variations among clinics in cost recovery rates: some clinics recovered up to 70 percent of the direct operating costs, and others recovered only 23 percent.

### **Cost-Effectiveness**

Cost-effectiveness is the ability to provide services with minimum resources. PROFIT's assessment found that FPAK's costs were rising while the workload remained stagnant or declined. On average, each nurse saw 12 clients per day, although the actual figures ranged from 7 in some clinics to 20 in others. Although seeing too many clients each day can adversely affect the quality of care, increasing the number of clients is a way to minimize the cost per visit. In addition, clinic managers and CBD supervisors had no training in financial management and control systems and did not consider themselves responsible for the finances of their operations.

### **Introducing New Products and Services**

Introducing new products and services was seen as one way to increase FPAK's financial sustainability by generating income that could be used to subsidize the family planning services. FPAK considered introducing laboratory services, curative services, pharmacies, and training services.

FPAK opened four laboratories in 1996 to perform Pap smears, based on its success with a laboratory opened in 1995. The first laboratory processed 16,000 Pap smears collected from all the FPAK clinics around the country and generated income for FPAK. The decision to open the additional laboratories was not based on sound financial analysis. For example, FPAK had not identified new customers for the additional labs, beyond its own clinics. The result was that five laboratories were processing the same volume of Pap smears that the first laboratory had handled

on its own, or about 3,200 smears per year. Each laboratory actually generated a loss because of its high fixed costs.

## Recommendations

- The financial management system should be improved. Specifically, internal financial controls and record-keeping should be improved, and field managers should be trained to be responsible for overseeing these areas.
- Staff members should be given incentives based on financial performance.
- A thorough analysis should be made of the causes for the downward trends in the number of clients and of the effect of price on demand.
- The size of the staff at each clinic should be re-examined in light of the clinic's workload.
- The number of area offices and their organizational structures should be re-examined to determine whether there is the potential for cost savings.
- Decisions to introduce new non-family planning products and services should be driven primarily by financial criteria. Activities should be undertaken only upon a thorough assessment of the market, the demand, and the projected financial returns. Each new product or service should be operated as a separate cost-revenue center, to make it apparent the new product or service makes a positive contribution to FPAK's financial sustainability.

The assessment also uncovered several institutional issues that were beyond PROFIT's initial Scope of Work but which affected FPAK's financial sustainability. One of these was the structure of the branch operations and volunteer services, which have been important parts of FPAK, but which are costly to maintain. There may be ways to minimize their costs and to improve their effectiveness. In 1995, FPAK spent over \$40,000 to maintain its network of volunteers, mainly for local branch expenses and for volunteers to attend national meetings. FPAK should consider allowing the branches to retain a large portion of the proceeds from local fundraising activities, which would comprise their entire budgets. This would give branches a strong incentive to increase their fundraising and would reduce the burden on the central office. Also, FPAK should encourage new volunteers in order to attract the most qualified people and should emphasize corporate sponsorship in its fundraising.

There was an initial reluctance to accept some of the findings and recommendations, which was not surprising given that FPAK had relied on donor funding for over 50 years. In the end, however, there was a general consensus among FPAK and the donors to support nearly all the initial recommendations. Along the way to consensus, there was discussion about delaying the difficult decisions, such as reducing staff size or closing some area offices. There was also some struggle about whether to adopt a commercial orientation, which surfaced in discussions of whether staff members should be given incentives based on financial results and whether decisions should be made on the basis of financial motives. There were suggestions to focus on soliciting new funding or donors.

Overall, the assessment provided a good foundation for FPAK's sustainability strategy. It took a new approach: analyzing an NGO from a commercial perspective and using financial criteria to make management decisions. FPAK will require continual training and assistance to implement the recommendations.

## Conclusions

The FPAK case provides a number of lessons that are applicable to efforts to improve the financial sustainability of other NGOs:

- Use an assessment to test specific assumptions about the potential effectiveness of various strategies — that is, limit the scope of the assessment.
- Use management consultants to provide a more thorough financial review.
- Involve all the stakeholders in the process, including other donors, members of the organization's board, and staff members.
- Solicit the support of a few respected, senior individuals within the organization early on, because they will be critical in generating broad support for change throughout the organization.
- Be prepared for defensive reactions to the recommendations.
- Expect to provide ongoing technical support to implement the recommendations.
- Use a workshop as a forum to build consensus among stakeholders and to encourage the people in the organization to take ownership of the new strategy.

Taking a commercial approach toward management and financial sustainability is new for the management and staff of most NGOs. Although such a change may be hard to undertake, taking a commercial approach is an important management tool because it quantifies the strengths and weaknesses of an organization in financial terms. The ultimate goal is not to encourage NGOs to seek a profit but to allow them to fulfil their objectives to serve the needs of their communities over the long run.

## 8. Lessons Learned

**This section distills key lessons from the PROFIT Project for involving the commercial sector in family planning.**

- A. Lessons from the PROFIT Experience
- B. Perspectives on Future Efforts to Increase Commercial Sector Involvement in Family Planning

### Lessons from the PROFIT Experience

PROFIT's mandate to mobilize the for-profit, private (commercial) sector for family planning enabled the project to conduct a broad spectrum of activities. These included contraceptive manufacturing and distribution; the provision of services by clinics, doctors, midwives, and pharmacists; and financing of family planning products and services by employers and health insurance companies. As part of these efforts, PROFIT also assessed the extent to which trade and regulatory barriers inhibited commercial sector involvement in family planning and sought to remove any barriers identified.

PROFIT's experience showed that project interventions that aim to mobilize the commercial sector to invest in family planning can be successful, under certain general conditions:

- ◆ The trade, policy, regulatory, and general business environments should facilitate commercial sector activities in general and commercial family planning activities in particular. A country's level of economic development, the government's commitment to family planning, and the level of contraceptive prevalence all affect the success of commercial sector family planning initiatives.
- ◆ Opportunities must exist for the commercial sector to offer family planning products and services to consumers who can afford to pay for them. To help ensure adequate demand for commercial family planning, the public sector must target free and subsidized contraceptive products and services to those who are least able to pay.
- ◆ All parties must recognize that the profit or business motivations of the commercial partners must be paramount if the partnership is to be sustainable. A commercial firm will enter a partnership only when doing so advances their long-run business interests and will not form partnerships solely for social or philanthropic purposes — even if serving social and philanthropic objectives is part of the firm's long-run business strategy.
- ◆ Projects should address the full range of supply, demand, policy, and regulatory barriers that constrain commercial involvement in family planning. Moreover,

## Lessons from the PROFIT Experience

supporting the expansion of private family planning services almost always means supporting provision of a broader range of health services, because family planning is not commercially viable on its own.

- ◆ Appropriate partners are those with credibility among the target audiences, a track record of commercial activity, a commitment to the project (particularly at senior management levels), and sufficient resources to fully implement all the activities.
- ◆ Commercial sector family planning projects may have less family planning impact in the short-term than traditional USAID-supported projects. However, they are more likely to be sustainable and to require fewer public sector resources over the long term.
- ◆ Those who design and implement commercial projects must retain the flexibility to overcome unforeseen challenges and exploit new opportunities by responding to changes that affect the country or sector environment or the circumstances of the partnership.

These general preconditions apply to public-private partnerships in all sectors. However, this paper focuses on the lessons learned from PROFIT's experience in five sectors:

- ◆ manufacturing and distribution
- ◆ private health care providers
- ◆ employers
- ◆ insurance
- ◆ trade, policy, and regulatory reform.

Specifically, this paper draws on PROFIT's experience in identifying, analyzing, developing, and implementing commercial sector family planning subprojects, providing technical assistance, and conducting research. This paper provides some brief background on PROFIT's work in each of the five sectors and offers the lessons learned from this experience, presented in order from the most general (and important) to the most specific.

Over a five-year period, PROFIT identified 80 potential subproject opportunities and developed 29 subprojects, of which 13 were implemented. In addition PROFIT conducted 28 consulting assignments for USAID missions in various countries.<sup>1</sup>

---

<sup>1</sup> Section 3 of this compendium includes detailed descriptions of the 13 subprojects implemented, and the Appendices in Section 9 include a listing of the 80 projects and 28 consultancies that were considered and/or implemented and a complete listing of PROFIT reports and publications, many of which report on or evaluate these activities.

## Lessons from the PROFIT Experience

### Contraceptive Manufacturing and Distribution

PROFIT's contract mandated that the project support the local manufacturing and distribution of contraceptive commodities. The goal was to improve the quality, price, and availability of contraceptives. PROFIT examined 32 potential subprojects in this area, but only four were actually implemented, three of which were in distribution rather than manufacturing.

#### ***Lessons Learned: Manufacturing***

When strict financial criteria are applied, the opportunities to engage in commercially viable manufacturing of contraceptives in developing countries are very limited, for several reasons:

- ◆ There are insufficient markets for contraceptive products, either because contraceptive prevalence is too low or because there are too few potential customers who can afford to pay for commercial products and services.
- ◆ In countries where the market is sufficient, large pharmaceutical manufacturers are already producing contraceptives to meet local demand.
- ◆ Subsidized or donated products are available, which constrains the private market.

In addition, USAID policy required that PROFIT work only with products approved by the U.S. Food and Drug Administration (FDA). This prevented PROFIT from exploiting many of the local manufacturing opportunities that did exist, including for Cyclofem® in Mexico, the SEMINA® diaphragm in Brazil, and several IUD projects in India.

#### ***Lessons Learned: Distribution***

##### Start-Up Distribution Companies

In Brazil, PROFIT established a distribution company, CEPEO. Among the tasks PROFIT performed were selecting a general manager, negotiating supplier arrangements, registering the products with the Ministry of Health, and opening offices in two cities. Registering the products and securing all necessary legal documentation to operate the business proved to be much more complicated and time-consuming than expected.

While some of the problems PROFIT encountered were unique to Brazil, the process would be time-consuming in any developing country. PROFIT's experience with CEPEO highlighted several factors that are critical to efforts to start up a distribution company:

- ◆ The company's general manager and salespeople must have experience with the product line and with potential clients.

