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# PRIVATE SECTOR CONTRIBUTION TO FAMILY PLANNING AND CONTRACEPTIVE SECURITY IN THE EUROPE AND EURASIA REGION

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**PSP-One**

PRIVATE SECTOR PARTNERSHIPS FOR BETTER HEALTH

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Public Health and Tropical Medicine

# **PRIVATE SECTOR CONTRIBUTION TO FAMILY PLANNING AND CONTRACEPTIVE SECURITY IN THE EUROPE AND EURASIA REGION**

## **DISCLAIMER**

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government



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# ACRONYMS

<b>ADP</b>	Additional Drug Program
<b>CPR</b>	Contraceptive Prevalence Rate
<b>DHS</b>	Demographic and Health Survey
<b>DMPA</b>	Three-month Injectable Formulation (depot medroxyprogesterone acetate)
<b>DTC</b>	Direct-to-Customer
<b>E&amp;E</b>	Europe and Eurasia
<b>EBM</b>	Evidence-based Medicine
<b>FDA</b>	Federal Drug Administration
<b>FP</b>	Family Planning
<b>GDP</b>	Gross Domestic Product
<b>GP</b>	General Practitioners
<b>IEC</b>	Information, Education, Communication
<b>IPC</b>	Interpersonal Communication
<b>IUD</b>	Intrauterine Device
<b>JSI</b>	John Snow International
<b>MHIF</b>	Mandatory Health Insurance Fund
<b>MOH</b>	Ministry of Health
<b>MOPH</b>	Ministry of Public Health
<b>NGO</b>	Nongovernmental Organization
<b>OC</b>	Oral Contraceptive
<b>POP</b>	Progestin-Only Pill
<b>PSP-One</b>	Private Sector Partnerships-One Project
<b>PSI</b>	Population Services International
<b>PvtHE</b>	Private Health Expenditures
<b>RFHI</b>	Romanian Family Health Initiative
<b>RH</b>	Reproductive Health
<b>TAR</b>	Total Abortion Rate
<b>TfH</b>	Together for Health Project
<b>THE</b>	Total Health Expenditure
<b>USAID</b>	United States Agency for International Development

<b>UNFPA</b>	United Nations Family Planning Agency
<b>WHO</b>	World Health Organization
<b>WRA</b>	Women of Reproductive Age

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# EXECUTIVE SUMMARY

## OBJECTIVES OF THE REPORT

The private sector is increasingly recognized globally as a key partner in addressing social sector issues in emerging markets. Product suppliers, private service providers, and nongovernmental organizations can help meet the public's demand for reproductive health and family planning (RH/FP) services and products. Yet, in many transitional economies such as those in the Eastern Europe and Eurasia (E&E) region, the private sector is not fully involved in meeting these health needs. Reasons range from restrictive legal and policy environments that impede expansion of private health services, to low public and private investment in growing the contraceptive market.

This report is the outcome of a request by USAID's E&E Bureau to the Private Sector Partnerships-One (PSP-One) project to conduct an assessment of the private sector potential in RH/FP. The assessment is designed to inform USAID Missions and bilateral RH/FP programs in the E&E region on the status of private sector involvement in RH/FP health care covering the following objectives:

- Examine the total FP market – that is, both the public and private sectors – to determine the role the private health sector can play in addressing FP product supply and services and how the public sector can facilitate the private sector role;
- Analyze opportunities and constraints to the private sector in the legal, regulatory, and policy environment in the E&E region;
- Identify current practices in the E&E region that foster a greater private sector role in the provision of FP services and products; and
- Recommend strategies to USAID Missions and programs to better engage and involve the private sector in RH/FP provision.

This report compiles and analyzes information collected during assessment visits to six countries of the E&E region in 2005-2006. The assessment analyzed the private sector market in those countries and looked at contraceptive security issues for FP. Assessment findings were supplemented with a literature review of project reports from existing USAID bilateral projects implementing FP and other health-related programs. Countries studied include Albania, Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Romania, Russia, Tajikistan, Ukraine, and Uzbekistan. These countries are considerably diverse in terms of income, economic and social development, unmet RH/FP need, and market maturity. At the same time, they share characteristics unique to this part of the world, particularly with respect to reproductive behavior, private sector growth, and health sector reforms.

## ORGANIZATION OF THE REPORT

The report is organized as a process with four steps:

- Step 1 prepares the USAID Mission by providing an introduction to the private sector, offering a rationale for acknowledging and working with the private health sector, and discussing what a Mission can realistically expect of the private sector in helping them achieve their FP goals. The

introduction presents a fundamental concept – the whole market approach – and provides a working definition of the private sector that has been adapted for this region in the world.

- Step 2 describes the PSP-One methodology for assessing market conditions that affect private sector potential for providing RH/FP services and products. It contains a checklist of indicators, with related data sources or analytical approaches, that private sector decision-makers and others can use to measure aspects of the country context and estimate the private sector’s potential.
- Step 3 discusses the key findings from six PSP-One country assessments as well as a literature review to provide a snapshot of the private sector in the E&E region today. Based on the analysis, the report categorizes the E&E countries along a continuum of private sector development, which is helpful in comparing the countries with respect to their level of private sector market development, as well as determining the goals, objectives, and strategies needed to mobilize the private sector and harness its potential. Three country groupings emerged along the continuum: advanced (a majority of positive conditions exist for the private sector in a country); intermediate (some positive conditions exist); and emerging (few or no positive conditions exist).
- Step 4 offers concrete actions for USAID Missions to pursue in order to marshal the private sector. This section presents guiding principles in designing an intervention, discusses what would be an optimal public/private mix given different market scenarios, and wraps up with a description of different private sector strategies.

## CONCLUSIONS

The assessment provides a framework for understanding the private sector and presents crosscutting findings about the role of the private sector in the E&E region, while pointing out limiting or encouraging factors in specific countries. It identifies multiple factors, such as method use, the political environment, health systems, provider attitudes, consumer demand, and socio-cultural factors that together create very different conditions from one country to another. The assessment also describes trends with regards to market growth, private sector strategies, and socio-economic factors that can help predict future contraceptive security.

Analyzing these factors and trends comprehensively helps offer a notional idea of how the countries in the region compare in terms of the level of development of the RH/FP private sector market. Of the E&E countries included in this report, four countries are firmly classified as advanced FP private sector markets: Kazakhstan, Russia, Romania, and Ukraine. In comparison, the three intermediate countries – Kyrgyzstan, Armenia, and Georgia – have a sufficient number of positive private sector conditions to be classified in the intermediate category but require focused interventions to make them more “private sector friendly.” In the emerging category, Azerbaijan has room for limited private sector development. Uzbekistan and Tajikistan, on the other hand, have almost no private sector potential in FP at this time.

USAID Missions and implementers of RH/FP programs in the region are advised to look at their own country context as unique. However, four basic guiding principles can be applied to any program that aims to leverage and motivate the private sector in achieving RH/FP goals: 1) taking a whole market approach, considering the benefits and limitations of both public and private sectors and how they can complement each other; 2) determining the optimal public/private mix; 3) strengthening the stewardship role of the public sector; and 4) developing public/private partnerships. The assessment concludes with recommended strategies based on these guiding principles and organized by country category (see Table ES-1), which USAID Missions can use to guide programming related to the private sector and to identify needs for future technical assistance.

**TABLE ES-I. RECOMMENDED STRATEGIES**

Country's private sector category	Objectives	Strategies
Advanced	<p>Maintain a strong private sector presence</p> <p>Ensure sustained contraceptive security</p> <p>Identify and address the needs of vulnerable populations</p>	<p><b>Whole market approach:</b> Market segmentation to be conducted every 3-5 years to identify supply gaps and monitor ability to pay, changes in the method mix, and changes in sourcing patterns.</p> <p><b>Public/private mix:</b> Private sector likely to ensure sustained product supply of a wide range of methods at different prices. Manufacturers expected to invest heavily in stimulating demand for hormonal methods and innovative products. Low private investment in intrauterine devices (IUDs) and injectables will require public sector intervention. Low-income users may require subsidized products and services.</p> <p><b>Stewardship:</b> 1) Address market and policy barriers to private provision of FP; 2) Make FP a health priority in Ministry of Health (MOH), 3) Allocate public funds to purchase FP methods and target them to population groups; 4) Ensure quality in private sector through: i) policies ensuring quality and safety, ii) strengthening FP clinical guidelines, iii) training public providers; and 5) Monitor private sector prices and quality</p> <p><b>Public/private partnerships:</b> Establish mechanisms for sustained communication between public and private sector entities. Consider joint promotional and training programs (example: Ukraine's' Together for Health project or SOMARC [Social Marketing for Change] Advisory Board).</p>
Intermediate	<p>Grow the contraceptive market</p> <p>Monitor product quality and safety</p> <p>Increase the role of the private sector in reaching underserved groups</p>	<p><b>Whole market approach:</b> Conduct client-focused market segmentation research to identify barriers to use among various population groups. Assess private sector presence and investment on the contraceptive market.</p> <p><b>Public/private mix:</b> The private sector is likely to focus on increasing its nascent consumer base in urban areas. Rural areas, low-income users, and specific methods (IUDs, injectables) may need public sector support. The public sector must also assume the primary role in provider education. The public sector also needs to educate the population on health benefits of FP thereby increasing demand for FP.</p> <p><b>Stewardship:</b> 1) Increase public and policy support for FP; 2) Make FP a health priority in MOH, 3) Allocate public funds to purchase FP methods for low-income users; 4) Address provider bias and misinformation; and 5) Address market and policy barriers to private sector products and services</p> <p><b>Public/private partnerships:</b> Consider partnering with low-cost manufacturer to increase demand for <i>and</i> access to contraceptives among underserved groups (example: through a social marketing intervention).</p>
Emerging	<p>Develop the contraceptive market</p> <p>Ensure demand and supply grow together</p>	<p><b>Whole market approach:</b> Conduct client-focused market segmentation research to identify barriers to use among various population groups. Assess private sector supply of products and services.</p> <p><b>Public/private mix:</b> Very limited interest in contraceptive market causes private suppliers to limit product range and investments. Public sector efforts to create demand expected to lead to increased private sector role over time.</p>

Country's private sector category	Objectives	Strategies
	Facilitate private sector investment in the contraceptive market	<p><b>Stewardship:</b> 1) Increase public and policy support for FP; 2) Make FP a health priority in MOH, 3) Address financial incentives that encourage repeat abortions; 4) Increase access to evidence-based information about modern methods; and 5) Address policy barriers to the growth of private sector products and services.</p> <p><b>Public/private partnerships:</b> Consider a large-scale (national-level) program to increase the use of modern methods (example: Red Apple program in Kazakhstan); smaller-scale programs can partner with a manufacturer to ensure product access (example: ACQUIRE project in Azerbaijan).</p>

# I. INTRODUCTION

## I.1 BACKGROUND

The Eastern Europe and Eurasia (the E&E) region is a socio-economically diverse area. For example, annual gross domestic product (GDP) per capita ranges from \$12,100 in Russia and \$8,800 in Romania to \$2,000 in Uzbekistan and \$1,300 in Tajikistan.<sup>1</sup> Despite these variations, E&E countries are similar in terms of reproductive health/family planning (RH/FP) usage patterns, access to contraceptive methods, and provider attitudes. Table I shows key RH/FP indicators for 11 United States Agency for International Development (USAID)-supported countries in the E&E region.

Most of the USAID-supported E&E countries (with the exception of those in Central Asia) have total fertility rates (TFRs) below the replacement level of 2.1 births per woman. While some of the data in Table I, though the most recent available, are several years old, it is understood that patterns and trends have not changed dramatically since the late 1990s, with the exception of Romania and Ukraine. TFRs vary across the region, ranging from 1.2 children per woman in Ukraine to 3.8 in Tajikistan. Total contraceptive prevalence rates (CPRs) range from 34 percent in Tajikistan to 75 percent in Albania.

**TABLE I. SELECTED RH/FP INDICATORS FOR SELECTED E&E COUNTRIES**

Country	TFR <sup>1</sup> (%)	Total CPR <sup>1</sup> (%)	Total modern methods <sup>1</sup> (%)	Total abortion rate per woman <sup>3</sup>	Most-used contraceptive method <sup>4</sup>
Albania	1.9	75	8	...	...
Armenia	1.7	53	20	2.6	Withdrawal
Azerbaijan	2.0	55	12	3.2	Withdrawal
Georgia	1.6	47	27	3.1	Withdrawal
Kazakhstan	2.2	66	53	1.4	IUD
Kyrgyzstan	2.6	60	49	1.5	IUD
Romania	1.3 <sup>2</sup>	64	38 <sup>2</sup>	0.8 <sup>2</sup>	Withdrawal
Russia	1.3	67	49	2.3	IUD
Tajikistan	3.8	34	27	...	...
Ukraine	1.2	68	38	1.6	IUD
Uzbekistan	2.7	68	63	0.6	IUD

<sup>1</sup> Population Reference Bureau (PRB) (2006)

<sup>2</sup> Romania Reproductive Health Survey 2004

<sup>3</sup> Centers for Disease Control and Prevention and ORC Macro. (2003)

<sup>4</sup> PRB (2003)

Low fertility in the region is attributable to the use of abortion more than to the use of modern contraceptive methods. Caucasus countries have the highest abortion rates (2.6 per woman in Armenia, 3.2 in Azerbaijan, and 3.1 in Georgia). In other countries, the abortion rate ranges between one and three abortions, although survey estimates tend to be far higher than official government statistics (Senlet and Kantner, 2005).