## Lessons from the PROFIT Experience

- ◆ The funding arrangements must be flexible to cover start-up costs and cash-flow shortfalls.
- ◆ Successful planning and implementation must be based on the results of a thorough and careful analysis of the market for each potential product.
- ◆ There must be evidence that the country's social sector organizations, including those that formerly received donated supplies, are willing and able to pay for contraceptives.
- ◆ Detailed financial analyses must demonstrate that the proposed company has the potential to be self-sustaining.
- ◆ Close supervision and adequate technical assistance are necessary to guide and support the company through the start-up phase.

### Existing Distribution Companies

In most countries, contraceptive distribution companies spring up quickly when the market is opened. For all but the largest distribution companies, competition is fierce and margins low. Therefore, it may be advisable to work with existing distribution companies, who have proven their mettle in a competitive market, instead of starting up a new distribution company, as PROFIT did with CEPEO in Brazil. The goal should be to let the commercial sector do what it does best, while injecting the technical know-how to ensure that products are correctly promoted and widely distributed.

Most private distribution companies are highly skilled at getting their products widely distributed. However, there may be an opportunity to induce or assist companies to broaden the number and types of contraceptive products they carry, to introduce contraceptives to new retail outlets, to improve in-store promotion of contraceptive products, and/or to reduce the price to consumers.

### Competition

Any effort to set-up or expand contraceptive distribution on a commercial basis requires that the government and donors commit to restrict the free or subsidized distribution of products and services to those who most need them. For example, in Zimbabwe PROFIT was asked to expand the role of the private sector in providing family planning services. Although PROFIT was able to train private providers (including doctors, midwives, and pharmacists) to provide family planning services, their potential role in delivering these services was limited by their inadequate access to affordable contraceptives. In fact, most contraceptive manufacturers had exited the market because they could not compete with the highly subsidized products that were widely distributed by the public sector. In the end, a working group was established that included representatives of both the public and the private sectors to address

## Lessons from the PROFIT Experience

this situation, and the manufacturers eventually agreed to re-enter the market with a greater variety of lower-priced products available to private providers.

### Product Supply

PROFIT was required by USAID regulations to use its funds to import only U.S.-made products, a policy aimed at giving U.S. companies access to new markets over the long run. However, U.S.-made pharmaceuticals are not always right for commercial distribution in a particular country. For example, in Romania, generic products from Hungary are available for a fraction of the price of U.S.-made pills. In Brazil, CEPEO fights to maintain its market for U.S.-made IUDs against competition from lower-priced Indian-made products.

## Private Health Care Providers

In many developing countries, family planning is available primarily in public sector clinics, where consumers face long lines, limited hours, and supply shortages. One main objective of the PROFIT Project was to expand the supply of family planning products and services available through private providers. This included working with private clinics, individual physicians, midwives, nurses, and pharmacists to establish, improve, or expand their private practices.

PROFIT supported private health care providers through various activities, including training (Brazil, Kenya, Philippines, Romania, and Zimbabwe) and financial assistance in the form of small grants (Zimbabwe) or loans (Brazil, Indonesia, Philippines) to cover the costs of basic equipment, renovations, and supplies. In addition, PROFIT conducted information, education, and communications (IEC) activities and marketing programs to motivate consumers to use private providers.

### ***Lessons Learned: General***

#### The Market

There are two key aspects to increasing utilization of private providers for family planning. First, there must be an active private health infrastructure with a sufficient number of well-trained providers. Second, there must be a base of clients who are willing and able to pay for these services. Increasing the quantity of private providers is not sufficient to achieve greater utilization of private services; there must be a sufficient pool of consumers who are able and willing to pay for these services.

## Lessons from the PROFIT Experience

### Motivations

Training and financial support can help increase the number of private providers that offer high-quality family planning services. However, increasing the supply of services does not necessarily increase the demand. It is critical to understand consumers' motivations for seeking services from the public or private sectors to determine whether and how to influence demand.

For example, PROFIT's research in the Philippines showed that price is by far the most critical factor in consumers' choices about where to obtain family planning services. This suggested that, unless the government and donors limited access to free or subsidized products and services to people who were least able to pay, private providers would find it difficult to establish themselves as alternative providers.

On the other hand, in Indonesia, convenience is the most important factor in people's choices about supply (measured by the providers' proximity to consumers' homes). This is an attribute that is much easier for the private sector to address on its own. For example, midwives, the leading private provider of family planning in Indonesia, make house calls, which is a direct response to consumers' willingness to pay for convenience.

### Information, Education, and Communications

IEC efforts seek to build demand for the services offered by private providers. To be effective, such activities must be grounded in market research that ensures that an appropriate message is targeted to the right audience. In the end, however, providers must be willing and able to meet the demand generated by these marketing efforts. In Zimbabwe, pharmacists indicated that they were fearful of being associated with a family planning IEC campaign until they were fully trained to provide the services. Moreover, because it is illegal for pharmacists to advertise, they were reluctant to display material that indicated they were part of a larger overall campaign to promote utilization of private providers because they feared legal repercussions.

### The Political Environment

It is critical to understand the local political environment. For example, despite government efforts, family planning continues to have a negative image in the Philippines, and this hampered the success of PROFIT's physicians' loan fund in several ways. First, it limited the number of professional medical associations that were willing to work with the subproject and made those associations that did endorse the subproject reluctant to promote its family planning aspects. In addition, PROFIT's partner bank was asked to lower the profile of the subproject when its board discovered that it included a family planning component.

## Lessons from the PROFIT Experience

### Combining Family Planning and Health Services

PROFIT failed to identify a single commercial firm that offered family planning services exclusively; all considered family planning to be one component of a broader set of health services. This means that supporting the expansion of private family planning services almost always means supporting the provision of a broader range of health services. For example, the loans provided under PROFIT's loan fund in Indonesia were used to support the midwives' practices overall, not just the provision of family planning.

### Training

Family planning training programs offer an opportunity to improve the skills of family planning providers and therefore the quality of their services. Most family planning training courses are focused on the needs of public sector providers and are not even always open to commercial providers. The courses are typically long and are held at hours that make them impractical for private providers.

For private providers, time is money. Therefore, training programs for private providers must address their needs and must be short and convenient. For example, in the Philippines, doctors preferred to have training sessions held over two weekends rather than extended over several weeks or months. In Romania, a survey indicated that a one-day weekend session best met the training needs and schedules of pharmacists. In Zimbabwe, doctors preferred that the course last no more than three days and that it focus exclusively on the training they needed most (i.e., Norplant® and IUD insertion). PROFIT's experience shows that use of participatory training techniques and a focus on the needs of the audience make training programs more effective in increasing the practical knowledge of participants.

In fact, training programs appear to follow the general rule that support for private family planning means support for a broad range of health services. PROFIT found that private providers were interested in how family planning training would affect their overall practices. In Zimbabwe, PROFIT's family planning training included efforts to improve providers' skills for communicating with patients, and in Romania, PROFIT's training program included business management skills to help pharmacists better manage their inventories, including contraceptive products, and to operate their businesses on a more sustainable basis.

Recruiting respected local professionals to serve as trainers lent additional credibility to PROFIT's training programs. In addition, recruiting trainers from the various geographic regions where the training workshops were held allowed the trainers to provide follow-up support to trainees and helped build a support network among providers. In addition, trainers should be allowed to adapt the curriculum and materials to the local context to insure that the training is of the highest quality, that it is appropriate to local conditions, and that it is recognized by respected local institutions such as universities and professional medical associations.

## Lessons from the PROFIT Experience

### Access to Capital

Providing access to capital can help encourage private providers to establish or expand private practices. This was the motivation for the PROFIT loan fund for midwives in Indonesia, where midwives were interested in establishing or improving their private practices but had little access to capital. PROFIT found a high demand for the loans among midwives, who commonly used the funds to rent and renovate clinic space and to purchase equipment.

### Efficient Implementation

Although all providers may be able to benefit from loans to establish or expand their private practices, it is inefficient to work with providers on an individual basis. Loan funds, administered by an independent financial intermediary, can be an effective way to reach a large number of private providers through a single program, as was the case for PROFIT's loan funds in the Philippines (for doctors) and Indonesia (for midwives).

### Evaluation

USAID evaluation practices often encouraged the collection of detailed data from providers about which contraceptive products and services were provided and to what types of customers (e.g., new acceptors, former public sector clients). It is difficult to collect this type of baseline and follow-up data from private providers for a variety of reasons. They may lack the time and staff to track such details; they may rely on time-consuming manual systems that may not always track the necessary information, they may fear tax repercussions; or they may not believe that tracking such information serves a practical business purpose.

## ***Lessons Learned: Doctors***

### Training

In the Philippines, PROFIT found that doctors who offered family planning services were only willing to attend training that they considered necessary, even if competency-based exams showed that they lacked skills in other areas. For example, PROFIT's research uncovered an *interest* among doctors in business training but a *need* for family planning training. In the end, both types of training programs were offered. Despite considerable effort to adapt the family planning curriculum and schedule to meet the needs and schedules of the physicians, there was a greater interest and willingness to attend the business training than the family planning course.

In Zimbabwe, PROFIT found that consumers were demanding family planning services from their private physicians that the providers were not trained to provide, which motivated the physicians to attend family planning training. This confirmed that private providers will participate in training programs when they perceive a need to acquire the knowledge offered.

## Lessons from the PROFIT Experience

### Loan Funds

Although PROFIT found an interest among doctors in the Philippines in borrowing to establish or expand their private practices, PROFIT never succeeded in attracting many borrowers, particularly among the target group of younger physicians. It seems that a lack of capital was not the only obstacle to establishing private practices and that PROFIT's initial research failed to identify the other constraints. However, those physicians that did borrow from the fund were motivated to do so by the favorable interest rates and reduced collateral requirements. Future lending programs should be based on more in-depth research on the obstacles to establishing private practices and should directly address those concerns, in addition to offering capital.

### ***Lessons Learned: Nurses and Midwives***

#### Provision of Family Planning

Overall, PROFIT found that the role of nurses in providing private family planning services was marginal compared to that of midwives. Nurses are much less likely to establish their own private practices and more often work for private physicians.

In many countries, midwives are a primary source of private family planning services. For example, in Indonesia, where midwives are permitted to provide a broad range of services in private practice, they are the primary private providers of family planning. They provide 57 percent of all private family planning products and services, compared to 18 percent for doctors and 7 percent for pharmacists.

PROFIT found that midwives in Indonesia, Philippines, and Zimbabwe had a very strong desire to expand into the private sector and a strong need for assistance to do so. In particular, because midwives' practices already focus on reproductive health, it is much easier to help and encourage midwives to provide basic family planning services than general practitioners or OB/GYNs, who tend to focus on more complex services and procedures.

#### Professional Associations

The professional associations of midwives in Indonesia and Zimbabwe proved to be critical to the success of PROFIT's subprojects in these countries. In particular, they helped PROFIT to understand the midwives' needs, to reach a large number of practicing midwives, and to gain their respect and trust.

### Loan Funds

There was demand among Indonesian midwives for loans to establish and/or renovate their private practices, particularly if the loans were low-cost. However, midwives that had less experience were less likely to apply for loans than their more established colleagues.

## Lessons from the PROFIT Experience

Anecdotal evidence suggests that it takes a midwife five to ten years to establish her reputation and hence to build a viable private practice. Other factors that might have contributed to the greater demand from older and more established midwives was that they were more likely to be recommended by the midwives association, which helped identify and screen applicants.

### Training

As part of its loan fund for midwives in Indonesia, PROFIT worked with a local training institute that had a reputation for promoting entrepreneurship among women to develop a business training course for the midwife borrowers. However, the course and manual were much too complex for the average midwife. Moreover, the training was provided to only two midwives in each target province, and there was no good system for disseminating the information more widely among the other borrowers. In the end, a group of midwives adapted and simplified the original manual to meet their needs, but it would have been more effective to involve the midwives in the original design of the manual. In addition, the training might better have been conducted at the provincial level.

### ***Lessons Learned: Pharmacists***

#### Provision of Family Planning

PROFIT found pharmacists to be willing sources of information and supply for family planning, if they have the proper training. Moreover, pharmacists can be effective family planning educators, particularly in countries where they can sell contraceptive pills without a doctor's prescription. In Romania and Zimbabwe, pharmacists were motivated by a sense of responsibility to meet the needs of their patients and a desire to provide a "quality service," which in their view, included educating their patients.

#### Pharmacist Structures and Networks

Working with respected local institutions can lend credibility to a subproject and improve the efficiency of its implementation. For example, PROFIT collaborated with the National Pharmacists Association (NPA) and the University Pharmacy Department in Romania to design an initiative that met the training needs of pharmacists. This collaboration provided PROFIT with ready contacts in various geographic areas, which was invaluable in recruiting participants and providing logistical support for the training workshops. It also gave the program instant credibility among pharmacists.

### Training

Private pharmacists are not only interested in profits. In Zimbabwe, pharmacists have a high demand for information about modern contraceptives, even though their potential profits from contraceptive sales are quite limited. In Romania, pharmacists view themselves to be

## Lessons from the PROFIT Experience

health care providers rather than business owners, and they were eager to participate in PROFIT's family planning training.

### Employer-Based Programs

Employer-financed programs are a potentially important mechanism for providing privately financed family planning services, particularly to those who would otherwise be unable to afford private products or services. In some countries, such as Zimbabwe, employer-based programs are well-established and do not involve ongoing subsidies. In other countries, companies contribute to the overall costs of providing family planning services, but employer-based programs could not be sustained without external subsidies in the form of commodities and IEC materials.

PROFIT built on previous USAID efforts to encourage employers to provide family planning benefits to employees by pointing out the potential cost savings (e.g., reduced medical costs, fewer sick days, less employee turnover) or by tapping their desire to be "good corporate citizens." PROFIT's efforts typically involved training, supplying basic equipment, providing access to contraceptive commodities, and supplying educational materials to motivate employees to use modern contraceptives and to use the employer-based services available.

### *Lessons Learned: Employers*

#### Reactions from the Field

Employer-based programs had been among the first efforts by USAID to work with the commercial sector, however, by the start of the PROFIT Project, many USAID missions had become less interested in initiating employer-based activities than in other, newer approaches. USAID often continued earlier projects that had been successful through local NGOs (e.g., in Kenya and the Philippines), and it sought to end support for those projects that were not sustainable. There were a few exceptions: PROFIT was asked to revitalize programs that had become dormant in India and Zimbabwe.

#### Employer Motivations

Each company is different, and its owners and managers may have different motivations for providing family planning. For example, economic considerations are not always the primary motivation; others may include a desire to improve labor relations, to position the company favorably in the eyes of the government, or to attract or retain employees. Companies that are willing to invest their own resources are much more committed to a subproject than those that do not.

## Lessons from the PROFIT Experience

### Employer Disincentives

Many company managers consider family planning to be a responsibility of the government, particularly if they already pay the government to provide health coverage for their employees (as under many of the social security systems in Latin America). Many companies are therefore reluctant to finance the provision of family planning services.

Even if there is no outright reluctance to provide family planning, companies may consider family planning a low priority, even among health care issues. Attempting to encourage managers to provide these services may be best done by those within the company; outsiders are not always welcome. In addition, support for such efforts must be broad-based if the program is to succeed. In particular, the support of senior managers is critical because they control the allocation of resources and determine employee benefits and work rules.

### Project Effectiveness and Sustainability

Efforts to expand employer-based services should be focused on large companies, particularly those with on-site health facilities where family planning can easily be added to the other services provided. PROFIT took this approach a step further in Zimbabwe. With only a year to implement its subproject, PROFIT chose companies that already offered at least one family planning method and sought to expand the methods offered and to increase IEC activities to improve utilization.

If employer-based programs are to be expanded, successful models must be developed for delivering services, and these must be easy for others to see, understand, and replicate. In India, PROFIT supported the establishment of an inhouse maternal and child health clinic in the Mawana Sugar Industries, a sugar-processing plant that is owned by Shriram Industrial Enterprises Limited, a diversified company that has five other sugar factories. The subproject provided a model that could be replicated in the company's other factories.

Working with employers on a one-to-one basis is very time-consuming. Working with insurance companies that provide health services to a large number of companies may be a more efficient means of encouraging employer financing for family planning benefits. However, such projects must include an IEC component to encourage use of the family planning benefit.

It would also be more efficient to reach companies through umbrella organizations, including professional associations, chambers of commerce, or regional cooperatives. For example, in its attempts to expand employer-based family planning in Zimbabwe, PROFIT worked with the Zimbabwe Occupational Nurses Association to directly reach a large number of nurses who work in company clinics. PROFIT also worked with the Confederation of Indian Industry (CII), whose members were interested in providing family planning services for their employees but were not sure where to begin. In particular, PROFIT developed a manual on how to establish family planning services, which the CII distributed to its 3,000 member companies, which employ a total of 2 million people.

## Lessons from the PROFIT Experience

Once a company has been convinced to provide family planning services, it will need some initial inputs very quickly, including training for clinic staff members, IEC materials, and access to an affordable supply of contraceptives. This does not mean that a project must always pay for these inputs; sometimes the employer simply needs help, for example, in linking up with appropriate suppliers.

### Health Insurance

In most developing countries, private health insurance does not include family planning benefits. This is because most traditional insurance companies view their role to be “pooling” risks for accidents, which include ill health, rather than covering the comprehensive health needs of the enrollees. Nonetheless, USAID projects have had some success in convincing health insurers to include family planning benefits, primarily by showing the cost savings of averting births (e.g., the costs of delivery).

PROFIT worked primarily with three types of insurance companies:

- ◆ insurance companies who could reach a large number of employers and hence a large pool of employees
- ◆ companies that were willing to experiment with expanding their client base to include more lower-income families (the upper-income individuals covered by most insurance plans are likely to already be contraceptive users and to obtain their services from the private sector)
- ◆ managed care plans, which presumably would be more likely to cover the comprehensive health care needs of enrollees, including family planning.

PROFIT implemented three substantial subprojects in this area: to establish a low-cost managed health plan in the Philippines (Philamcare), to expand family planning services provided by the largest HMO in Brazil (Unimed), and to work with a local insurer in Kenya (AAR) to launch a managed care plan in the industrial area of Nairobi which included family planning services. In addition, PROFIT conducted an assessment for a large insurance project in Jamaica and provided technical assistance for expansion of an insurance project in Zimbabwe.

### ***Lessons Learned: Insurance***

Commercial insurers are basically conservative and risk-adverse, and donors may be required to cover any initial losses or provide other risk-protection arrangements in order to obtain their participation.

## Lessons from the PROFIT Experience

### Traditional Indemnity Insurance

Traditional private indemnity health insurance companies are unlikely to add coverage for family planning benefits. These plans tend to cover affluent people who are already more likely to be practicing family planning and paying for private sector family planning services. For example, in Jamaica, PROFIT's analysis showed that the cost savings (i.e., reduced claims) to be realized by averting births did not cover the costs of implementing the program since the largely white-collar insured population was already paying for private sector family planning services.

### Managed Care

Managed care companies may be more likely to include family planning benefits because they are more likely to offer comprehensive health services including preventive care. PROFIT's partners in both the Philippines and Kenya were selected because of their genuine interest in introducing managed health care principles and in providing comprehensive health services, including family planning.

However, managed care is a relatively new concept in developing countries. Substantial technical assistance and ongoing commitment are required to shift attitudes and administrative capabilities in order to adopt and implement managed care and to take the risk of a capitation contract. For example, in the Philippines, using a capitation model for a health insurance plan represented a new approach for paying for and managing health care and was perceived to carry considerable financial risk. Therefore a greater amount of time and effort than originally anticipated went into recruiting participating providers and educating them on the merits of implementing a managed care system.

Finally, the success of managed care programs is highly dependent on the reputation and quality of the providers included in the system. Potential members will not enroll if they are not attracted to the medical facilities and providers in the network.