<sup>1</sup> Purchasing power parity, 2006 estimate. CIA World Factbook.

Use of modern contraceptive methods is quite low by Western standards but has been improving throughout the region. Total modern method use ranges from as low as 8 percent in Albania to 64 percent in Uzbekistan. Intrauterine devices (IUDs) are still a preferred method, but withdrawal remains widely used. Oral contraceptives (OCs) are becoming increasingly popular with young women in the region and are accessed primarily through the private sector. Many barriers exist in accessing modern methods. In some cases, the barrier is financial: the limited supply of free and subsidized contraceptive methods for those who cannot afford to pay is a concern. Other obstacles are unnecessary tests and examinations required for certain methods, and limited FP service provision by obstetricians/ gynecologists. High rates of discontinuation and contraceptive failure occur due to poor counseling and limited access to reliable information.

## **1.2 OBJECTIVES OF THE ASSESSMENT**

The private sector is increasingly recognized globally as a key partner in addressing social sector issues in emerging markets. Product suppliers, private service providers, and nongovernmental organizations (NGOs) can help meet the public's demand for RH and FP. Yet, in many transitional economies such as those in the E&E region, the private sector is less involved in meeting these health needs than it is in more developed countries. Reasons range from restrictive legal and policy environments that impede expansion of private health services, to low levels of public and private investment in growing the contraceptive market.

The USAID E&E Bureau works to expand access to and use of RH/FP care as part of its Strategic Objective 3.2, Increased Health Promotion and Access to Quality Health Care. Through its Regional Family Planning Activity, the Bureau's Office of Democracy, Governance and Social Transition aims to identify, describe, and leverage successful private sector experiences and lessons learned to build the capacity of USAID E&E Missions and bilateral programs to use the private sector to increase access to quality FP services and products. The Bureau thus asked PSP-One to assess private sector potential to provide FP services and products in the region. The assessment has the following objectives:

- Examine the total FP market – that is, both the public and private sectors – to determine the role the private health sector can play in addressing FP product supply and services and how the public sector can facilitate the private sector role;
- Analyze opportunities and constraints to the private sector in the legal, regulatory, and policy environment in the E&E region; and
- Identify current practices in the E&E region that foster a greater private sector role in the provision of FP services and products.

## **1.3 OVERVIEW OF THE REPORT**

This report compiles and analyzes information collected during assessment visits that PSP-One and/or John Snow International (JSI) teams made to six E&E countries in 2005-2006. The assessments did private sector market analyses and looked at contraceptive security issues for FP. Assessment findings were supplemented with a review of reports produced by USAID bilateral projects implementing FP and other health-related programs in the region. Table 2 lists the 11 countries studied.

**TABLE 2. COUNTRIES COVERED IN REPORT**

Albania	Romania
Armenia	Russia*
Azerbaijan*	Tajikistan*
Georgia	Ukraine*
Kazakhstan*	Uzbekistan
Kyrgyzstan*	

\*Countries assessed by PSP-One

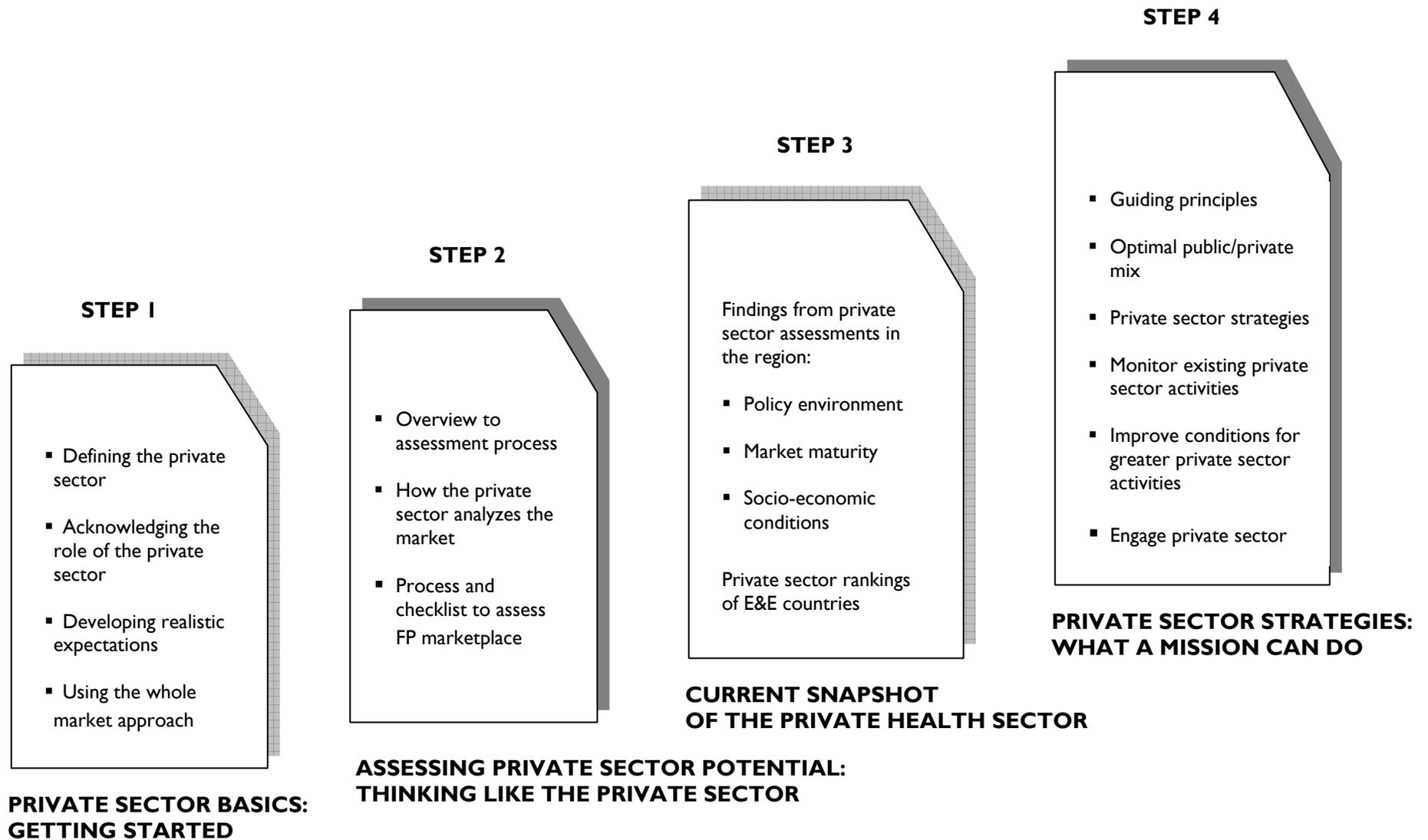
The report is organized as a four-step process (See Figure 1). Step 1 introduces the USAID Mission to the private sector: defining it in terms of the regional context, offering a rationale for acknowledging and working with it, and discussing what a Mission can realistically expect of the private sector in helping them achieve their FP goals. Step 1 also introduces a fundamental concept, the whole market approach.

Step 2 presents the PSP-One methodology for assessing private sector potential. The assessment calls for an analysis of market factors (socio-economic conditions, policy environment, market maturity, stakeholders), by way of indicators; the checklist in Table 4 lists the indicators and data sources for each. PSP-One used the methodology to conduct the six country assessments.

Step 3 discusses the key findings from the country assessments and literature review, resulting in a snapshot of the region's private sector today. Based on the findings, the report categorizes the E&E countries along a continuum of private sector development. As Step 4 will illustrate, the continuum is helpful in determining the goals, objectives, and strategies needed to mobilize the private sector and harness its potential.

Finally, Step 4 offers concrete actions for Missions to pursue in order to marshal the private sector. This section presents guiding principles in designing an intervention, discusses what would be an optimal public/private mix given different market scenarios, and concludes with a description of different private sector strategies.

**FIGURE I. OVERVIEW OF REPORT**



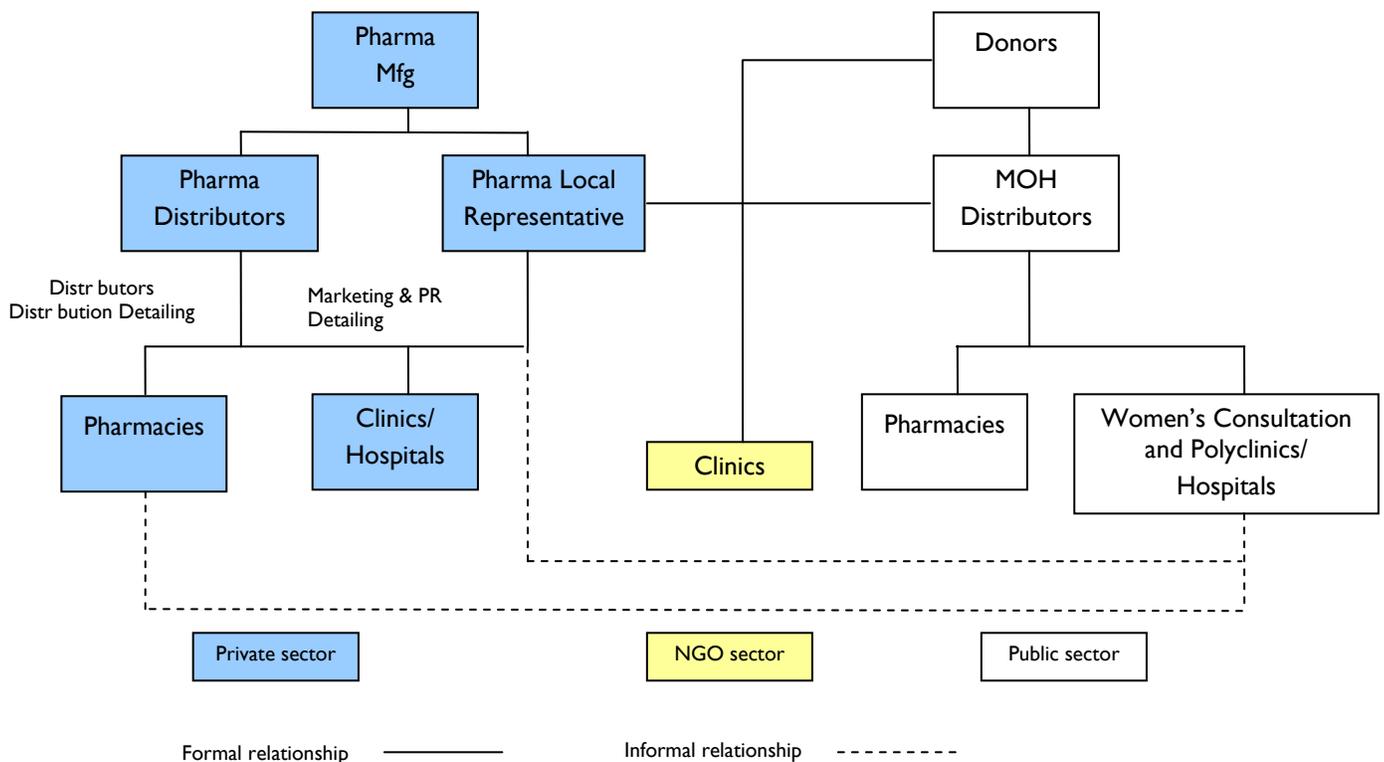
## 2. STEP 1: PRIVATE SECTOR BASICS

This section describes Step 1 in the private health sector assessment process. It begins by defining the private sector health sector and its different participants, then provides a rationale for working with the private sector to help achieve RH/FP goals. It discusses the limitations of the private sector, and closes with a discussion of the whole market approach.

### 2.1 DEFINITION OF THE PRIVATE HEALTH SECTOR

Defining the “private health sector” is an important first step in understanding its potential role in addressing FP issues in the E&E region. The private sector, simply put, is anything not public (Marek et al., 2005); it includes commercial or for-profit entities in the business and financial sectors, non-profit organizations, and a small but growing number of private providers, such as doctors, pharmacists, and hospital staff. Figure 2 illustrates the relationships of the key players in the FP market in E&E countries. A limited number of private providers and NGOs do provide FP services and/or information but their numbers are much smaller than in other regions of the world. Moreover, many of the NGOs are still quasi-state entities more akin to professional organizations, with limited incentives to engage in method supply or advocacy.

**FIGURE 2. UNDERSTANDING THE WHOLE FP MARKET IN E&E COUNTRIES**



A unique characteristic of the private sector in the E&E region is the presence of a substantial number of private suppliers of contraceptive products using commercial distribution and service delivery channels. Manufacturers, distributors, and retailers for contraceptive products are included in our definition of private sector suppliers.

## 2.2 WHY WORK WITH THE PRIVATE SECTOR?

A commonly asked question is whether the private sector can address some of the long-standing challenges confronting the E&E region in regard to FP. First, the private health infrastructure and networks can deliver services and drugs in areas not reached by ministries of health (MOHs). In many E&E countries, the MOH does not purchase or maintain an adequate supply of contraceptives, so the private sector has stepped in to fill the gap. For example, in Kazakhstan, the MOH procures a very limited supply of FP products. As a result, most FP users go to the MOH for counseling and examinations but then walk across the street – or in some instances down the hall in the same public health facility – to purchase their FP product at a private sector pharmacy. This model of de facto public/private coordination is found even in rural areas of Kazakhstan. In fact, in most E&E countries, the public sector rarely includes contraceptives in public tenders, whether centralized or at the oblast (region)-level. As a result, the private sector has become the key supplier of condoms, spermicides, oral and injectable contraceptives, and IUDs.

Second, collaboration with the private health sector can generate more resources for FP. In many countries, private spending on health care exceeds public spending. Data from the 11 countries reviewed for this report demonstrate that private sources (private and out-of-pocket combined) finance a significant portion of health care spending (as much as 75.3 percent in Tajikistan, 73.5 percent in Azerbaijan, and 70.2 percent in Armenia). Table 3 shows the data for all reviewed countries. In seven of the 11 countries, more than half of the total health expenditure (THE) comes from private sources. A large share of private health care expenditure (90 percent or more in nine of the countries) is out-of-pocket expenditures by households; these include expenditures on FP.

**TABLE 3. PRIVATE SECTOR AND OUT-OF-POCKET EXPENDITURES**

Country	Private sector expenditure on health (PvtHE) as % of THE	Households' out-of-pocket spending on health care as % of PvtHE
Albania	56.5	99.8
Armenia	70.2	89.1
Azerbaijan	73.5	93.7
Georgia	69.4	94.6
Kazakhstan	36.3	100.0
Kyrgyzstan	57.3	94.7
Romania	34.0	93.4
Russia	35.7	77.3
Tajikistan	75.3	97.4
Ukraine	43.8	84.3
Uzbekistan	51.4	96.2

Source: 2005 World Health Organization estimates based on country National Health Accounts data. (<<http://www.who.int/nha/country/aze/en/>> accessed March 2, 2007). Private sector expenditures include prepaid plans and risk-pooling arrangements; firms' expenditure on health; and nonprofit institutions serving mainly households. Out-of-pocket expenditures include household payments on public services; the commercial sector; nonprofit institutions; governmental organizations; and non-reimbursable cost-sharing deductibles, copayments, and fees-for-service.

Considering the limitations on public health budgets, the lack of public purchases of commodities, and the reality of out-of-pocket spending flowing to the private health sector, it is time to consider the private sector as an ally in the effort to ensure contraceptive security in the region.

Finally, the private sector can help decrease the burden on the public health sector, allowing it to focus its limited resources on vulnerable population groups. A recent study demonstrates that many MOH service subsidies benefit the wealthier segments of the population (Gwatkin et al., 2004). Its review of 21 countries around the world, including two E&E countries (Armenia and Bulgaria), found that the richest quintile of the population consumed on average more than 26 percent of total financial subsidies provided through government health expenditures, compared with less than 16 percent consumed by the poorest quintile of the population. Creating policies and incentives that encourage those who can afford to pay to use the private sector for their health needs frees up resources for providing services to those segments of the population who cannot.

## **2.3 REALISTIC EXPECTATIONS OF THE PRIVATE SECTOR**

As important as the private sector contribution is to contraceptive security in the E&E region, donors and country policymakers must also recognize its limitations. The private sector, in particular commercial suppliers, tends to analyze business opportunity in terms of relative cost and return on investment. There may not be much incentive for manufacturers and distributors in a relatively untapped market to serve the poor with FP products. In the short term, the needs of low-income consumers are often ignored because market demand for FP tends to materialize first in the highest income categories, where information and counseling are more readily available. Underserved groups may eventually be targeted with products, services, and promotional activities but not until more profitable alternatives (such as serving the well-off in convenient urban areas) have been exhausted.

The cost of launching, promoting, and distributing products to various population groups in different geographic locations also influences private sector investment choices. It is much more cost effective (and therefore more profitable) to focus on densely populated urban areas – where consumers can easily be reached and served – than on rural areas. So one cannot expect the private sector to spontaneously focus on serving hard-to-reach and rural areas where demand may also be lower due to socio-economic factors. The private sector also tends to promote products that offer the highest return on investment (such as high-margin innovative methods like the hormone-releasing IUD). These products receive the bulk of promotional investment, including detailing, educational material, and mass media advertising when permitted.

In short, the private sector is not a panacea for all FP-related challenges. The public sector still has a fundamental role in setting the parameters of service provision by motivating or discouraging private sector participation. One cannot expect the private sector to make it a priority to ensure a balanced method mix or guarantee the universal affordability of all commercially sold contraceptive brands. However, efforts by governments and donors to increase demand for underutilized methods, address provider bias, and identify special needs groups can foster private sector response in the form of increased investment, or improved supply and quality of services (see John Snow International, 2006).

## **2.4 THE WHOLE MARKET APPROACH**

Although this report focuses on the private sector role in delivering FP services and products, one needs to understand the private sector in the context of a larger, whole market that responds to the different FP needs in a country. Using a whole market approach ensures that the entire market of

clients – from those who require free supplies in the public sector to those who can pay and will pay for commercial products in the private sector – is covered in a coordinated way. It offers a comprehensive “snapshot” of supply of and demand for FP services and products in all sectors – public, commercial private, and nongovernmental. A whole market approach helps identify different market segments, target subsidies more effectively, address market inefficiencies, and engage private suppliers that may play a role in meeting public health goals.

It is difficult to discuss the private sector without also looking at the public sector. After all, the public sector sets some of the parameters of the FP marketplace through health policies, legal and regulatory frameworks, and norms and protocols. These policies create market conditions that either encourage or create barriers for the private sector. But there are also actions, based on a whole market approach that the public sector can take to address market inefficiencies:

**Increasing method use** requires looking beyond socio-economic differences among users and understanding barriers to use and attitudinal differences between various FP market segments. This analysis helps design campaigns and develops products and services for underserved segments that ultimately grow the FP market. In the case of the E&E region, for example, one needs to examine the role of abortion as a substitute for FP.

**Addressing sustainability and supply gaps** in FP commodities begins by monitoring contraceptive availability, quality, and prices; looking at multiple distribution channels (public, private, and NGO); and analyzing funding needs and shortfalls.

**Adopting a targeted approach to FP subsidies**, focusing on those who need them the most, such as users who cannot afford commercial products. The driving principle behind subsidized programs is that they should not serve the same users as those targeted by the private sector.

**Identifying and collaborating with different partners.** Effective partnering requires that the public sector take the lead in building synergies between government programs, donor-funded activities, and private sector investment. Finding common ground between public and private interests also helps build trust and create a symbiotic relationship over time.

Using a whole market approach, this paper will not only recommend strategies to increase private sector participation – when appropriate – but also recommend actions by the public sector to facilitate greater private sector participation and collaboration. This approach underscores the *complementary* roles of the public, NGO, and commercial private sectors in the region, with the understanding that the private cannot substitute for the public sector and vice versa. Instead, the whole market approach strives to create a balance between the sectors and draw from their respective capabilities to achieve public health goals.

## 3. STEP 2: ASSESSING PRIVATE SECTOR POTENTIAL

Step 2 focuses on the assessment process. First, one first learns what motivates the private sector and the type of information the private sector uses to analyze the FP marketplace before deciding to enter, stay, or leave a market. Private sector data are organized into three categories: 1) socio-economic, 2) policy environment, and 3) market maturity. Second, we outline a process and provide a checklist by which to examine the private sector potential in a respective country.

### 3.1 HOW THE PRIVATE SECTOR APPROACHES THE FP MARKET

The private sector is driven by incentives and motivations that may differ substantially from those of the public sector. Whereas the public sector is driven by unmet needs, the private sector looks for untapped market potential. The private sector – whether it is a pharmaceutical manufacturer or a local physician looking to establish a private practice – responds to a variety of socio-economic and political factors that may or may not translate into a market opportunity. Below is an overview of key factors that influence private sector decision-making.

**Socio-economic:** The most significant factor is the socio-economic status of a country or local market. First, private sector suppliers look at population size to see how many potential consumers exist in a given marketplace. Second, they review the geographic distribution of the population; the higher the concentration of people residing in urban areas, the easier it is to get their product or services to consumers. Third, they look at the education levels, particularly among women, because better-educated women are usually first adopters of new ideas, products, and services. Finally, the private sector analyzes a variety of economic factors to determine consumers' ability and willingness to pay, including income levels (GDP/capita) and (in the current case) private health sector and out-of-pocket expenditures.

**Market maturity:** The private sector prefers entering into a marketplace where there is demonstrable demand for FP services and products, thus reducing the need for high marketing costs including public and provider education. Private sector suppliers assume that they only need to focus on existing users, irregular users, or those intending to become users in the near future. They often choose to ignore the needs of low-income consumers because demand for products and services tends to materialize first in the highest income categories. As markets grow and demand among the highest quintiles becomes saturated, private sector suppliers may begin to look for new customers and develop products that meet their needs. Therefore, market maturity is an important factor in the private sector's willingness to serve a country's contraceptive security needs.

**Policy environment:** Sustainable supply of contraceptive products by the private sector depends largely on the overall profitability of these products to the manufacturers, importers, distributors, and retailers who make them accessible to the consuming public. Profitability is determined not only by the size of the market and the price of each product but also by the time, money, and effort costs of bringing those products to market. Unwarranted regulation or inefficient implementation of regulations by governing agencies can increase these "costs" to the private sector of supplying necessary products and can, consequently, decrease or eliminate the private sector's willingness and ability to maintain a

consistent supply of quality contraceptives. Cumbersome product registration, price controls, restrictive laws on tariffs, taxes, and repatriation of profits are policies that influence product supply (Ravenholt, 2006).

Policies governing the conditions for provision, or standards of practice, also influence individuals' ability – pharmacists and medical providers alike – to establish a private practice. The private practice of every provider type is a business; consequently, the sustainability of RH/FP service delivery in the private sector depends on the profitability of each provider's practice. Laws, regulations, and policies that have impact on the feasibility and costs of doing business directly affect FP service provision in the private sector. They include: qualifications for practice, scope of practice, requirement to establish private practice, and quality control and monitoring (Ravenholt, 2006). In addition, in some cases commercial legislation may impede providers' ability to establish a new business and to grow or improve an established private practice with external financing. The challenge for the public sector is how to balance appropriate regulations and quality control, while at the same time creating conducive market conditions to attract private sector supply of FP services and products.

### **3.2 HOW PRIVATE PROVIDERS APPROACH THE FP MARKET**

As in any for-profit endeavor, private providers need to earn a profit to stay in business. Therefore, private providers will also look for opportunities to deliver services to consumers who can afford to pay for them and to offer the type of services that can generate a profit. In the E&E region, recent experience in privatizing the health sector shows that the first health services to become private are in dentistry, ophthalmology, and curative care. Initially serving the more affluent consumers, private physicians can make a profit and therefore these types of services grow quickly. Once private providers can demonstrate sustained profits, then other types of physicians assume the risk to start up a new business and the sector diversifies into other types of health services, such as obstetrics/gynecology. FP, however, has been a “loss leader” for the private health sector because it is difficult to earn a profit on FP services. Usually private providers combine FP, with other more lucrative services, such as maternal and curative care, to make it worth their while.

In the E&E region, there are additional disincentives for providing FP services. As long as physicians continue to receive informal payments for services rendered in the public health system, these physicians will not be inclined to assume the risk to establish a private practice. Moreover, informal payments for abortion will continue to discourage public sector physicians from promoting FP methods. There have been, however, some successful initiatives to create incentives that address these barriers. In Kyrgyzstan, the Ministry of Health has “formalized” these under-the-table payments through a copayment system in the Mandatory Health Insurance program. Additionally, the Romanian Ministry of Health has successfully motivated an entire cadre of health professionals, family physicians, to provide FP services and products in a for-profit setting (See Step 4 – Romania case study).

### **3.3 HOW PRIVATE SUPPLIERS OF FP PRODUCTS APPROACH THE FP MARKET**

Manufacturers typically provide a range of products at different price levels that reflect perceived willingness to pay among consumer groups, as well as the cost of producing, distributing, and promoting those products. As in other regions of the world, contraceptive manufacturers in the E&E region offer OCs at very low prices because they know that some users cannot afford more expensive products. They choose to invest, however, in the latest product introductions – especially those still under patent

– because they are much more profitable. Thus, products that may be too expensive for a large proportion of users attract the bulk of commercial investment because they are simply more profitable.

Private sector interest in and financial commitment to FP, however, varies substantially from one country to another. In some countries with high purchasing power and fast-growing use of modern contraceptive methods, private sector presence and level of effort are considerable (Russia, Ukraine, Kazakhstan). In other countries, the contraceptive market offers so little profit potential that manufacturers offer a limited product range and do not invest in the product category. For example, in Azerbaijan, Gedeon Richter does not promote its contraceptive lines, Schering does not offer a Progestin-Only Pill product, and Organon is not present in the market.

Beyond market considerations, companies may also decide that contraceptives are not a profitable or timely investment area and choose not to register or promote the brands they own. Schering's Norplant and Organon's three-month injectable, Megestron, are currently not registered in E&E countries. Other methods for which there is still high demand (such as copper-T IUDs) but low profit margins and no exclusive patent are typically brought in on demand by local distributors but do not receive any marketing investment. In some cases, a new method may be promoted for a limited period until the company decides to focus its resources elsewhere. In Russia, the contraceptive patch (Ortho-Evra) initially received support from its manufacturer (Janssen-Cilag) but is no longer actively promoted. This is not the result of low demand but rather a decision led by the company's internal opportunity/cost analysis.

Convincing manufacturers to refocus on contraceptives, register products not currently on the market (such as implants), or invest in underutilized methods (such as injectables) may require substantial negotiation, as well as the leveraging of donor and government resources. Creative approaches tested in other parts of the world, such as the PSP-One project to increase the use of injectables through a private provider network in India, may be appropriate for the E&E region.