### Family Planning Impact

In some countries, the success of the government in delivering family planning services may discourage consumers from utilizing their insurance benefits for family planning, even if services are free. The insured may continue to go to familiar government clinics for family planning while using the private providers covered under the plan for other health care services.

To have an impact on family planning through an insurance-based program, the pool of beneficiaries must be expanded to include lower-income groups, who are less likely to be current users of contraception and are more likely to be using public sector services. However, the short-term costs of delivering services to lower-income individuals is high, and few insurance companies are willing to take the necessary financial risks to tap this market.

## Lessons from the PROFIT Experience

Therefore, it may be necessary to underwrite efforts to expand insurance coverage to lower-income groups in order to demonstrate to insurers the longer-term benefits.

### Lower-Income Markets

In the Philippines, PROFIT launched a managed care plan aimed at lower-income individuals and families, particularly those outside the formal economic sector. PROFIT found that there is a market for health insurance among this group but that the costs of recruiting enrollees was high, as were drop-out rates. This argues for innovative sales approaches and special efforts to increase retention (e.g., group payments, a specialized sales force).

The managers and providers of any plan aimed at reaching lower-income groups must be in agreement about the strategy. For example, the population covered by PROFIT's partner in Brazil, UNIMED, was better-educated and wealthier than the general population, and this group already had access to private sector family planning services. PROFIT encouraged UNIMED to serve lower-income populations on a fee-for-service basis because of the opportunity to improve clinic utilization and to have a family planning impact, but UNIMED's member doctors resisted changing their client profiles.

## Trade, Policy, and Regulatory Reform

Efforts to remove trade, policy, and regulatory barriers are essential for expanding the role of the commercial sector in family planning. Government regulations often make it impossible or unprofitable for the commercial sector to offer contraceptive services and products at an affordable price. They may also impede the market entry of a given provider, make it difficult for new products to come to market, or limit the methods that providers can offer. Identifying and removing such barriers requires collaborating with the government and educating both providers and regulators.

PROFIT assessed trade, policy, and regulatory constraints during the country assessments used to identify and develop potential subprojects. PROFIT chose primarily to work in countries that had limited barriers or where existing barriers were not expected to impede the implementation of its subprojects. In a few cases, PROFIT choose to address constraints directly:

- ◆ In the Philippines, PROFIT was asked to conduct an analysis of regulatory constraints to the private provision of family planning for the Department of Health as part of an effort to increase private provision.
- ◆ In Brazil, CEPEO lobbied the state and municipal authorities to implement the federally mandated women's health program, to conduct commodity bids that included the Cu-T380A IUD, and to reduce taxes on interstate sales.

## Lessons from the PROFIT Experience

- ◆ In Zimbabwe, PROFIT established a public-private sector working group to address tax policies that increased the cost of contraceptives in the private sector and worked with midwives and regulatory authorities to grant midwives the right to establish private practices.
- ◆ In Zimbabwe, PROFIT established a working group of representatives from the public and private sectors to improve the policy and regulatory environment for private family planning.

### ***Lessons Learned: Trade, Policy, and Regulatory Reform***

In conducting regulatory assessments, PROFIT found that a regulator's understanding of a law was different than the actual meaning of the law. It is important to review the text of relevant laws and regulations, using independent translations.

Unwritten and informal regulations may have a large impact. For example, in Zimbabwe midwives are legally permitted to establish private practices, but the medical authorities have been unwilling to grant midwives licenses because of their personal beliefs or fears. Search for such practices or bias.

Removing import taxes will not necessarily lead importers and distributors to pass on the savings to consumers or retail distributors. Understand the ramifications of tax and trade barriers at the retail level.

While regulatory reform is an important component of any commercial sector strategy, no single strategy will work in every country. It is essential to understand the regulatory constraints, determine their impact, and analyze the feasibility and timeframe of reform.

Dialogue among donors, the government, and representatives of the private sector can lead to policy and regulatory reform. For example, in Zimbabwe, PROFIT established a working group of representatives from the public and private sectors to improve the policy and regulatory environment for the private provision of family planning. Through this committee, the subproject succeeded in opening dialogue regarding competition between the public and private sectors, increasing the scheduled reimbursement for family planning among both private and public health insurance plans, and lifting import duties on contraceptive pills.

Efforts to remove trade, policy, regulatory barriers are essential for expansion of the commercial sector's role in family planning. However, such reform takes considerable time and requires having access to individuals, organizations, and government agencies that can influence the process.

## Lessons from the PROFIT Experience

### Conclusions

According to the United Nations Population Fund, the estimated cost of providing family planning in developing countries was \$4 billion in 1994, of which developing country governments paid 66 percent and private consumers only 14 percent. Certainly, many people in developing countries cannot afford to pay for private family planning services, but many others can afford to pay for private services and, in fact, seek alternatives to government-provided services.

PROFIT's mission was to experiment with various mechanisms to increase the financing and provision of family planning through the private sector. PROFIT's broad experience offers several key lessons for future programs that seek to promote private provision and financing of family planning.

- ◆ Project interventions that aim to mobilize the commercial sector to invest in family planning can be successful, under certain general conditions:
  - ◇ an economic, political, and regulatory environment that facilitates commercial sector activity in general and family planning activity in particular
  - ◇ minimal market distortions, particularly from untargeted free and/or subsidized distribution of contraceptive products
  - ◇ compatibility of goals among the organizations involved
  - ◇ sufficient and appropriate resources and inputs
  - ◇ willingness on the part of the public sector or donor partner to become involved in addressing the broader business concerns of the commercial partner
  - ◇ flexibility
  - ◇ a focus on the longer term.
- ◆ There are few opportunities for projects to promote local manufacturing, primarily because:
  - ◇ There are insufficient markets for contraceptive products, either because contraceptive prevalence is too low or because there are too few potential customers who can afford to pay for commercial products and services.
  - ◇ In countries where the market is sufficient, large pharmaceutical manufacturers are already producing contraceptives to meet local demand.

## Lessons from the PROFIT Experience

- ◇ Subsidized or donated products are available, which constrains the private market.
- ◆ There are more opportunities to work with contraceptive distributors to broaden the number and types of contraceptive products carried, to introduce contraceptives to new retail outlets, to improve in-store promotion of contraceptives, and to reduce prices. It is advisable to work with existing distributors, which have already proven themselves in the competitive marketplace, rather than to start a new company.
- ◆ Efforts to expand the supply of family planning products and services available through private providers requires that there be a sufficient number of well-trained providers and enough consumers who are able and willing to pay for such services.
- ◆ Training and financial support can help increase the number of private providers that offer high-quality services, but increasing the supply does not necessarily increase demand. It is critical to understand consumers' motivations for seeking services from various sources of supply (public and private).
- ◆ Employer-based programs are a potentially important mechanism for providing privately financed family planning services, particularly to those otherwise unable to afford them. However, companies have different motivations for providing such services, including economic considerations, building a better corporate image, or attracting and retaining employees. Companies that already offer some social benefits to their employees, such as housing or health care, are more likely to offer family planning. Working with employers individually can be less efficient than working through insurance companies or umbrella organizations.
- ◆ Including family planning in private health insurance plans is another mechanism for shifting users of publicly financed family planning services to privately financed alternatives. However, traditional indemnity insurance plans are poor targets for such efforts. Managed care plans are more likely to offer comprehensive health services including preventive services such as family planning.
- ◆ Removing trade, policy, and regulatory barriers is an essential component of any effort to expand the commercial sector role in family planning. However, such reform can take considerable time and requires gaining access to individuals, organizations, and government agencies that can influence the process.

### **Perspectives on Future Efforts to Expand Commercial Sector Involvement in Family Planning**

The PROFIT Project was designed to increase the involvement of the commercial sector in family planning activities in developing countries. Over the past six years, PROFIT implemented a wide range of activities with a variety of commercial sector partners, including health insurance companies, private employers, pharmaceutical distributors, and health care professionals (doctors, nurses, midwives, and traditional practitioners). PROFIT's interventions included equity investments, large and small loans, training, technical assistance, and research. This paper provides PROFIT's perspectives on future commercial sector family planning efforts based on this experience.

The paper is organized into three major sections. The first discusses broad issues related to the conceptualization and design of future efforts to increase commercial sector involvement in family planning activities. The second section discusses broad issues related to the implementation of such projects. The final section outlines recommendations specific to the design of future USAID projects, although they may be applicable to other donors as well.

## **Conceptualization and Design**

### ***Objectives for Involvement***

There are three major objectives for involving the commercial sector in family planning activities. The most common is to shift users who can afford to pay from the public to the commercial sector in order to free public resources to better serve the poor. This helps narrow the resource gap for family planning services and allows greater numbers of people in developing countries to be served. This was a primary objective of the PROFIT Project.

Two other objectives of commercial involvement are less common but are also important: to benefit from the efficiencies often associated with commercial sector activities;

## **Perspectives on Future Efforts to Expand Commercial Sector Involvement in Family Planning**

and to achieve the higher level of quality often associated with commercial sector products and services. These two objectives are generally less known and less understood among USAID staff members and host country government officials, particularly those who deal with population issues. Part of any commercial sector family planning project, therefore, must be to communicate the advantages and strengths of commercial sector involvement.

### ***Commercial Sector Partners***

There are a wide range of individuals and organizations in the commercial sector that can be involved in family planning activities, including:

- ◆ service providers such as private doctors, nurses, midwives, and traditional practitioners
- ◆ commercial hospitals and clinics
- ◆ retailers such as pharmacists, shopkeepers, and individual entrepreneurs
- ◆ manufacturers and distributors of pharmaceuticals and medical supplies
- ◆ health insurance companies
- ◆ large employers that provide health benefits to their employees
- ◆ advertising companies.

Although these individuals and groups can be approached individually, some of PROFIT's most successful efforts involved working with associations or umbrella organizations of providers or businesses. It is important to note, however, that none of these commercial entities is likely to enter into partnerships solely to provide family planning, and so the project must also address a broader range of business and/or health concerns.