Distributors and retailers (i.e., pharmacists) are generally mostly concerned about high product rotation (sales volume and speed). Their livelihood depends on offering a range of brands and prices that reflect both local demand and purchasing power. Because of this, product choice is typically highest in urban areas and more limited in rural and low-income areas. The prices of contraceptives sold in pharmacies tend to reflect consumers' ability and willingness to pay in different neighborhoods. Distributors and retailers are incentivized in their choice of products through promotional support from manufacturers, demand from local providers and users, and/or donor-funded initiatives such as the ACQUIRE project in Azerbaijan.

It is important to keep in mind that private suppliers may be convinced to trade profit for volume but never to carry low-margin products in low demand. This assumption is verified in the contraceptive product range found throughout the E&E region. The most widely found method in private sector is OC, for which demand is growing, and new methods such as the contraceptive patch and hormonal vaginal ring, which health providers prescribe increasingly in spite of their relatively high costs. In contrast, because demand for injectables and implants is very low, there is only one three-month injectable (DMPA) product on the market (Depo-Provera) and no brand of implants.

### 3.4 PROCESS AND TOOLS TO ASSESS PRIVATE SECTOR POTENTIAL

PSP-One has developed an assessment process and various tools to examine the private sector’s role in RH/FP, and design interventions to strengthen its contribution. What distinguishes the PSP-One assessment process and tools from others is the fact that they are based on a private sector perspective.

Prior to any country assessment, the team conducts a preliminary review of documents and literature and develops a country profile comprising socio-economic and FP indicators. Most information, however, is gathered in-country, by a 2-3 member team that analyzes private sector products and supply, private service delivery, and the policy environment. Table 4 provides a checklist of the types of information (and data sources for each) that the team will need to analyze the country’s private sector. Indicators are organized into four categories – socio-economic conditions, policy environment, market maturity, and potential partners/stakeholders.

**TABLE 4. PRIVATE SECTOR CHECKLIST**

	<b>Indicator</b>	<b>Source</b>
<b>Socio-Economic Conditions</b>	<ul style="list-style-type: none"> <li>√ Total Population size</li> <li>√ PPP</li> <li>√ Literacy rate</li> <li>√ TFR</li> <li>√ TAR</li> <li>√ Unmet need</li> </ul>	<ul style="list-style-type: none"> <li>√ GDP per capita</li> <li>√ Percent Urban</li> <li>√ # of WRA</li> <li>√ Modern CPR</li> <li>√ Ideal family size</li> </ul> <p>DHS PRB &amp; PSP-One wall charts WHO reports World Bank Development Indicators (WDI)</p>
<b>Policy Environment</b>	<ul style="list-style-type: none"> <li>√ MOH support for FP</li> <li>√ Perspective toward private sector</li> <li>√ Legal &amp; regulatory environment for FP products (easy product registration, no price controls, no import tariffs, etc)</li> <li>√ Legal &amp; regulatory environment for private provision of FP services &amp; methods</li> <li>√ Legal &amp; regulatory environment for private provision of FP in pharmacies</li> <li>√ Public sector supply of contraceptives are targeted</li> <li>√ Public sector supply of contraceptives not competing with private sector brands</li> </ul>	<p>Review of laws, policies, norms and protocols</p> <p>Key informant interviews with MOH (leadership, M/RH director, pharmacy director, FDA equivalent, etc.)</p> <p>Key informant interviews with manufacturers, distributors, pharmacists, providers, physician and pharmacists associations</p>
<b>Market Maturity</b>	<ul style="list-style-type: none"> <li>√ Product supply (methods in market place, price points)</li> <li>√ Consumer demand (consumer knowledge of FP; consumer use and access to FP methods; consumer preference for certain methods, certain brands; ability to pay for methods)</li> <li>√ Provider preference (provider knowledge of FP; provider attitude towards FP, provider attitudes towards specific methods; access to private providers)</li> </ul>	<p>Market study of product supply</p> <p>Market segmentation analysis</p> <p>Key informant interviews with manufacturers, distributors, pharmacists, providers, physician and pharmacists associations</p>
<b>Potential Partners/ Stakeholders</b>	<ul style="list-style-type: none"> <li>√ List private and NGO sector entities and other key stakeholders who could potentially become partners (private provider and pharmacy networks, social marketing NGOs, contraceptive manufacturers, etc.)</li> </ul>	<p>Stakeholder analysis</p> <p>Health sector mapping</p> <p>Key informant interviews</p>

Note: DHS=Demographic and Health Survey, WRA=women of reproductive age, WHO=World Health Organization, TAR=total abortion rate, M/RH=maternal/reproductive health, FDA=U.S. Food and Drug Administration

Following the assessment, the team produces a report that focuses on two areas: the current status of the private health sector and opportunities to leverage the private sector to help address FP goals and objectives in a respective country. The first part of the report provides an in-depth description of:

- The different private health sector entities and organizations;
- FP services and products provided in the private sector;
- Barriers to private sector expansion;
- Provider perspective towards FP in both the public and private sectors; and
- Consumer attitudes and preferences regarding FP methods and sources.

The second part of the report discusses the different opportunities and strategies a Mission can pursue to mobilize the private sector. As Step 4 demonstrates, there are a wide range of strategies depending on the Missions' objectives and the status of the private sector. The report clearly lays out the various options for a Mission.

Often an assessment uncovers issues that require further analysis before a Mission can design a program of activities to work with the private health sector. Table 5 provides an overview of the different analytical tools used by the PSP-One project to design interventions involving the private health sector. For example, one may want to research key legal and regulatory barriers to private sector expansion in order to design strategies to address these barriers. Or one may want to conduct a market segmentation analysis to determine what public sector clients could afford to seek FP services and products in the private sector and at what price levels. This market analysis would help Missions determine potential size for private sector market, public sector strategies to encourage these consumers to go to the private sector, and price points for private sector products. There may be also resistance from the public sector to acknowledge or engage the private sector on FP issues so additional information on public sector attitudes and perceptions toward the private sector would be helpful to inform an advocacy initiative.

**TABLE 5. PRIVATE SECTOR TOOLS AND ANALYSIS**

<b>Tool</b>	<b>Purpose</b>	<b>Description</b>
Legal & regulatory review	Identify the policy barriers and opportunities to promote greater private sector involvement in FP	In-depth analysis of all relevant policy, legal, and regulatory documents with dual focus on regulation and commercial legislation. Review conducted by local lawyer and supplemented by key informant interviews with policymakers in MOH and private sector providers.
Private health sector inventory	Identify private sector entities and organizations	Overview of private sector individuals, groups, and organizations, their client base, and the products and services they provide.
Commercial sales data analysis	Understand consumer and industry trends	Sales data is proprietary but can be purchased from research firms such as IMS Health.
Stakeholder analysis	Determine support for and opposition to the private sector, and identify strategies to create better coordination between the public and private sectors	Informant interviews with both public and private sector individuals.

<b>Tool</b>	<b>Purpose</b>	<b>Description</b>
Health sector mapping & inventory	Develop a whole market picture of FP supply and identify supply gaps	Map of public, private, and NGO providers and corresponding demand for FP services and products.
Socio-economic (supply side) market Segmentation	Determine where various socio-economic segments obtain products and services and determine needed interventions	Secondary analysis of DHS.
Client-focused (demand-side) market segmentation	Determine the components of demand (contributing factors and barriers) for RH/FP products and look for homogenous segments that can be targeted with specific programs	Population-based quantitative study followed by in-depth analysis.
Willingness-to-pay survey	Determine users' willingness to pay more for products and services that they are currently accessing	Population-based quantitative survey (questions relating to willingness to pay can be included in a DHS or market segmentation survey).
Distribution survey	Determine with accuracy the actual availability of FP products	Outlet-based survey. May include reported sales, stock levels and outages, and retail prices, in addition to product availability.
Access-to-finance assessment	Identify constraints and opportunities for private providers and distributors to access finance for business sustenance, improvement and growth	Desktop review, informant interviews, and focus groups with provider groups, distributors, and financial institutions.
Business development & support assessment	To assess level of business development of private providers and distributors with focus on business support needs	Review of state of development of private sector enterprises and their operating environment, possibly including a privatization process, contracting, provider networks, access to training in business and financial management and clinical skills. May be combined with access-to-finance assessment

Once the analysis is complete, the PSP-One team works with the Mission, USAID bilateral projects and local counterparts to design activities for the private sector. Depending on the level of activities, many of them can be integrated into existing bilateral projects. For example, the PSP-One assessment in Kazakhstan identified specific policy reforms that would provide financial reimbursement of FP methods obtained in the private sector under the Outpatient Drug Benefit Plan. The ZdravPlus project could promote these reforms along with their other health financing reform initiatives. In Azerbaijan and Russia, the PSP-One team recommended that the USAID-funded RH/FP projects partner with manufacturers of OCs to increase the demand for this method because it is the most likely to attract private investment.

## **4. STEP 3: KEY FINDINGS ON THE E&E PRIVATE SECTOR**

The following discussion presents findings from PSP-One private sector assessments conducted in six countries (Azerbaijan, Kazakhstan, Kyrgyzstan, Russia, Tajikistan, and Ukraine). PSP-One supplemented each country assessment with a review of project documents and PSP-One's country experience in Georgia and Romania. The findings are organized in three categories:

- Policy environment
- Market maturity
- Socio-economic conditions

### **4.1 INFLUENCES OF PUBLIC SECTOR POLICIES ON THE PRIVATE SECTOR**

#### **4.1.1 CHANGES IN THE HEALTH SYSTEM**

Health systems across the E&E region are in various stages of development and reform. Over the past 15 years, most countries in the region have moved away from the Soviet-era Semashko health care model – with state-financed comprehensive health care that is free for everyone at the point of service – toward the Bismarck health care model with social insurance at its core.

After the fall of the Soviet Union, the countries of Central Asia began to improve and modernize their health systems, reducing excess capacity and specialization in secondary and tertiary care, reorienting the system to be more focused on universal access to primary health care, and increasing emphasis on disease prevention. Over-centralization of decision-making paired with input-based financing of providers contributed to inefficiencies in the delivery of care, and a strategy was needed to change the financial incentives faced by health providers and become a catalyst for reform.

For the most part, reform efforts have included the separation of state purchasing and health care provision, introduction of health insurance financing systems to replace or complement general taxation models, introduction of private payments or copayments, and limited privatization. Reforms were designed to address inefficiencies of the old centralized systems characterized by an excessive network of over-staffed health care facilities and an over-reliance on specialty care, introducing incentives for rationalization, and focusing on improving primary health care and disease prevention.

Privatization of pharmacies and dental services occurred quickly in the vast majority of countries in the region, and health care facilities themselves often have nongovernmental or commercial status while still receiving the majority of their formal funding from the state through contracts. The number of truly for-profit private providers remains small and concentrated in urban areas. The exception to this rule is Romania, where the foundation of primary health care, the family doctors' practices, have been privatized and operate as fully private entities under contract with the government.

The number of NGOs in the E&E region providing RH/FP services is limited, but has increased in recent years in response to donor funding for drug demand reduction and HIV/AIDS prevention, especially among target populations not typically served by government providers.

Health reform efforts have been affected by the broader political and economic situation in each country, specific health care policies, and the capacity to implement reforms at all levels of the system. Despite visible successes in several countries, as a whole the numbers of hospital beds and specialists per capita remain high relative to European standards, insufficient emphasis on prevention continues, health workers are poorly compensated, both the costs of and patient spending on medicines are increasing dramatically, and informal payments remain commonplace.

In most countries in the region, the 15-year time horizon has been too short to see real gains in health outcomes. Romania is an exception where significant and measurable gains have been made in increasing CPR and reducing the total abortion rate in just the past five years.<sup>2</sup> Further health systems strengthening, taking into account both public and private sector provision of services, is needed.

#### Health reform in Central Asia

USAID's *ZdravPlus* Project works in all five countries of Central Asia. The project is in its third phase, continuing to provide technical assistance and operational support to help governments in each country strengthen its health systems. The project has four areas of focus – stewardship, resource use, service delivery and quality improvement, and community and population involvement.

Over the past 10 years, major health policy shifts have been achieved, and incentive-based financing and provider payment systems have been introduced to improve efficiency and responsiveness of the system, without sacrificing access to care. These system-level changes have been paired with service delivery and community health interventions that have improved quality of care, especially in priority areas like maternal and child health, infectious diseases, and chronic diseases, such as hypertension. Through open enrollment of primary health care providers, mass media campaigns, inter-personal communications, mobilization of communities, and grant programs, the population has become increasingly involved in managing its own health and making lifestyle changes that contribute to disease prevention.

The main focus of health systems strengthening has been to improve systems and services in the public sector; however, many of the health reforms, especially in Kazakhstan and Kyrgyzstan, also have the potential to benefit private sector health care providers.

## 4.1.2 POLICIES THAT AFFECT METHOD SUPPLY

### Support and funding for FP

Funding allocated to purchase contraceptive methods is a strong indicator of a country's commitment to FP. Most countries assessed do not actively support FP at the national level, resulting in little or no funds to purchase FP methods. In Azerbaijan, opposition to FP stems from a lack of knowledge of its impact on health indicators, and out-of-date assumptions about women's fertility preferences. In Kazakhstan and Russia, government leaders and many legislators have espoused pro-natalist positions. In Kyrgyzstan, FP has been kept out of the country's key health strategy document, *Manas Taalimi*. Lack of MOH support combined with dwindling commodity donations for the public sector has resulted in limited supplies of FP methods in public facilities. Seizing an opportunity (growing demand for contraceptive products not met by the public sector), the private sector has stepped in to provide a wide range of methods in the most promising markets (Kazakhstan, Russia, Romania, and Ukraine).

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<sup>2</sup> Courtesy of Society for Contraception and Sexuality, Romania, 2006

Despite the lack of high-level support within ministries and cabinets for FP programs, many MOH officials and staff in mid-management and in local leadership positions are committed to providing FP services and methods. In Kazakhstan, several health officials in the four oblasts visited described “creative” solutions to address the lack of FP methods, particularly for the socially vulnerable population groups. In South Kazakhstan, several oblast administrators pooled their budgets to organize public tenders to purchase commodities. In Almaty, the city administration established a budget line item for contraceptives; it now is purchasing pills and will soon purchase IUDs. Unlike senior officials, mid-level MOH staff in Azerbaijan have also demonstrated leadership, raising awareness of FP needs. Within the MOH, there are some key RH advocates in mid-level advisory positions to the Minister of Health who have joined forces with two Parliamentarians to advocate for FP issues. Nonetheless, these pockets of support have not been able to translate into more funding for FP programs and a consistent supply of methods in the public sector.

### **New public sector financing schemes**

Health sector reforms sweeping the region are experimenting with different financing mechanisms to pay for health services. These financing schemes can create opportunities for the private sector *if* properly designed. In an effort to pool more resources for health and to address households’ high informal payments for health services – a problem throughout the E&E region – the government of Kyrgyzstan introduced mandatory health insurance and formal copayments, which vary by type of patient and service rendered. The MOH has assumed that Kyrgyz women will obtain their FP methods through the Additional Drug Program (ADP). Unfortunately the ADP has not been sufficient to stimulate FP demand in either the public or private sector. Possible reasons for not using the ADP to pay for contraceptives range from the existence of free products in the public sector (for low-income users), lack of provider involvement and support, low patient awareness, and high willingness to pay (for high-income users). In Kazakhstan, the Outpatient Drug Benefit Plan has had a negative impact on the availability of contraceptives because it restricts access to subsidized OCs, DMPA, and IUDs to inpatient care facilities (maternity hospitals and polyclinics). Despite limited support from the senior MOH leadership to include FP methods in the drug benefit plan, efforts are underway to address this policy constraint.

### **Policies for vulnerable groups**

Although “free” FP services are available almost universally in the public sector throughout the region, subsidized methods are seldom available for vulnerable population groups (low-income, rural, and youth). This is due to a combination of insufficient resources, stock-outs, and dwindling supplies of donor-supplied commodities. In some countries (primarily Kazakhstan, Romania, Russia, and Ukraine), the private sector meets supply needs for current users but commercial products may be out of reach for some groups, especially those with unmet RH/FP needs.

Commendable efforts by some MOH leaders (see box) do not substitute for the fundamental role of the public sector as the guarantor of services and products for the vulnerable populations.

#### **Addressing unmet need in vulnerable populations – sometimes**

With increased funding levels in the Kazakh MOH trickling down to the oblasts, the oblasts with strong FP leadership use their own budget to purchase commodities. The others oblasts – particularly those with highest unmet needs and maternal mortality rates due to rising abortion rates – do not purchase FP methods. These oblasts also have large numbers of vulnerable population groups, resulting in limited or no access to free FP methods.

### 4.1.3 POLICIES AFFECTING PRIVATE SECTOR PRODUCT SUPPLY

#### Legal and regulatory environment

There are minimal legal and regulatory barriers to private sector supply of commodities in the E&E region. Key barriers – onerous product registration, price controls, import or VAT taxes – do not exist in most countries. There is also minimal government oversight and monitoring of marketing practices by the corporate sector. Ethical contraceptives (such as hormonal contraceptives and IUDs) cannot be advertised directly to consumers, but there are no apparent limitations of marketing to providers.

The quality of drugs sold in the private sector is reportedly cause for concern in some E&E countries (such as Kyrgyzstan and Azerbaijan), particularly where donated contraceptives are exempted from registration regulations. However, market assessments by PSP-One and other organizations have not encountered much evidence of counterfeit or low-quality contraceptives (with the exception of donated condoms in Kyrgyzstan). The regional trend is to strengthen the regulatory framework for private sector supply and distribution of pharmaceuticals. Kazakhstan and Ukraine have invested in updating their legal and regulatory framework, using US and European systems as models. These efforts include creating regulatory bodies, and strengthening drug quality laws governing sales and distribution practices.

#### Policies for the pharmaceutical industry

Most of the MOHs in E&E countries assessed by PSP-One were open and receptive to the private sector despite the recent advent of the capitalist economy. MOH receptivity ranged from ambivalence (Armenia, Azerbaijan) to collaboration (Kyrgyzstan, Romania, Ukraine) to enthusiastic support (Kazakhstan).

The current method mix in many E&E countries is driven in large part by pharmaceutical industry activities and resulting provider attitudes. The fluid and close relationship between public sector physicians and pharmaceutical companies in countries with high-income markets (Kazakhstan, Romania, Russia, and Ukraine) have a great influence on prescription practices. Pharmaceutical companies employ large teams of medical detailers, who regularly visit public and private providers to promote company products and provide technical support. Detailers have played a critical role in increasing provider confidence in hormonal contraception, which had a bad reputation in the region until the mid-1990s. Public sector physicians now display a clear preference for OCs, reflecting intensive marketing efforts by manufacturers. Many health providers in both the private and public sectors also believe, incorrectly, that older generation and generic contraceptives are “inferior” products and tend to prescribe expensive, latest-generation pills.

#### Providing objective information

Pharma companies are naturally inclined to favor high-margin products and therefore focus their marketing and promotion activities on these products. In the case of Romania, the MOH conducted contraceptive technology updates to providers and implemented public campaigns educating the public in an effort to create complementary and objective information for providers and consumers to counterbalance pharmaceutical marketing.

Open access to public sector providers (who provide the bulk of RH/FP services) by pharmaceutical companies is widely tolerated because it compensates for limited resources for provider training and continued education. As in most countries, medical associations in the E&E region tend to welcome the investment made by contraceptive manufacturers in their professional events and programs. In this region, however, pharmaceutical representatives are typically the only source of RH/FP information for service providers.

Pharmaceutical retailers are increasingly regulated in the E&E region. In most countries, however, the provision of OCs, injectables, and IUDs without a prescription is widely tolerated. As a result, many users obtain contraceptives from pharmacies without prior counseling. Because many pharmacists (especially in Azerbaijan) lack sufficient knowledge of FP methods, women often end up receiving insufficient or inadequate information.

#### **4.1.4 POLICIES AFFECTING PRIVATE SECTOR SERVICE PROVISION**

The PSP-One project examined private provision of FP services (in addition to contraceptive commodities) in Azerbaijan and Ukraine; therefore private service delivery findings are limited to those two countries. In both countries, private provision of health care is still nascent and tends to serve higher-income groups. Ukraine has some private health insurance schemes, but they are offered only to commercial employers such as banks and other financial institutions. Access to capital remains the largest obstacle for health professionals establishing a private practice. Regulation and supervision of private health care varies – in Azerbaijan, private health care is mostly unregulated by the public sector, while in Ukraine, there are clear and transparent regulations. Most private health providers do not offer FP services and instead focus on more lucrative health services, such as curative care, dentistry, and ophthalmology. If FP services are offered, they are usually in combination with gynecological or maternal services.

While most countries have licensure requirements for private practitioners, quality of care in the private sector (particularly for RH/FP services) is largely unregulated and not monitored. The public sector typically has limited access to reliable data on the volume of products and services provided by the private sector, and scant information on the availability and price of those products/services.

Private health insurance has been slow to develop in the region due to both supply and demand factors. The absence of a legal and regulatory framework governing insurance is another factor impeding private health insurance. Indeed, many European insurance companies are keen to enter these markets, particularly the larger and more developed markets such as Romania and others in southeastern Europe, once the legal and regulatory reforms take place.

Informal payments for public sector services, particularly abortion services, are a major barrier to increased private sector provision of FP services. As long as informal payments are tolerated, there is little incentive for public sector providers to take the financial risk of starting a private practice unless they cater to a small, wealthy clientele. Necessary steps to increase private sector provision of FP services therefore require major efforts to discourage informal payments in the public sector. This may be accomplished by instituting formal copayments (as stipulated in Kyrgyzstan's insurance scheme) or allowing private general practitioners (GPs) and family doctors to provide RH/FP services (as in Romania).

## **4.2 MARKET CONDITIONS AND MATURITY**

### **4.2.1 CLIENT PREFERENCES AFFECTING DEMAND**

Although modern method use is rising, there is still substantial unmet need in many of the E&E countries. The proportion of married women who say they would prefer to avoid pregnancy but who are not using any method of contraception varies among the countries highlighted in this report, as shown in Table 6. Almost one quarter of married WRA in Kazakhstan and Kyrgyzstan state they do not

want another pregnancy. This percentage climbs to almost one half in Georgia and Azerbaijan. Unmet need is concentrated among rural, poor, and ethnic population groups.

Many women in the region continue to rely on abortion as if it were an acceptable method of birth control. Although abortions are relatively unrestricted and available for free in the public sector, providers receive some form of informal payment for this service. Often this payment is less than the cost of modern contraceptives, particularly when providers demand a series of medically unnecessary tests and exams in order for women to receive a modern method. This practice occurs not only in public sector FP services but also in private FP services as well.

**TABLE 6. UNMET NEED FOR MODERN CONTRACEPTIVE METHODS**

Country	Percentage of married women ages 15-44
Kazakhstan	22
Kyrgyzstan	22
Romania	39
Georgia	44
Azerbaijan	53

Source: PRB (2003)

Another trend influencing demand is provider bias, which can influence client demand for certain methods. Strong provider preference in Kazakhstan, Romania, Russia, and Ukraine appears to be driving the demand for OCs while decreasing reliance on IUDs and injectables. Providers also influence demand for specific brands because they are the focus of promotional efforts by pharmaceutical companies operating in the region. Providers tend to believe that older-generation and generic hormonal contraceptives are “inferior” products and often prescribe expensive, latest-generation pills. Pharmacists also confirmed client preference for the latest brands of OCs, in spite of their high prices. Romania is an exception because the market leader in that country is a generic OC product.

Users of modern methods in the E&E region also show a growing preference for new hormonal methods such as the contraceptive patch, the hormone-releasing IUD, and the hormonal vaginal ring. These products, however, are likely to be beyond the means of many users. Because they are still under patent and cannot be copied by generic companies, their price is unlikely to come down significantly in the near future.

#### **4.2.2 PRIVATE PRODUCT SUPPLY**

##### **Product range**

The private sector has become the key supplier of condoms, spermicides, oral and injectable contraceptives, and IUDs in the region. However, more emphasis is given to promoting OCs and new hormonal methods than any other method. The OC supply in former Soviet republics is influenced by global product introductions, trends in the Russian market, local cultural preferences, and purchasing power.

Pharmaceutical companies generally hope to create a market in the region that will be similar to Western Europe and Russia, with a focus on the latest product formulations. The provider community has been very receptive to these efforts: health providers in the region tend to favor the newest and most expensive brands, even though safe and effective low-dose OC brands are also available. Although

so-called “high-dose” pills containing 50 mcg or more of estrogen are no longer found in most E&E countries, many providers assume that older formulations have too high a hormonal dosage and/or use inferior ingredients.

Nevertheless, ability to pay by users also influences the product offer. Although new brands are prominent in urban areas, the low-priced combined OC Rigevidon appears to be widely available in both urban and rural areas. In addition to OCs, one can also find IUDs, injectables, spermicides, and condoms in private sector pharmacies. For a list of brands and prices in countries assessed by PSP-One, please refer to the Annex.

### **Marketing of contraceptives**

Throughout the E&E region, pharmaceutical companies have adopted the practices and techniques used in Western countries to promote their products, all the while tailoring their approach to national specificities. The companies that manufacture pharmaceutical products (mostly based in Europe and the United States) maintain local marketing offices in most E&E markets. These offices are not usually allowed to import and sell products but support local distributors contracted to do this work through their outreach efforts. Manufacturers focus on lobbying government officials and influencing prescribing practices in a particular market. Unlike distributors that focus on product supply, representative offices invest in creating demand for their products. The presence of a scientific office is a good indicator of a manufacturer’s willingness to invest in a particular country.

Pharmaceutical companies often support continued education for health providers through conferences, workshops, and “detailing” (regular visiting of prescribing providers). Direct-to-consumer communication efforts, however, are limited by the prohibition of branded advertising for prescription drugs. As a result, providers have widely benefited from industry efforts to promote the use of modern contraceptives, but potential users remain relatively uninformed about these methods.

Although condoms can be freely advertised to consumers, there is limited private sector investment in these products because they are mostly brought in by distributors that merely respond to demand from pharmacists and do not invest much in marketing. IUDs are also seldom promoted in the private sector because they have a low turnover and carry low profit margins. One exception is the hormone releasing IUD Mirena, which is actively promoted by Schering in the E&E region.

Scientific offices adapt their marketing strategy and product portfolio to the specificities of each market, but they also follow a global corporate approach that typically includes the following objectives:

- Promote hormonal methods, especially their non-contraceptive benefits;
- Focus on increasing the sales of high-margin brands;
- Target most likely users (such as young, educated urban women);
- Concentrate on “captive provider audience” (doctors who already prescribe, or are likely to prescribe contraceptives);
- Establish goodwill and recruit champions within the public sector; and
- Respond to country-specific demand.