### ***Level of Involvement***

The involvement of the commercial sector in family planning activities varies widely among developing countries. In the Dominican Republic and Egypt, for example, the commercial sector provides services to more than 20 percent of married women of reproductive age (MWRA) and serves more women than the public sector. In most developing countries, however, the commercial sector serves fewer than 5 percent of MWRA and many fewer women than the public sector.

Many people in the population community believe that the commercial sector is necessarily limited to serving those with higher incomes. PROFIT's research showed,

## **Perspectives on Future Efforts to Expand Commercial Sector Involvement in Family Planning**

however, that commercial family planning providers now serve people in every income group. Some people in even the lowest-income segments of the population will use commercial sources for family planning, particularly when low-cost options are available (such as pharmacies, midwives, or traditional practitioners).

The potential for commercial involvement is influenced by the general economic and business conditions in the country, the commercial sector role in other health services, and the availability of other low-cost products and services. Although the level of commercial sector involvement will vary by country, it can be expanded beyond current levels in virtually all developing countries. In particular, there are opportunities to lower the costs of contraceptive products and to expand the availability of low-cost providers such as midwives and pharmacists.

### ***Expectations for Growth***

The PROFIT experience suggests that, in most cases, commercial sector involvement in family planning will grow slowly, mirroring the incremental growth of the commercial health sector as a whole. Typically, the commercial health sector in developing countries initially serves those in higher socioeconomic groups and then expands “down-market.”

There are a variety of factors that constrain the growth of the commercial sector in family planning. Perhaps the most important is competition from free or very-low-priced products and services offered by the public sector. The other factors include restrictive government policies and regulations on commercial contraceptive sales and services; a general lack of business and commercial skills; and the fact that commercial entities will be involved in a broader range of health-related activities that may detract from their attention to family planning.

Any approach to commercial sector involvement therefore should have a long-term view. Making grants directly to public sector or nonprofit providers is likely to generate a greater short-term impact on family planning than seeking to mobilize the commercial sector. However, the impact from commercial sector interventions is likely to be more sustainable over the long term because donor resources will not be required on an ongoing basis.

### ***Types of Involvement***

There are three ways the commercial sector can be involved in family planning activities in developing countries:

- ◆ as profit-making businesses providing family planning goods and services on a commercial basis

## **Perspectives on Future Efforts to Expand Commercial Sector Involvement in Family Planning**

- ◆ as good corporate citizens providing products or services at or near cost to serve social objectives or to improve their corporate images
- ◆ as philanthropists providing money or resources to support family planning efforts.

The first of these was the one most often used by PROFIT. However, many individuals within USAID and host country governments wanted or expected the commercial sector to subsidize services or products for the poor. Appealing to the desires of commercial entities to be good corporate citizens or philanthropists may generate some immediate short-term benefits, but partnerships established on the basis of profit and business motives are most likely to produce sustainable results over the long term. Businesses must be profitable to operate, and so it is important to develop ways to integrate social goals into general business objectives.

### ***The Profitability of Family Planning***

Commercial manufacturers, distributors, retailers, and service providers all offer family planning products and services in developing countries, and this attests to the fact that family planning activities can be commercially viable. A survey of doctors and midwives in private practice in the Philippines indicated that most found family planning to be “profitable” (36 percent) or “very profitable” (33 percent). The fact that PROFIT was able to identify more than 80 subproject opportunities also indicates that commercial companies are interested in family planning.

Nonetheless, family planning is unlikely to generate large profits and, in most cases, will be provided as part of a broader range of health services or products. This is because the profitability of family planning activities is often severely constrained by competition from subsidized products or services provided by the public sector or by policies and regulations that impede private investment and commercial activity. In addition, many health analysts believe that preventive health services are inherently less profitable than curative health services.

### ***Appropriateness of USAID Support***

PROFIT believes it is appropriate for USAID to support commercial family planning activities for the following reasons:

- ◆ Such activities are often consonant with USAID’s family planning goals in that they help to address the resource gap.
- ◆ A broad range of consumers now rely on commercial sources for other health services and seek options for gaining access to commercial family planning services as well.

## **Perspectives on Future Efforts to Expand Commercial Sector Involvement in Family Planning**

- ◆ The U.S. government supports the further development of the commercial health sector in developing countries.
- ◆ Commercial involvement holds promise for generating sustainable health and economic improvements.

PROFIT staff members encountered a number of individuals within USAID and in host country governments (particularly among those working on population issues) who communicated a distrust of the commercial sector and an uneasiness about profit-making in family planning. These individuals must be convinced that profit motives and family planning goals can be compatible. The arguments for commercial sector involvement in family planning must be clearly communicated, and the concerns of those who distrust the commercial sector must be addressed.

### ***Appropriate Assistance***

Assistance to the commercial sector should be offered on a non-discriminatory basis and should not result in a significant commercial advantage for one individual or organization. This means that:

- ◆ Training and technical assistance are generally appropriate when they are offered broadly and without discrimination.
- ◆ Grants should not be provided to specific individuals or organizations but may be appropriate for broad-based associations or umbrella organizations.
- ◆ Associations or umbrella organizations can be assisted in negotiating with governments to address burdensome policies and regulations, but individuals and individual organizations should not.
- ◆ Subsidized loans or investments should be made only if they are tied to particular family planning objectives or if they are offered broadly and without discrimination.

Although loans, investments, and other assistance may serve a family planning objective, they are likely also to serve broader purposes. For example, a loan may be used by a practitioner to expand his or her medical offices which are used for family planning as well as a range of other maternal and child health services.

### ***Investments***

It was originally assumed that PROFIT could make profitable investments *and* generate a significant family planning impact. However, the family planning impact of PROFIT's

## **Perspectives on Future Efforts to Expand Commercial Sector Involvement in Family Planning**

subprojects were limited by a number of factors, including the scope of individual subprojects, implementation challenges, and the commercial viability of the family planning activities.

PROFIT's access to capital did improve its credibility among potential partners, and PROFIT's ability to develop nearly 30 substantive subprojects reflected that there was interest among commercial entities in tapping this resource. However, most of PROFIT's initiatives that specifically targeted family planning had capital needs of less than \$500,000. The subprojects with larger investment demands were mostly in manufacturing, and these were generally not implemented because they were commercially unfeasible or because of USAID policy constraints.

PROFIT considers making investments to be one of many tools appropriate for expanding commercial sector involvement in family planning. Investment funds should be made available to support promising interventions but should not be the primary emphasis of future efforts.

### ***Financial Leveraging***

Contrary to initial expectations, PROFIT was unable to use debt conversions and blocked corporate funds to leverage its investment capital. Changes in developing country debt markets and the removal of foreign exchange restrictions virtually eliminated options for financial leveraging through such mechanisms.

PROFIT was able to leverage its funds by having local partners or, in a few cases, other donors invest in subprojects. However, the achievement of leveraging objectives did not translate into significantly improved family planning impact. Also, the time and effort PROFIT expended to solicit investments from its partners sometimes diverted resources away from the family planning aspects of the subprojects.

In addition to making financial commitments, PROFIT's partners invested considerable time and effort in planning and improving their family planning services and products. This included attending training sessions, developing and using data systems to document family planning results, and disseminating those results to others in the commercial sector. These inputs were essential to the success of many subprojects.

PROFIT believes it is important for commercial partners to investment their time and effort in subproject activities. However, financial leveraging probably should not be a major emphasis of future projects unless the goal is to encourage companies to make charitable contributions to the effort.

## **Perspectives on Future Efforts to Expand Commercial Sector Involvement in Family Planning**

### **Implementation Issues**

#### ***Combining Business and Family Planning Expertise***

People involved in efforts to mobilize the commercial sector in family planning must have expertise in both business and family planning. They need business expertise to interact effectively with commercial partners, understand the local business environment, analyze market and financial issues, and negotiate and structure financial agreements with commercial partners. They need family planning expertise to design and implement meaningful subprojects, provide input for training and information efforts, evaluate the family planning results, and disseminate lessons to the family planning community.

Because few individuals have strong skills in both areas, it is important to recruit a range of people with a balanced combination of skills and to employ them in roles that best use those skills. Initially, PROFIT's staff had primarily commercial expertise, but more staff members were added who had family planning backgrounds. It was a challenge for PROFIT to develop an appropriate balance and to create an environment that fostered the integration and sharing of both areas of expertise, which was largely accomplished by informal exchanges among staff members and shared review of subproject proposals. Future projects might encourage an exchange of skills through staff retreats, workshops, and conferences.

#### ***Balancing Commercial and Family Planning Goals***

Although the goals of PROFIT's commercial partners often overlapped with the family planning goals of USAID, there was almost always tension between these two sets of goals. The main motivating force for commercial partners is financial (profits, market share, etc.), and the major motivation for donors is family planning impact. Commercial sector interventions in family planning must recognize and deal with this inherent tension. PROFIT was able to balance commercial goals and family planning goals by:

- ◆ clearly articulating PROFIT's overall commercial and family planning goals
- ◆ including both types of goals in subproject activities and agreements
- ◆ frequently assessing the progress of PROFIT and its subprojects in meeting business and family planning goals
- ◆ redesigning and redirecting activities to maintain the balance between goals.

## **Perspectives on Future Efforts to Expand Commercial Sector Involvement in Family Planning**

### ***Working within USAID's Organizational Structure***

PROFIT often found differences between the objectives and priorities of USAID's Population Office and the individual USAID missions. In particular, mission personnel (particularly in population offices) often did not support commercial involvement efforts. In addition, changes in the composition of missions' staffs sometimes led to changes in objectives and priorities, which complicated PROFIT's work in some countries. The missions' funding constraints, staff cuts, concern with monitoring requirements, and emphasis on immediate and significant impact often made it difficult for PROFIT to convince them to include commercial sector projects in their portfolios.

To facilitate future commercial sector involvement efforts, the Population Office and others in USAID/Washington should clearly communicate the rationale and benefits of commercial sector involvement to their colleagues in the field. They should also continue to identify countries where the potential for commercial sector involvement is greater and where mission personnel support such approaches.