### 4.2.3 PRIVATE SECTOR SUPPLY NETWORKS

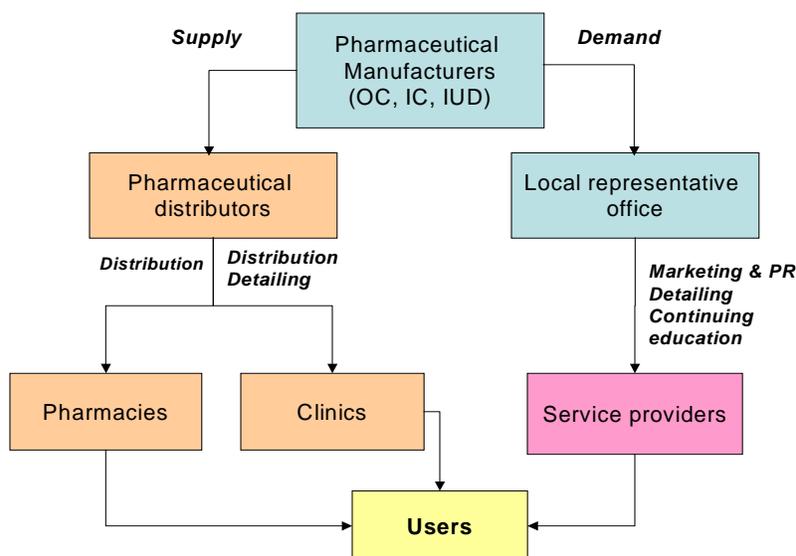
Most pharmaceutical products sold in the E&E region are manufactured in other parts of the world and imported by national distributors. Distributors are locally based companies that supply a wide variety of products to wholesalers and retailers (pharmacies and clinics). As a result, distributors play a key role in controlling product availability and prices.

OCs, IUDs, and condoms share similar distribution patterns. All are sold almost exclusively through registered pharmacies as required by law (OCs and IUDs) or custom (condoms). The same 2-3 large distributors tend to import most contraceptive products in any given country.

All pharmaceutical products must be registered through the country's MOH. In most E&E countries, WHO-based procedures for registering pharmaceutical products have been put in place. According to registration rules, manufacturers (through their appointed distributors) must provide all necessary paperwork and make their products available for testing.

The private sector supply network (as shown in Figure 3) offers two significant advantages over a public distribution system. Private sector distribution networks use highly efficient supply channels that reach far into the country's retailer network, including rural areas. In addition to geographic reach, private sector supply networks are also sustainable. As long as there is consumer demand for them, these networks are able to supply a wide range of products to thousands of retail outlets. Thus, stock-outs are less likely to occur in the private sector. Universal access to a wide range of products for everyone, however, is not guaranteed through the private sector because commercial suppliers respond to, rather than anticipate, consumer demand.

**FIGURE 3. PRIVATE SECTOR SUPPLY**



Note: IC-injectable contraceptive

The only true barriers to the private sector's *ability* to supply products that are in demand are the cost of reaching geographically remote areas, and the absence of retail outlets. The *willingness* of private sector suppliers to supply products is influenced by their perception of the demand for these products. Demand varies with price, thus commercial suppliers strive to reach a balance between their profitability goals and consumers' ability and willingness to pay.

### **Distributors**

There are typically hundreds of pharmaceutical distributors in E&E countries (though some countries like Russia have seen a substantial consolidation of the distribution industry). Typically, a few large distributors import the bulk of contraceptive products sold in the country. Some distributors reportedly import contraceptives from large Russian consolidators (such as Moscow-based Protek). Distributors handle hundreds of products on which they earn a 10–20 percent margin. Their strategy is to focus on products with a fast turnover or high margin (preferably both). Contraceptives have a low turnover but major distributors carry these products because they are part of a manufacturer's larger portfolio (such as Pfizer's) or receive promotional support from manufacturers (such as Schering). Condom and IUD importation and distribution tend to be opportunistic, that is, essentially driven by demand and not based on a long-term market development strategy.

Exclusive distribution contracts are rare in the region. Most manufacturers sell their products to several major distributors who then compete with each other for the wholesale and retail business. In some countries (such as Azerbaijan), distributors exchange goods with other companies appointed to distribute products they are not contracted to carry. Although the distributor's core business (wholesalers and retailers) tends to be concentrated in urban areas, especially capital cities, it does not mean that rural regions are inadequately supplied. In Azerbaijan, for example, many district pharmacies obtain their products by ordering from Baku wholesalers.

Because few manufacturers have the resources to maintain a marketing office in every country, the largest distributors in the E&E region offer marketing services, such as provider detailing and promotional activities. Riadfarm in Azerbaijan employs 100 medical representatives in the Baku area who promote the more than 60 house brands carried by this distributor. The presence of distributors with marketing capacity increases the range of products that can be sold in a given country, particularly those made in countries with low production costs. HB, another large Azeri distributor, specializes in importing, repackaging, and marketing pharmaceutical products made in Asia.

### **Wholesalers and retailers**

The pharmaceutical sector is an industry in transformation. Post-Soviet markets have experienced explosive growth in the number of wholesalers and retailers in the past decade, leading to intense competition and lower profit margins. In some countries (e.g., Ukraine), this sector is undergoing consolidation, as reflected in the closing of a number of wholesalers. But the number of retail pharmacy outlets is actually growing in many E&E countries. In response to the pharmaceutical sector growth, many E&E countries are rushing to establish policies and structures to regulate this industry and ensure product quality and pharmacist competency. Of note are the Kazakh and Ukrainian government's efforts to develop regulations and create institutions in line with European and U.S. standards.

This rapid growth in the retail pharmacy industry may explain why many pharmacists tend to be misinformed about contraceptive products. In Azerbaijan, the PSP-One team observed a striking contrast between pharmacists trained and monitored by the ACQUIRE project and those outside the project intervention area. Untrained pharmacists displayed all women's health products together and frequently mistook abortive and gynecological treatments for contraceptives.

### 4.3 PRIVATE SECTOR “OPPORTUNITY” RANKINGS OF E&E COUNTRIES

The PSP-One team developed a classification of the status of the FP private sector marketplace in each country in the region. This typology helps compare countries in the region with respect to their level of private sector market development. It can also be used to demonstrate the potential role of the private sector and to develop strategies to increase private sector contribution to FP goals.

To develop this classification, the team examined many of the same factors the private sector considers to determine a potential market for FP, particularly the policy environment, market maturity, and socio-economic conditions. Table 7 provides further detail of the conditions the private sector looks for in a marketplace. (Please note that many of the data sources for these indicators are listed in Table 4 in Step 2.) The greater the number of these factors in a market place, the more “private sector friendly” the country. Conversely, if few of these conditions are present, then less private sector potential exists in a country. This is not a rigorous methodology but one that offers a notional idea of how the countries in this region compare.

Three groupings emerged from this analysis:

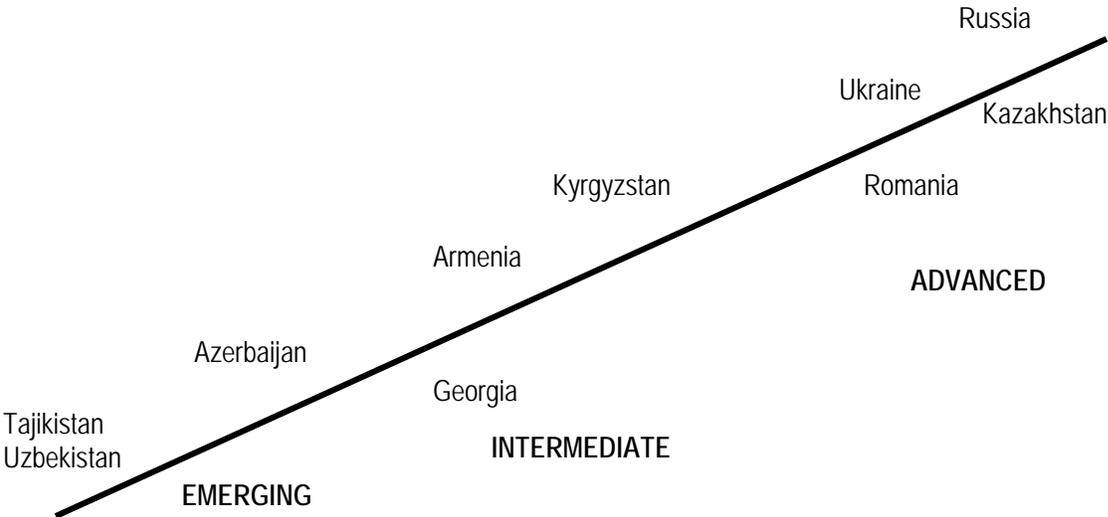
- **Advanced:** A majority of positive conditions exist for the private sector in a country.
- **Intermediate:** Some positive conditions exist.
- **Emerging:** Few or no positive conditions exist.

**TABLE 7. KEY INDICATORS AND THEIR CHARACTERISTICS**

<b>Socio-economic</b>	<b>Policy environment</b>			<b>Market maturity</b>	
<b>Socio-economic</b>	<b>Socio-political</b>	<b>Policy</b>	<b>Health systems</b>	<b>Providers</b>	<b>Consumers</b>
GDP per capita (middle- or higher-income country)	Government open to private sector	MOH supports &/or has established FP policy (offers client choice in methods & providers)	MOH understands total market approach and recognizes private sector contribution	Declining provider economic dependence on abortion	Age structure (significant number of WRA)
Significant segment of population able and willing to pay for FP services &/or products	Government is favorable toward and supports FP	Supportive legal and regulatory environment for products (easy product registration, no price controls, import tariffs, etc.)	No informal payment mechanisms for FP services and products	Favorable provider attitudes toward FP & all modern FP methods	CPR (CPR of at least 35% indicating actual demand for FP)
Large population/size (market size)	Minimal &/or no opposition to FP from key social groups (religious, women's, etc.)	Supportive legal and regulatory environment for private providers and private pharmacies	Financing mechanisms in place to reimburse FP methods (social insurance, ADP, outpatient drug benefits plan, etc.)	Ob/gyn and GPs are both authorized and able to offer wide range of FP methods	Significant segment of population has disposable income to purchase methods
Urbanization (higher % of population living in urban areas)	Declining social acceptability of & reliance on abortion (decrease in TAR)	Limited or no quantity of donated contraceptives	Policies and programs for innovative partnerships (contracting out, etc.)	GPs, ob/gyns & pharmacists are knowledgeable about current FP methods	Cultural preference for smaller family size (ideal family size)
Literacy and education levels (high literacy among women)		Donated FP products are targeted & not competing with private sector	Product supply (methods in market place & price points)	Easy access to private & public sector providers	High knowledge level of FP & modern methods
Financial sector offers sufficient funds (credit) to providers & distributors			Established distributors & networks to place products at reasonable cost	Physicians & pharmacists understand business potential of FP	Positive experiences with use of FP

Figure 4 illustrates a notional idea of how developed the FP private sector market is in each of the countries. Of the E&E countries included in this report, four countries are *firmly* classified as advanced FP private sector markets: Kazakhstan, Russia, Romania, and Ukraine. In comparison, the three intermediate countries have a sufficient number of positive private sector conditions to be classified in the intermediate category but will require focused interventions to make them more private sector friendly. Of the three, Kyrgyzstan has the strongest potential for private sector development. The last category is emerging countries. Two of the three countries – Uzbekistan and Tajikistan – have almost no private sector potential in FP at this time. Azerbaijan, on the other hand, has room for a limited private sector. The following section provides further detail on these countries.

**FIGURE 4. PRIVATE SECTOR RANKING**



*Note:* Please refer to Table 4 for a list of the quantitative and qualitative analyses and data sources used

**4.3.1 ADVANCED MARKETS: COMPLEMENTARY PUBLIC AND PRIVATE SECTORS**

In the advanced markets, the private sector plays a major role in addressing contraceptive security. The FP market is essentially dominated by the commercial sector through private pharmacies whereas service delivery is ensured by the public sector. Table 8 provides an overview of the complementary roles the public and private sector have in delivering FP services and products. In some countries, (Russia and Ukraine), NGOs are taking a lead role in activities not undertaken by the public or private sectors, such as information campaigns directed at consumers and generating demand. Romania is the exception; there, NGOs are slowly phasing out, as donor subsidies are no longer available. Romanian women now have greater access to FP services at the primary health care level through private sector family doctors.

**TABLE 8. OVERVIEW OF PRIVATE/PUBLIC MIX IN ADVANCED COUNTRIES**

	<b>Supply</b>	<b>Demand</b>
<b>Products</b>	Private <ul style="list-style-type: none"> <li>▪ Pharma companies</li> <li>▪ Wholesalers</li> <li>▪ Private and semi-private pharmacies</li> </ul>	<ul style="list-style-type: none"> <li>▪ Public providers through counseling &amp; prescriptions</li> <li>▪ NGOs through information, education and communication (IEC) materials and activities</li> <li>▪ Pharma companies through promotional materials and detailing</li> </ul>
<b>Services</b>	Public <ul style="list-style-type: none"> <li>▪ Ambulatory clinics (w/ family medicine doctors)</li> <li>▪ FP centers at women’s health centers with Ob/gyns</li> <li>▪ Maternity hospitals - limited post-partum care</li> </ul>	<ul style="list-style-type: none"> <li>▪ NGOs through IEC, counseling, and referrals</li> <li>▪ Limited internal referrals within public health system</li> </ul>

In the advanced markets, the private sector will continue to be the dominant supplier of FP contraceptives in the absence of a major market distortion (such as price controls or massive product subsidization by the public sector). There are, however, few incentives for the commercial private sector to increase provision of FP services as long as public providers continue to receive informal payments for services. The exception to this among the countries in this group is Romania, where women get their FP services and products in the private sector.