### ***Choosing Partners***

PROFIT found that the choice of commercial partners was a key factor for success. The most effective partners are those that have a strong commitment to the project (especially among senior managers), a track record in commercial activities, and sufficient capabilities and resources. Those organizations with diffuse organizations, weak or temporary management, or financial difficulties are generally poor partners.

PROFIT increasingly worked with associations and umbrella organizations of professionals and businesses. The advantages included the ability to increase the scope and potential impact of the efforts. However, associations are not always run efficiently — many are staffed by volunteers — and working with them typically requires technical assistance and other forms of support.

### ***Monitoring and Evaluation***

PROFIT's subprojects and other activities had markedly diverse goals, which required specially tailored evaluation plans, indicators, and data collection methodologies. Comparisons across subprojects or sectors were very difficult. PROFIT's partners also had different information needs, and the evaluation plans and activities usually needed to be negotiated. PROFIT's partners sometimes viewed data collection activities to be contrary to their business interests, especially if they involved proprietary commercial information, major time commitments, or any involvement by customers. As a result, PROFIT was not always able to get the information it sought. In response to these potential constraints to evaluation, USAID

## **Perspectives on Future Efforts to Expand Commercial Sector Involvement in Family Planning**

should define minimum data requirements for all partners, provide financing for data collection activities, and include flexible evaluation systems in the design of future projects.

### **Specific Recommendations for Project Design**

#### ***General Structure***

PROFIT believes that a project to broaden the involvement of the commercial sector in family planning is worthwhile and that it should:

- ◆ focus on five to eight key countries that have strong potential for commercial sector development, strong or expanding commercial health sectors, support among USAID mission personnel for commercial sector initiatives, and a supportive host country government
- ◆ work with missions and host country governments to develop country-specific plans for commercial involvement which reflect the country environment and involve multiple partners, such as associations or umbrella organizations of professionals and businesses
- ◆ have a core staff with a range of expertise, including family planning and business training, market and operations research, product marketing and distribution, commercial sector and health policy reform, health finance, investing and micro-lending, evaluation, and information, education, and communications (IEC); these skills should be viewed as a “toolkit” to be used in individual countries as needed
- ◆ have staff members in target countries — ideally, host country nationals — with experience in family planning and/or commercial sector development
- ◆ coordinate with USAID/Washington’s Office of Health and Nutrition and with mission health officers to integrate family planning into broader health programs, particularly efforts involving managed care systems and health insurance reform (the project could be administered by the USAID Population, Health and Nutrition Center or be a joint project of the Population Office and the Health and Nutrition in order to achieve this integration)
- ◆ include a mechanism for making capital investments, including the current resources of The Summa Foundation as well as new capital (perhaps \$5 million).

## **Perspectives on Future Efforts to Expand Commercial Sector Involvement in Family Planning**

### ***Focus***

The project should include four major areas of focus:

- ◆ Expanding the commercial supply of family planning products and services: This would include training providers, making capital investments or loans for facilities or equipment, conducting research on the needs and motivations of providers, and facilitating distribution networks for contraceptives.
- ◆ Demand generation: This would include market research and IEC campaigns to encourage consumers to use commercial providers and products.
- ◆ Policy Analysis: This would include conducting research on using policy to expand commercial sector involvement and facilitating interactions among groups in the commercial sector and the host country governments.
- ◆ Operations research and evaluation.

In specific countries, the project might also focus on including family planning in insurance systems.

There are some activities that should *not* be pursued. For example, developing manufacturing facilities and contraceptive technology requires long time horizons and highly specialized expertise; developing employer-provided family planning services is too labor-intensive; and improving the sustainability of nongovernmental organizations (NGOs) that provide family planning services goes beyond the main target audience and objectives of the project.

### ***Research and Evaluation***

The project should include applied research in such areas as consumer and provider attitudes, price sensitivities to commercial products and services, and the feasibility of including family planning in managed care and other insurance systems. Where appropriate and feasible, the project should also conduct operations research to compare the effects of different types of interventions on commercial family planning outcomes.

There should be evaluation objectives for the overall project as well as for specific subprojects and activities. There also should be a framework for relating subproject and project objectives.

## **Perspectives on Future Efforts to Expand Commercial Sector Involvement in Family Planning**

### **Conclusions**

The PROFIT Project employed a broad range of strategies and approaches to increase the involvement of the commercial sector in family planning activities, many of which were untested. This paper provides recommendations for future efforts based on PROFIT's experiences in implementing those strategies and approaches. PROFIT hopes that the insights gleaned from this experience can help future projects develop more effective relationships with funding organizations and commercial sector partners.

## **9. Appendices**

- A. PROFIT Subprojects
- B. Recommended Resources
- C. PROFIT Publications

## **Appendix A. PROFIT Subprojects**

PROJECTS & CONSULTANCIES/ASSESSMENTS IDENTIFIED AND DEVELOPED BY PROFIT							
Country	Project Name	Project/CA	Sector	dvlped	dropped	apprved	implem
1	Bangladesh	SMC-Endowment Assessment	CA	provider	n/a		
2	Bangladesh	SMC Manufacturing Initiative/Squibb	project	manufacturing	no		
3	Bangladesh	FP Movie	project	other	no		
4	Bangladesh	Dhaka Ambulance	project	provider	no		
5	Bangladesh	BRAC	project	provider	no		
6	Bangladesh	Garment Industry Clinics	project	provider	no		
7	Bangladesh	Kumudini Foundation	project	provider	no		
8	Bangladesh	Grameen Bank/Health Insurance	project	provider	no		
9	Bolivia	ProSalud	CA	provider	n/a		
10	Brazil	Pop'ln Prgm Phase-out Assessment	CA	marketing	n/a		
11	Brazil	Semina	project	manufacturing	no		
12	Brazil	Contraceptive Jelly	project	manufacturing	no		
13	Brazil	CEPEO	project	mkting/distrib.	yes	no	yes
14	Brazil	HMO Clinic Franchise	project	provider	no		
15	Brazil	UNIMED Aracaju	project	provider	yes	no	yes
16	Brazil	UNIMED Maceio	project	provider	yes	no	yes
17	Brazil	PRO-PATER	project	provider	no		
18	Brazil	Odebrecht	project	insurance	yes	yes	
19	Colombia	PROFAMILIA-Endowment	CA	provider	n/a		
20	Dom. Rep	MUDE Endowment	CA	provider	n/a		
21	Dom. Rep	NGO Sustainability	CA	provider	n/a		
22	Dom. Rep	ADOPLAFAM Marketing Support	CA	provider	n/a		
23	Ecuador	Endowment Assessment	CA	provider	n/a		
24	Ecuador	Debt Swap	CA	provider	n/a		
25	Egypt	IUD Study	CA	manufacturer	n/a		
26	El Salvador	Employer-based clinic assessment	CA	employer	n/a		
27	El Salvador	Comm. sector assess. in FP	CA	provider	n/a		
28	El Salvador	Rural Health Organization assessment	CA	provider	n/a		
29	Ghana	Ashanti Goldfield Company	project	employer	no		
30	Ghana	Superior Medical Center	project	provider	yes	yes	
31	India	UP/Employer	CA	employer	n/a		
32	India	CII Employer Manual	CA	employer	n/a		
33	India	PACT-ICICI	CA	manufacturer	n/a		
34	India	IFPS Society-Endowment	CA	other	n/a	yes	

	Country	Project Name	Project/CA	Sector	dvlped	dropped	apprved	impl
35	India	ISM Practitioners	project	provider	yes	yes		
36	India	Mawana Sugar Works (MSW)	project	employer	yes		yes	yes
37	India	Giants	CA	employer	n/a			
38	India	JK Chemicals	project	manufacturer	no			
39	India	Condom Quality Improvement project	project	manufacturer	yes	yes	n/a	n/a
40	India	Reddy Labs	project	manufacturer	no			
41	India	Famy Care	project	manufacturer	no			
42	India	Zieta Pharmaceutical	project	manufacturer	no			
43	India	Contech Devices	project	manufacturer	no			
44	India	Community-based Social Marketing/IFH	project	mkting/distr	yes	no	yes	yes
45	India	Dr. Jain Video on Wheels, Limited	project	other	no			
46	India	Parivar Seva Sanstha (PSS)	project	provider	yes	no	yes	no
47	India	Indian System of Medicine (ISM)	project	provider	no			
48	Indonesia	PKMI Manufacturing	CA	manufacturer	n/a			
49	Indonesia	YKB/JIEP Industrial Estates	project	employer	yes	yes		
50	Indonesia	Norplant	project	manufacturer	no			
51	Indonesia	Upjohn Injectable	project	manufacturer	no			
52	Indonesia	Tunggal	project	manufacturer	no			
53	Indonesia	Cycloferm	project	mkting/distr	no			
54	Indonesia	Commodity Distribution	project	mkting/distr	no			
55	Indonesia	YKB Franchise	project	provider	no			
56	Indonesia	P.T. Bonnys	project	provider	yes	no	yes	yes
57	Indonesia	Catholic Hospitals	project	provider	no			
58	Indonesia	Midwives' Loan Fund	project	provider	yes	no	yes	yes
59	Indonesia	Marie Stopes/YBK/YKM	project	provider	yes	no	yes	no
60	Indonesia	Nasantura TV	project	other	no			
61	Jamaica	Blue Cross Jamaica	project	insurance	yes	yes		
62	Jamaica	Private insurance	project	insurance	yes	yes		
63	Kazakhstan	Social Marketing Technical Assistance	CA	mkting/distr	n/a			
64	Kenya	Private insurance assessment	CA	provider	n/a			
65	Kenya	FPAK Sustainability	CA	provider	n/a			
66	Kenya	Marie Stopes	project	provider	no			
67	Kenya	AAR Health Services/Industrial	project	insurance	yes	no	yes	yes
68	Kenya	AAR Sulmac	project	employer	yes	yes		
69	Kenya	FP Loan Fund	project	provider	no			
70	Mexico	FEMAP/Debt Swap	CA	other	n/a			
71	Mexico	FEMAP/MEXFAM/Maquiladora	project	employer	no			

	Country	Project Name	Project/CA	Sector	dvlped	dropped	apprvd	impl
72	Mexico	Grupo PROFAM	project	manufacturer	yes	yes		
73	Mexico	Grupo Farma. AF/Carnot Labs	project	manufacturer	yes	yes		
74	Mexico	Upjohn	project	mkting/distr	no			
75	Mexico	London Rubber Condom project	project	mkting/distr	no			
76	Mexico	Media Project	project	other	no			
77	Mexico	FEMAP/Community Doctors	project	provider	yes	yes		
78	Mexico	FEMAP/Affiliate Labs	project	provider	yes	yes		
79	Mexico	Joint SOMARC/AVSC	project	provider	no			
80	Mexico	MEXFAM Clinic	project	provider	no			
81	Mexico	Sharp Healthcare	project	provider	no			
82	Nigeria	FP Assessment Paper	CA	provider	n/a			
83	Nigeria	Employer-based investment	project	employer	no			
84	Nigeria	Depo Provera/Juli Pharmaceutical	project	mkting/distr.	yes	yes		
85	Nigeria	Debt swap	project	other	no			
86	Nigeria	Merchant Bank Hospitals	project	provider	yes	yes		
87	Nigeria	Training Medical Finance Hospitals	project	provider	no			
88	Peru	NGO /PRISMA Project Evaluation	CA	provider	n/a			
89	Philippines	Strategy paper	CA	other	n/a			
90	Philippines	LAGUNA Indus. Est./Empl.-based proj.	project	employer	no			
91	Philippines	SIFI	project	employer	no			
92	Philippines	Contraceptive Manufacturing/Distribution	project	mkting/distr	no			
93	Philippines	Upjohn Injectable	project	mkting/distr	no			
94	Philippines	Debt Swap	project	other	no			
95	Philippines	Drama Television Series	project	other	no			
96	Philippines	Doctor's loan fund	project	provider	yes	no	yes	yes
97	Philippines	PhilamCare Low Cost Health Care Plan	project	insurance	yes	no	yes	yes
98	Romania	Commercial Distrib. Sector Assess.	CA	mkting/distr	n/a			
99	Romania	Pharmacist/IEC Project	project	mkting/distr	yes	no	yes	yes
100	Russia	CAMA/WHP	project	mkting/distr	yes	no	yes	yes
101	Russia	Private insurance	project	insurance	no			
102	Russia	AIHA	project	provider	no			
103	Russia	KomiCare	project	provider	no			
104	Zimbabwe	Condom Manufacturing Assessment	CA	manufacturer	n/a			
105	Zimbabwe	Private sector initiative	project	provider	yes	no	yes	yes
106	Worldwide	Contraceptive Technology Dvlpt	project	manufacturer	yes	no	yes	yes
107	worldwide	American International group	project	insurance	yes	yes		
108	worldwide	Endowment Manual & Conference	CA	other	n/a			

108

## **Appendix B. Recommended Resources**

## Appendix B: Recommended Resources on the Commercial Sector and Health and Population Issues

Andreasen, Alan

1995 *Marketing Social Change*. San Francisco: Jossey-Bass Publishers.

Bennett, Sara, and Ellias Ngalande-Banda

1994 *Public and Private Roles in Health: A Review and Analysis of Experience in Sub-Saharan Africa*. SHS Paper No. 6. World Health Organization, Division of Strengthening Health Services, Geneva.

Berman, Peter, and Laura Rose

1994 *The Role of Private Providers in Maternal and Child Health and Family Planning Services in Developing Countries: Analysis of DHS Data from 11 Countries*. Data for Decision Making Project, Department of Population and International Health, Harvard School of Public Health, Boston, MA.

Bulatao, Rudolfo

1991 "The Private Sector in Family Planning: Its Role and Financing," in Lori Ashford and Med Bouzidi, eds., *Family Planning Programme Sustainability: A Review of Cost Recovery Approaches*. London: International Planned Parenthood Federation, 1992.

Cross, Harry

1993 *Policy Issues in Expanding Private Sector Family Planning*. Policy Paper Series Number 3. OPTIONS for Population Policy, The Futures Group, Washington, DC.

The Enterprise Program

1992 *Enterprise Program Final Report*. JSI, Arlington, VA.

## Appendix B: Recommended Resources

Foreit, Karen

- 1992 *Private Sector Approaches to Effective Family Planning*. Policy Research Working Paper Series 940. World Bank, Washington, DC

Fort, Catherine

- 1994 *The Enterprise Program Follow-up Study: Were Private Sector Family Planning Services Sustained?* JSI Working Paper No. 6. The SEATS Project, John Snow, Inc., Arlington, VA.

Fort, Catherine, and Carolyn Hart

- 1991 *Market-Based Family Planning: The Enterprise Program Experience*. John Snow, Inc., Arlington, VA.

Gillepsie, Duff G., H. Cross, J. Crowley, and S. Radloff

- 1988 "Financing the Delivery of Contraceptives: The Challenge of the Next Twenty Years." in *The Demographic and Programmatic Consequences of Contraceptive Innovations*, Committee on Population, National Academy of Sciences, Washington, DC.

Gold, Rachel B., and Cory L. Richards

- 1996 *Improving the Fit: Reproductive Health Services in Managed Care Settings*. The Alan Guttmacher Institute, New York, NY.

Griffin, Charles

- 1989 "The Private Sector and Health Care Policy in Developing Countries" in *Strengthening Health Services in Developing Countries through the Private Sector*. International Finance Corporation Discussion Paper Number 4. World Bank, Washington, DC.
- 1992 *Insurance and Development of the Private Medical Sector in the Philippines: History and Prospects for Change*. The Urban Institute, Washington, DC.

Health Financing and Sustainability Project

- 1995 *Bibliography of Abstracts*. Abt Associates Inc., Bethesda, MD.

Hanson, Kara, and Peter Burman

- 1994 *Assessing the Private Sector: Using Non-Government Resources to Strengthen Public Health Goals*. Data for Decision Making Project, Department of Population and International Health, Harvard School of Public Health, Boston, MA.

Janowitz, Barbara, et. al.

- 1990 *Investing in the Future: A Report on the Cost of Family Planning in the Year 2000*. Family Health International, Research Triangle Park, NC.

## Appendix B: Recommended Resources

Janowitz, Barbara, and John Bratt

- 1994 *Methods for Costing Family Planning Services*. Family Health International, Research Triangle Park, NC; United Nations Population Fund, New York, NY.

Kenny, Genevieve

- 1993 *Assessing Legal and Regulatory Reform in Family Planning: Manual on Legal and Regulatory Reform*. OPTIONS II Policy Paper Series, Number 1. OPTIONS, Washington, DC.

Knowles, James, and John Akin

- 1995 *Methodologies for Evaluating Private Sector Family Planning Program Outcomes*. The EVALUATION Project. Chapel Hill, NC.

Krystall, Eric

- 1985 "Private Sector Family Planning," *Populi* 12, (3) 34-39

LaForgia, Gerard, Charles Griffin, and Randall Bovbjerg

- 1993 *Extending Coverage and Benefits of Social Financing Systems in Developing Countries, Phase I*. Major Applied Research Paper Number 3. Health Financing Systems and Sustainability (HFS) Project, Abt Associates, Bethesda, MD.

LaForgia, Gerard, and Charles Griffin (eds.)

- 1993 *Health Insurance in Practice: Fifteen Case Studies from Developing Countries*. Small Applied Research Paper Number 4. Health Financing Systems and Sustainability (HFS) Project, Abt Associates, Bethesda, MD.

Lande, Robert, and Judith Geller

- 1991 *Paying for Family Planning*. Population Reports, Series J. Number 39. Johns Hopkins University, Center for Communications Programs, Baltimore, MD.

Lewis, Maureen, and Genevieve Kenny

- 1988 *The Private Sector and Family Planning in Developing Countries: Its Role, Achievements and Potential*. The Urban Institute, Washington, DC.

Lewis, Maureen

- 1988 *The Private Sector and Health Care Delivery in Developing Countries: Definition, Experience and Potential*. The Urban Institute, Washington, DC.

Logan, David, Matthew Friedman, and Marianne Lown

- 1989 *Mobilizing the Resources of the For-Profit Sector to Support the Expansion of Family Planning Services in the Developing World*. POPTECH Occasional Paper Number 3. Population Technical Assistance Project (POPTECH), Arlington, VA.

## Appendix B: Recommended Resources

Logan, David, Roy Delwin, and Laurie Regelbrugge

1997 *Global Corporate Citizenship — Rationale and Strategies*. The Hitachi Foundation, Washington, DC.

Mitchell, M., H. Lipton, and P. Lee

1987 "Client Provider Transactions in Commercial Distribution Systems," in Robert Lapham and George Simmons, eds., *Organization of Effective Family Planning Programs*, National Academy Press, Washington, DC.

Moore, Richard

1991 *Issues in Private Sector Family Planning: The Experience of the Enterprise Program*. John Snow, Inc., Arlington, VA.

Mwabu, Germano

1993 *Financing Health Services through Insurance*. HEDRA Ltd. for Health Financing and Sustainability (HFS) Project, Abt Associates, Bethesda, MD.

Program for Appropriate Technology in Health (PATH)

1991 *Current Trends in the Local Production of Contraceptives: Toward Meeting the Commodity Requirements in the Year 2000*. Policy Paper for UNFPA. PATH, Seattle, WA.

Rinehart, Ward, R. Blackburn, and S. Moore

1987 *Employment-Based Family Planning Programs*. Population Reports, Series J, Number 4, September-October 1987. Johns Hopkins University, Center for Communications Programs, Baltimore, MD.

Ross, J., and S. Isaacs

1988 "Costs, Payments, and Incentives in Family Planning Programs: A Review for Developing Countries," *Studies in Family Planning* 19 (5), pp. 270-83

Saadé, Camille

1993 *Enlisting the Commercial Sector in Public Health*. Occasional Operations Papers. PRITECH, Technologies for Primary Health Care Project. Management Sciences for Health, Arlington, VA

Shaw, Paul, and Martha Ainsworth

1996 *Financing Health Services through User Fees and Insurance: Case Studies from Sub-Saharan Africa*. World Bank Discussion Papers, Africa Technical Department Series, World Bank, Washington, DC.