This division of labor between the public sector supply of services and commercial sector supply of FP methods works relatively well except for vulnerable population groups who cannot afford to pay commercial prices. With the exception of Ukraine, most governments in these countries are in a position to purchase the small quantities needed by the vulnerable groups. This is what Romania has started to do in purchasing a sufficient supply of FP methods for the rural (poor) populations only.

Another issue is stimulating demand among certain population groups. Much needs to be done to educate the public on the health benefits of FP, yet the combination of advertising restrictions and low returns on investments make large-scale promotional campaigns unprofitable for the private sector. Most private sector suppliers believe that the responsibility of educating the public and serving the neediest should fall to the public sector. Yet few countries in this group are carrying out public awareness campaigns or targeted education strategies for population groups expressing unmet need.

#### **4.3.2 INTERMEDIATE MARKETS: GROWING PRIVATE SECTOR PRESENCE**

In comparison, the three intermediate countries are *barely* in the intermediate category, presenting challenges to stimulate private sector potential. Of the three, Kyrgyzstan has the strongest potential for private sector development. The private sector is responding to existing demand for OCs and condoms, but only two manufacturers have made an investment to grow the Kyrgyz market – Gedeon Richter and Innotech (this is compared to intense competition in the advanced markets). The primary limitation for increased investment in Kyrgyzstan is the low demand for FP methods.

Countries like Kyrgyzstan may benefit from the introduction of low-cost generic products. Indian companies already supply IUDs to local distributors and may not encounter major difficulties in registering hormonal methods. But the greatest disincentive for generic manufacturers is the very low

demand for OCs in the private sector, together with the absence of any significant contraceptive tenders in the public sector. To address this constraint, Kyrgyzstan may benefit from a social marketing program to increase the use of and access to FP methods. Social marketing is one of the most effective ways to achieve simultaneous increase in demand and supply. A social marketing program, combined with a partnership for a low-cost generic supplier, could prime the private sector market, while, at the same time, increase access and generate demand. It is critical, however, to ensure that social marketing programs have an exit strategy rather than create a need for more public subsidies. They should also partner with commercial suppliers (such as low-cost manufacturer Gedeon Richter) instead of competing for their customers.

In Georgia and Armenia, the private sector is growing but is slow to take off in the health sector. Manufacturers of FP products are facing small populations where the median age is around 37 years of age and slightly older for women. Another private sector limitation is the population's ability to pay outside of major urban settings. Like Kyrgyzstan, Georgia and Armenia offer opportunities for low-cost generic manufacturers; legal and regulatory barriers for entering the market are fewer than in the emerging states described below, but difficulties still exist. Also as in Kyrgyzstan, there is low demand for FP commodities and a social marketing program combined with a partnership for a low-cost generic supplier may be effective mechanisms to address this. Specifically in Armenia, the private sector will also face a pro-natalist government. In Georgia, the Orthodox Church has not made public statements against FP but it also has not endorsed it – however, it has condemned abortion practices.

#### **4.3.3 EMERGING MARKETS: LIMITED MARKET APPEAL BUT....**

The last category, emerging markets, contains three countries of which two – Uzbekistan and Tajikistan – have almost no private sector potential in FP at this time. In these countries, one should consider a multi-pronged approach that cultivates a range of options to increase demand for FP and ensure a secure supply FP services and methods. While some initiatives may fail or be abandoned, others will succeed and be sustained. Because one cannot predict which ones will succeed, it is important to ensure contraceptive products and services are integrated into as many ongoing efforts as possible.

Despite difficult FP conditions in countries like Uzbekistan and Tajikistan, there are some activities Missions can consider to put in place the building blocks to grow the FP market and plant the seed for eventual private sector participation. In Tajikistan, donors provide virtually all contraceptives; however, the country faces a likely and significant decline in donated products before the end of the decade. There are four strategies to help Tajikistan prepare for this transition. Because high levels of household payments go for health, a possible strategy would be to include contraceptives in existing and planned Revolving Drug Funds. Such small-scale pilot efforts are likely to serve as models for scaling up drug financing in the future interventions. Including contraceptives would mainstream FP products along with financing other primary health care products. A second strategy focuses on laying the groundwork for public purchase of contraceptives. Although prospects are dim for increasing republic-level funds to purchase FP products, there is a precedent for financing contraceptives through oblast-level health budgets. Securing commitment at oblast levels, however small, to help secure eventual public financing of contraceptives is an important first step. A third strategy entails exploring the availability of nonproduct-dependent contraceptives. Given the problems of chronic shortages of FP methods and client/provider mistrust of OCs, identifying long- and short-term contraceptive alternatives, such as Standard Days Method (SDM), Lactational Amenorrhea Method (LAM) and female sterilization is needed. There are opportunities to build on UNFPA (United Nations Family Planning Agency) and other initiatives attempting to increase acceptance of these methods. A final strategy is to explore opportunities to improve awareness and educate consumers and their providers about OCs through

social marketing programs. The positive Population Services International (PSI) experience with the Favorite condom suggests that promotion and education activities aimed at dispelling misperceptions about hormonal methods among potential users and providers in urban areas would likely have a favorable impact in building acceptability and demand for this method.

Azerbaijan, unlike Tajikistan and Uzbekistan, has room for limited private sector growth. Segmenting the market to encourage each sector to assume a role compatible with its comparative advantage would help set the stage for growing the FP market through *both* sectors. The FP market in Azerbaijan can be broadly classified by source of supply, geographic location/wealth of clients, and the methods they use. While products are available in private pharmacies and accessible for wealthier clients in Baku and regional towns, there is less accessibility for the urban and rural poor. Therefore, to improve access to all segments of the population, the private sector should be encouraged to serve the needs of the urban populations while the public sector strives to reach the rural poor more effectively. Although contraceptive products are reasonably available in the private sector, especially in urban areas, availability varies by method. There is a potential to form public/private partnerships that focus on ensuring affordable access to OC products. Other products with limited commercial potential can be made available by partnering with local distributors and a network of providers interested in this method. A limited supply of free OCs, IUDs, and condoms is needed to ensure that demand is generated through education and counseling efforts by the public sector. But it is crucial that these subsidized products be targeted to the neediest groups only and not crowd out the nascent private sector in Azerbaijan.



# 5. STEP 4: PRIVATE SECTOR STRATEGIES

## 5.1 GUIDING PRINCIPLES

Four basic principles can be applied to any program aiming to leverage and motivate the private sector in achieving RH/FP goals. These principles can also be used to identify needs for technical assistance (see text box).

### GUIDING PRINCIPLES

- **Take a whole market approach.** A whole market approach analyzes the supply of RH/FP products and services by assessing the respective market shares of the public and private sectors and identifying areas of complementarity, overlap, and/or gaps. This approach maximizes efficient use of public resources, helps advocate for increasing the role of the private sector, and may serve as the basis for public/private partnerships. It is facilitated by segmentation research and contraceptive security assessments.
- **Determine the optimal public/private mix.** Depending on the public health goal (decrease abortion, increase modern method use, improve method choice, or simply expand private sector use), the mix of public and private contribution is likely to vary. It also changes with each method because private suppliers and providers display different levels of interest and commitment for different methods. Market segmentation analysis and policy dialogue are the cornerstones of getting the optimal balance between public and private sector.
- **Strengthen the stewardship role of the public sector.** The government has primary responsibility for ensuring a favorable environment for the private sector, while protecting the health of citizens. The public sector should regulate the quality of RH/FP services and the safety of the product supply, identify underserved groups and unmet needs, monitor the accuracy of information accessed by providers and users, and engage the private sector when appropriate. Creating a "private sector agenda" helps focus the MOH's activities as steward of the entire health sector.
- **Develop public/private partnerships.** In countries where commercial presence and investment are low, or prices too high for the average user, it may be necessary to actively engage the private sector in addressing supply gaps. Partnerships can be used to introduce new methods, increase the use of low-demand methods, increase overall use of contraceptives, and/or build sustainability in highly subsidized markets. Effective participation of the private sector, however, is subject to the successful leveraging of public sector programs to increase overall contraceptive use.

## 5.2 THE WHOLE MARKET APPROACH

For FP, the total market includes all providers of contraceptive products and services, including public clinics and hospitals, nongovernmental and faith-based organizations, social marketing organizations, private pharmacies, manufacturers, distributors, and private service providers. The best way to assess the whole market is to conduct market segmentation research and contraceptive security assessments.

A market segmentation analysis for contraceptive security purposes uses population-based research to identify usage and sourcing patterns among different socio-economic groups. This analysis may also identify segments of users who do not have access to products and services or cannot afford them. Market segmentation research often includes ability/willingness to pay surveys in order to determine whether commercial prices are within the means of most users. Primary data collection is preferable to secondary analyses using income quintiles and the use of arbitrary affordability thresholds (such as a percentage of GDP per capita).

Market segmentation analysis can be supplemented with other studies to inform policymakers. For example, multi-sectoral contraceptive security assessments study government supply channels and procurement systems, as well as commercial brands and distribution, providing a comprehensive picture of the country's commodity supplies. The information generated by these different analyses is used to identify groups of users who can be served by the private sector and "underserved" segments that may require subsidies or special programs. The Ukraine Together for Health Project described in the text box below offers a good example of the applications of market segmentation.

## Ukraine's Together for Health (TfH) Project

There are few instances of formal partnerships between publicly funded RH/FP programs and commercial suppliers of contraceptive products in the E&E region. In most cases, the complementarity between public and private sector efforts is de facto: private companies fill the vacuum created by the termination of subsidized programs, or introduce new methods based on perceived market potential, independent of public sector initiatives. In Ukraine, however, USAID is supporting efforts to involve the pharmaceutical sector in improving the availability and affordability of a range of contraceptive methods. This partnership is being implemented by the TfH Project, which is managed by John Snow International in collaboration with the Academy for Educational Development.

There are no donated contraceptives in Ukraine. In the absence of a publicly funded contraceptive procurement program, the MOH has adopted a policy of referring FP patients to commercial pharmacies. As is the case throughout the region, however, many commercial brands found in Ukraine (mostly OCs) fetch very high prices, such as US\$6-10 per cycle. In a country where the average monthly salary is only \$200, many users are left with few options. In addition, the choice of methods available in pharmacies tends to be very limited: while most carry OCs and condoms, many do not offer progestin-only pills (POP), injectables or emergency contraception.

As shown in the diagram, the commercial private sector already meets the demand of the "A" tier group – wealthy urban women who can afford to pay high-priced, latest-generation contraceptives. TfH is focusing its efforts on the "B" tier by developing and actively promoting a Contraceptive Availability Minimum Package (CAMP). Most of these products are already in the marketplace but not actively promoted by the pharmaceutical companies. To reach the "C" tier groups, TfH is working with the government to procure contraceptives.

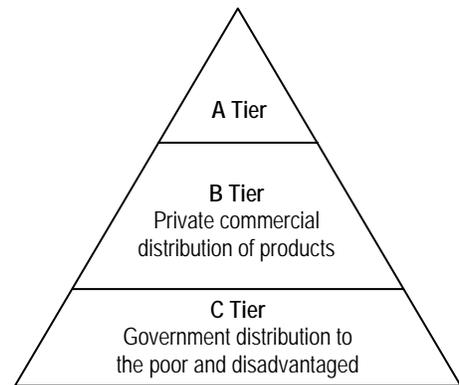
Under this model, all commercial partners contribute in-kind resources, including informational materials and public awareness activities, training for health providers and pharmacists, and continuous marketing support for their specific brands. In addition, some manufacturers agree to reduce their prices on key products. For its part, the USAID-funded TfH project supports training efforts for about 2,000 health workers and 3,500 pharmacists in the first year of the partnership, the production of educational materials and information for the public, and the development of favorable policies for RH/FP activities. TfH also plays the role of coordinator and evaluator for the partnership.

With the signing of a Memorandum of Partnership on December 7, 2006, the TfH project secured the formal commitment of Ukraine's MOH and the following private sector companies:

- Jansen-Cilag, which produces OCs and the contraceptive patch;
- MedCom, the largest distributor of condoms in Ukraine;
- Organon, makers of the only POP on the market and the NuvaRing vaginal ring;
- Richter-Gedeon, a manufacturer of OCs and emergency contraceptives;
- Schering AG, which produces OCs and the Mirena hormonal IUD;
- SMD which conducts research and analysis for the pharmaceutical community; and
- Tespro, the distributor of a copper-T IUD.

The Ukrainian government is also a key partner in this initiative, particularly in efforts to meet the needs of the "C Tier" user group. TfH is working with the government to include a budget line-item for contraceptive procurement for the neediest users. The project is also helping oblasts (regions) allocate and program funds to procure contraceptives for select population groups.

Source: John Snow International (2006)



### 5.3 OPTIMAL PUBLIC/PRIVATE MIX

Because some methods/products are more interesting (profitable) than others for private sector suppliers (manufacturers, distributors, and retailers), as well as for service providers, the first step in any partnership is to determine appropriate levels of effort and financial support from the public and private sectors. More profitable methods should require less public support while less profitable methods are likely to need more. For example, increasing the use of injectables in the E&E region requires substantial changes in provider attitudes and increased awareness of the method among potential users. Because injectables are not favored by the private sector, the demand-side burden is likely to be borne by the public sector.