Sherris, J., and G. Perkin

1988 "Introducing New Contraceptive Technologies in Developing Countries," in Sheldon Segal, Amy Tsui, and Susan Rogers eds., *Demographic and Programmatic Consequences of Contraceptive Innovations*. Plenum Press. New York, NY.

## Appendix B: Recommended Resources

Skibiak, John

- 1991 Employer-Provided Family Planning in the Private Sector: The Lessons of Enterprise. John Snow, Inc., Arlington, VA.
- 1990 Enterprise in Mexico: A Strategic Approach to Private Sector Family Planning. John Snow Inc., Arlington, VA.

Slater, Sharon Rose, and Camille Saadé

- 1996 Mobilizing the Commercial Sector for Public Health Objectives. A Practical Guide. BASICS, Arlington, VA., and UNICEF, New York, NY.

TIPPS Project

- 1991 Technical Information on Population for the Private Sector: Final Project Report. JSA Healthcare Corporation, Columbia, MD.

United Nations Population Fund (UNFPA)

- 1995 *Report on Family Planning Programme Sustainability*. Technical Report, Number 26, UNFPA, New York, NY.

Van Der Gaag, Jacques

- 1995 Private and Public Initiatives: Working Together for Health and Education. World Bank, Washington, DC.

**Appendix C. PROFIT Publications**

# PROFIT

Promoting Financial Investments and Transfers  
to Involve the Commercial Sector in Family Planning

Suite 601  
1925 N. Lynn Street  
Arlington, Virginia 22209

Telephone: (703) 276-0220  
Facsimile: (703) 276-8213

## Publications from The PROFIT Project

September 1997

The PROFIT (Promoting Financial Investments and Transfers) Project sought to mobilize the resources of the commercial sector to expand and improve the delivery of family planning services in selected developing countries. PROFIT was a project of the U.S. Agency for International Development (USAID) from September 1991 to September 1997.

Using funds provided by USAID, PROFIT employed various financial mechanisms to develop and support sustainable family planning projects. PROFIT worked primarily in three areas: innovative investments, private health care service delivery, and employer-provided services.

Below is a list of publications from the PROFIT Project and its subprojects in individual countries. Many are available in an abbreviated format as indicated by [Also *In Brief*]. They are listed in chronological order by the following types:

- **General Project Information:** background and overview information about the activities and results of the PROFIT Project
- **Discussion Papers:** examination of topics related to various aspects of the commercial sector
- **Practical Guides:** materials to guide health care professionals in planning, developing, and implementing strategies for working within the private sector
- **Evaluation Reports:** evaluations of PROFIT subprojects, including descriptions of the subprojects — evolution, goals, outcomes, and conclusions.
- **Special Studies:** descriptions of data gathering and opportunity assessments in individual countries
- **Country Assessments:** the results of visits made by PROFIT Project staff members to a number of countries to assess the opportunities for involving the commercial sector in delivering family planning services
- **Feasibility Studies:** analyses of the feasibility of specific subprojects or programs

206

## General Project Information

- Reissued POPTECH Report: Mobilizing the Resources of the For-Profit Sector to Support the Expansion of Family Planning Services in the Developing World, by David Logan, Matthew Friedman, and Marianne Lown (Arlington, VA: Population Technical Assistance Project, POPTECH), December 1989 [Also *In Brief*]
- PROFIT Profiles of Current Subprojects [Also in *Compendium*]
- Summary Proceedings: Invitational Meeting of Experts on Opportunities for Commercial Sector Involvement in Developing Country Family Planning Services, November 1996 [Also *In Brief*]
- PROFIT Project Final Report, September 1997
- The PROFIT Project: A Compendium of Experience and Findings, September 1997

## Discussion Papers

- Employer-Based Family Planning Projects: Past Guidance and Future Implications, November 1996 [Also *In Brief*]
- Debt Conversion Transaction Update, June 1997 [Also *In Brief*]
- Local Manufacture of Contraceptives in Developing Countries, August 1997 [Also *In Brief*]
- Leveraging Donor and Investor Funds, September 1997 [Also *In Brief*]
- Providers and Consumers of Commercial Sector Family Planning Services in Developing Countries, September 1997 [Also *In Brief*]
- Assessment of Family Planning and Health Insurance Programs, September 1997 [Also *In Brief*]
- Involvement of the Commercial Sector in Family Planning Services in Developing Countries, September 1997 [Also in *Compendium*]

## Practical Guides

- Endowments as a Tool for Financial Sustainability: A Manual for NGOs, 1993 [Also *In Brief*]
- Physician Education in Reproductive Medicine/Family Planning: Philippine Curriculum, October 1994
- Managing a Private Medical Clinic: A Business Training Workshop (Philippines), December 1995

201

- CII Manual for Corporate Initiatives in Family Health Care (India), September 1996  
[Also *In Brief*]
- Romanian Pharmacists' Guide to Contraception Technology and Quality Client Services, March 1997 (*in Romanian only*)
- Zimbabwe Pharmacists' Guide to Contraception Technology and Quality Client Services, July 1997 (*in English*)
- Training Private Providers to Improve Access to Quality Contraceptive Services, August 1997, [Only *In Brief*]
- Practical Pointers for Conducting Commercial Sector Family Planning Regulatory Assessments, September 1997 [Also *In Brief*]
- Conducting a Private Sector Family Planning Country Assessment, September 1997 [Also in *Compendium*]
- The PROFIT Model for Implementing Partnerships, September 1997 [Also in *Compendium*]

## **Evaluation Reports**

- Revolving Loan Fund for Midwives (Indonesia)
- UNIMED Maceio Hospital-Based MCH Clinic (Brazil)
- The Commodities Procurement Organization (CEPEO) (Brazil)
- PhilamCare Low-Cost Health Plan (Philippines)
- Advancing Modern Contraceptives and Pharmacist Services (Romania)
- AAR Health Care Services (Kenya)
- Private Sector Initiative (Zimbabwe)
- Physician's Loan Fund (Philippines)
- IFH, Community Based Social Marketing (India)
- Employer-Based Services (India)

## **Special Studies**

- Sustainability Assessment of Dominican Republic Non-governmental Organizations, December 1993

- Family Planning and Socio-economic Status of HMO Members in Urban Northeast Brazil, April 1994
- UNIMED/MACEIO (Health Insurance) Baseline Survey (Brazil), April 1994
- Attitudes and Practice Survey among Health Professionals in the Philippines Private Sector, January 1996
- Consumer Survey on Preferred Source of Basic Health Care and Family Planning Services in the Philippines, March 1996
- A Strategy to Increase Private Commercial Sector Involvement in the Philippines Family Planning Program: Situation Analysis, September 1996
- Study of Romanian Private Pharmacists, November 1996 [Also *In Brief*]
- Traditional Practitioners Survey Report (India), December 1996
- Baseline and Follow-Up Data on Participants in the PROFIT Midwives Revolving Loan Fund (Indonesia), June 1997 [Also *In Brief*]
- Employer-Based Survey (Zimbabwe), September 1997
- Phase-Out of Donated Contraceptives: Lessons from the Case of CEPEO (Brazil), August 1997
- Assessing an NGO (FPAK) Regarding Financial Sustainability (Kenya), September 1997 [Only *In Brief*]

## Country Assessments

- Brazil, September 1992
- Indonesia, September 1992
- Mexico, September 1992
- Nigeria, September 1992
- Philippines, June 1993
- Kenya, September 1993
- Russia, September 1993
- Marketing Assessment for the Sale of Contraceptives in the Private Sector, Romania, September 1994; updated September 1997
- India, January 1995
- Assessment of the Private Medical Sector in Zimbabwe, January 1996

## Feasibility Studies

- Local Condom Testing and Packaging in Zimbabwe: A Cost Analysis, September 1993
- Health Care Providers in the Philippines: Testing the Concept of a Loan Fund for Private Provision of Family Planning, January 1994
- Developing Prepaid Health Programs in Kenya: A Private Insurance Assessment, May 1994
- The Feasibility of Producing Falope Rings in Indonesia, August 1994
- Marketing Assessment for the Sale of Contraceptives in the Private Sector of Romania, September 1994
- Rural Midwives: Loan Fund Assessment in a District of Central Java (Indonesia), December 1994
- Survey Summary of Superior Medical Center in Ghana, February 1995
- Feasibility Study of Primary Health Care System for Union of the Agrarian Reform Cooperatives (UCRAPROBEX) (El Salvador), February 1997 [Also *In Brief*]

### Ordering PROFIT Publications

**USAID**  
**Development Experience Clearinghouse**  
1611 N. Kent Street, Suite 200  
Arlington, VA 22209-2111  
Tel: 703-351-4006; Fax: 703-351-4039  
E-mail: [docorder@disc.mhs.compuserve.com](mailto:docorder@disc.mhs.compuserve.com)

**10. Additional Information on PROFIT**

### Additional Information on PROFIT

We hope this compendium serves as an invitation to explore the wealth of information and experience generated by PROFIT, which can be requested from the addresses below.

#### PROFIT Publications

Request copies of PROFIT publications from:

USAID's Development Experience Clearinghouse  
1611 North Kent Street, Suite 200  
Arlington, VA 22209-2111  
Telephone: 703-351-4006  
Fax: 703-351-4039  
E-mail: [docorder@disc.mhs.compuserve.com](mailto:docorder@disc.mhs.compuserve.com)

#### Other USAID Projects and Activities

Request information on other USAID projects and activities related to family planning in developing countries from:

Center for Population, Health and Nutrition  
U.S. Agency for International Development  
Washington, DC 20523  
Telephone: 202-712-0540  
Fax: 202-216-3046

## Additional Information on PROFIT

### **Deloitte Touche Tohmatsu International**

Request information about the international financial services and accounting firm that led the PROFIT Project from:

Deloitte Touche Tohmatsu International

555 12<sup>th</sup> Street, NW, Suite 500

Washington, DC 20004

Telephone: 202-879-5656

Fax: 202-879-5607