On the other hand, it may be possible to leverage substantial support from the pharmaceutical industry for the promotion of OCs and new methods. Early USAID-funded programs such as the Red Apple project in Kazakhstan were designed to stimulate nascent pharmaceutical interest in contraceptive markets of the 1990s. They included donor and government support (for awareness and education programs) and private sector investment (in the marketing and distribution of contraceptive brands). The Red Apple hotline, a key element of the Social Marketing for Change (SOMARC) project, was still supported by private sector partners in 2006 (see text box below).

Identifying the appropriate public/private mix is an analytical exercise. Data collected for the market segmentation exercise are used to determine the *likely* role of the private sector, to what extent private resources could be leveraged, and which segments (clients) require public sector support. In addition to market data, interviews of various stakeholders in the private sector (manufacturers, distributors, and private service providers) are necessary to accurately determine the optimum public/private mix.

### **The SOMARC Program in Kazakhstan (1994-1997)**

The first attempt to grow the contraceptive market during the transition to a market economy in former Soviet republics took place in Kazakhstan in the mid-1990s. The approach consisted of creating a market opportunity for international pharmaceutical companies to sell new products by building demand for contraceptive methods. Key strategies included the training of pharmacists and consumer-directed campaigns, both interpersonal and through the mass media.

#### **Background**

In Kazakhstan, contraceptive prevalence was high, with nearly half of all women of childbearing age using some form of contraception, usually a modern method. Nevertheless, limited product availability and concerns about the quality of contraceptives on the market contributed to high reliance on induced abortions. After the breakup of the Soviet Union, government resources and state-owned drug distributor Farmatsiya proved insufficient to ensure access to contraception. The SOMARC program aimed to increase contraceptive use and improve the method mix by developing a viable, private pharmaceutical market for contraceptives.

#### **Approach**

The project forged partnerships among five international manufacturers and local distributors to sell six brands of OCs, two injectable contraceptives, and one type of condom. JHPIEGO trained RH/FP providers while SOMARC led advertising, market research, and public relation efforts. SOMARC also conducted training workshops for pharmacists to improve their knowledge of contraceptive methods. The project developed a brand (Red Apple) for this program that was used to link participating providers (pharmacies, clinics, and doctor's offices), the consumer marketing campaign, and the products sold on the market.

To foster an environment of collaboration, SOMARC created a Reproductive Health Advisory Board. The board was composed of MOH officials, prominent physicians, pharmaceutical representatives (SOMARC partners), members of women's organizations, religious leaders, and influential private business people. The Board's responsibilities were to provide input, help review consumer and provider educational materials and promotional pieces, and make the program sensitive to the political and cultural environment.

A key component of the Red Apple program was a client hotline created in 1994 to provide accurate and up-to-date information about RH/FP methods. The hotline remains in operation today and calls have increased steadily. The hotline staff also organizes roundtables and seminars for medical students, schools, teachers, parents, and patient associations. Through ZdravPlusII project grants, USAID continues to provide support for this hotline, which is now managed by a private organization, the Business Women's Association of Kazakhstan. The Association also raises money from other donors and local businesses to sustain this valuable service to the public.

*Source: Thompson, R., Baugh, T. and Bennett, D. (1997)*

## **5.4 THE PUBLIC SECTOR'S STEWARDSHIP ROLE**

The public sector's main stewardship functions include monitoring the availability, safety, and price of products and services, providing accurate information to the public about contraceptive methods, ensuring sustained access to products and services by vulnerable groups, and developing policies that encourage private sector investment in the contraceptive market.

### **Ensuring quality and safety**

Most countries in the E&E region have fairly stringent drug regulations and are increasingly efficient in enforcing them. Some countries (Ukraine, Kazakhstan) now require generic products to demonstrate bioequivalence with originator drugs, which will improve the quality of pharmaceuticals imported from non-Organization for Economic Development and Cooperation (OECD) countries. In those countries where illegally imported products and fake contraceptives (mostly condoms) are of concern (Kyrgyzstan,

Azerbaijan), the public sector has a responsibility to locate and remove suspicious products from the market.

Based on market information, the public sector can determine whether significant supply gaps exist that require an intervention. Those groups needing special assistance or subsidies may then be targeted with public programs and, if necessary, free commodities.

### **Strengthening clinical guidelines**

Other important stewardship activities include ensuring adequate knowledge about contraceptive methods among licensed service providers. The current method mix in many E&E countries is driven by pharmaceutical marketing and provider attitudes rather than public health goals. Contraceptive security implies a choice of methods and counseling that is based on patients' needs and preferences. Because public sector providers have substantial influence on women's choices, it is important for the MOH to provide independent, objective contraceptive updates on the full range of methods and formulations.

Training and continuing education for doctors can be conducted in partnership with pharmaceutical manufacturers, and with NGOs that have the capacity to do so. However, the few manufacturers willing to invest in training (Schering, Organon, Gedeon Richter) focus essentially on hormonal methods. As a result, it is necessary to provide complementary information about other methods in order to ensure a balanced method mix. For example, contraceptive updates supported by the public sector should provide information about safe, low-cost hormonal contraceptives, as well as IUDs and injectables, which the private sector rarely promotes. This can be achieved through improvements of the medical curriculum, regular contraceptive technology updates, and state-sponsored continuing education. More encompassing, ongoing efforts to modernize clinical practice and promote evidence-based medicine (EBM) in the region can also be leveraged to include RH/FP practices (see text box).

#### **Promoting evidence-based medicine in Central Asia**

In Central Asia, the USAID/ZdravPlus project has worked with ministries of health to improve the content of medical practice through involvement of medical leadership and through multi-specialty and consensus-based development of clinical practice guidelines. EBM centers have been established in Kazakhstan, Kyrgyzstan, and Uzbekistan, and in December 2006 a regional network of these centers was created to enhance collaboration on EBM issues across countries.

The project also has begun work to help expand the role of professional associations to introduce self-regulation and increase their ownership of new evidence-based practices and quality improvement. Additionally, ZdravPlus has begun to work with undergraduate and post-graduate medical institutes to revise their curricula to incorporate EBM and to reorient teaching methodologies. These activities have occurred within larger scale efforts to institutionalize family medicine as the underpinning of better primary health care service delivery and to improve the availability, accessibility, and rational use of pharmaceuticals, which is essential to expanding primary health care services.

### **Improving the regulatory and policy framework**

A legal and regulatory review is the first step in any strategy to expand private sector participation in FP. The review identifies constraints and opportunities in the overall policy climate. With this analysis in hand, the public sector can then carry out reforms to remove barriers or create opportunities (see text box). In some cases, the best strategy is to do nothing – if no significant barriers exist, no change is needed; over-regulation of the FP market would only serve as a disincentive to private sector.

### **Creating opportunities through legal reform**

In Georgia, a RH policy was drafted in 2006 and adopted in 2007. Subsequent legal and regulatory acts are now being drafted to incorporate FP services into the government's basic package of services for the general population and to include additional services in a supplemental package for the poor. These reforms will alleviate some of the financial barriers to accessing care. In addition, service guidelines for FP practitioners are being updated and disseminated. Audits will be done to ensure adherence to these standards and will affect contracting of newly privatized services in the future.

Another important policy area is building support for FP as a health priority through advocacy. Consistent government support for FP is lacking at the highest levels in the region. Through awareness raising and dialogue, USAID and other international donors can help demonstrate the role of RH/FP in improving maternal health and reducing abortions.

### **Monitoring the contraceptive market**

One of the most the most important stewardship activities for the public sector is the monitoring of private contraceptive supply. Regular assessments of contraceptive products available in pharmacies, including their quality and prices, are the only way to determine whether substantial supply gaps exist on the market. This can be done by purchasing retail audit data from research firms, or systematic surveys by public sector staff. Secondary analyses of DHS data or market segmentation studies may also provide information regarding potential supply gaps.

### **Adapting existing financing schemes**

Financial incentives – such as insurance and contracting schemes – can also be created to motivate sustained private sector contribution to RH/FP goals. As worldwide experience demonstrates, financial schemes can be very effective in encouraging users to source products and services in the private sector (Colombia, Philippines). Romania's experience in contracting private GPs to provide primary health care (including FP counseling) suggests that such approaches also increase access to RH/FP services.

Outpatient drug benefit packages currently in place in Kazakhstan and Kyrgyzstan present a good vehicle for increasing user access to contraceptives. For example, Kyrgyzstan's Mandatory Health Insurance Fund (MHIF) contracted with private pharmacies to provide drugs prescribed by primary health care providers at a discount. The list of subsidized drugs is available to people covered under mandatory health insurance in Kyrgyzstan (roughly 80 percent of the population) and includes a limited set of medicines for key primary health care conditions. To access the reduced prices, patients receive from the primary care provider a prescription form that they redeem at a nearby private pharmacy that has a contract with the MHIF. The MHIF then reimburses the pharmacy for the prescribed medicine.

Since its introduction, the ADP has dramatically increased utilization of primary health care, contributed to reducing referrals to hospitals for primary care conditions, and reduced overall market prices for drugs on the ADP list. This outpatient drug benefit has included four types of OCs since 2003 at roughly 50 percent of the price of the contraceptive. Unlike many of the drugs on the list, however, utilization of these contraceptives has been low, perhaps due to availability of donated contraceptives, provider reluctance to prescribe them, or limited knowledge among the population of their inclusion in the benefit package. These points to the need to identify all barriers to contraceptive use (not just financial ones) and combine economic incentives with other types of interventions (such as education and provider training).

## 5.5 DEVELOPING PUBLIC/PRIVATE PARTNERSHIPS

### Engaging the private sector

It is possible to leverage the private sector simply by allowing it to serve users who can pay commercial prices and concentrating public resources on low-income and other underserved groups. Informal collaboration with manufacturers, distributors, industry groups, and provider associations is highly desirable because it may lead to occasional joint activities (such as provider conferences). Full-fledged partnerships, however, require more effort and the ability to leverage public resources to motivate increased private sector contribution.

The first step toward engaging the private sector is to identify key players in a given country. Manufacturers are the most likely partners for public health initiatives because they have a long-term view and considerable resources. In contrast, distributors offer limited leveraging opportunities beyond ensuring that products are adequately stocked. If products are not available as a result of low demand (which is more than often the case), distributors have little to contribute because they do not invest in demand creation. Pharmacy chains may offer opportunities for partnerships because they are consumer-oriented and can make their staff available for training. Private provider associations are also important partners because they represent the profession, organize training programs, and help produce “champions” to support RH/FP initiatives.

## Enlisting the private sector in RH/FP programs: the ACQUIRE project in Azerbaijan

### Background

According to the 2001 Reproductive and Health Survey, Azerbaijan has the second highest induced abortion rate in the E&E region – 3.2 per woman age 15-44. The overall reported CPR is 55 percent with only 12 percent of couples using modern contraceptive method. The remaining population uses traditional methods (mostly withdrawal), with a high rate of failure. The reasons behind these indicators include regulations that restrict access to counseling, prescriptions, and IUD insertions; lack of free or subsidized products for low-income clients; strong financial incentives to provide abortion services; and misinformation about contraception among service providers and pharmacists.

In 2004, the USAID-supported ACQUIRE project, managed by Engender Health in partnership with Adventist Development and Relief Agency International (ADRA), Meridian, and Intrahealth, launched a new RH program in five districts in Azerbaijan. Its goals were the following:

- Educate Azeri women and men about RH and FP
- Build an accessible network of RH services
- Train providers on a range of contraceptive methods
- Help improve the general quality of services
- Increase the availability of contraceptive methods

### Approach

ACQUIRE's activities in Azerbaijan included fostering a partnership between the public sector, rural communities, manufacturers, and pharmacists to increase access to FP information and services in underserved areas. The project developed an umbrella campaign designed to create a positive image for FP and link the various elements of the initiative. A logo was used to identify participating providers, pharmacies, promotional material, and a national mass media campaign. The two major suppliers of hormonal contraceptives (Gedeon Richter and Schering) agreed to have their products bear the project logo. The ACQUIRE project put special emphasis on improving the quality of service at the pharmacy level, notably by developing a detailing program for pharmacists, producing and donating display cases for FP products, and hiring an "aptek mobiliser" to monitor product availability.

The ACQUIRE project provides a good example of addressing multiple long-standing barriers to contraceptive use: improving quality of care at the provider level, ensuring product presence at the pharmacy level, and building demand for FP methods through a mass media campaign. During an assessment of private sector contraceptive supply in August 2006, the PSP-One project observed a striking contrast between pharmacies trained and monitored by the ACQUIRE project and non-participating pharmacies: Untrained providers displayed a lack of understanding of contraceptive methods, offered a very limited range of products, and frequently confused FP products with gynecological, abortive, and hormonal replacement drugs.

Projects that aim to address both demand and supply in areas of high unmet need play an important watchdog and coordination role through their relationship with commercial suppliers; although manufacturers have limited resources to invest in Azerbaijan, the ACQUIRE projects ensures that low-cost brands (such as Gedeon Richter's *Rigevidon*) remain on the market, establishes linkages between demand creation efforts and commercial brands, and monitors the availability of contraceptive products in the commercial distribution.

Source: PSP-One and DELIVER projects. (2006)

### Identifying common ground

Engaging the private sector for the purpose of partnering requires concrete goals that are compatible with business interests, clearly articulated incentives, and the willingness to seek common ground. Many attempts at partnering fail because the private sector is asked simply to support public sector goals. Instead, efforts to leverage private sector resources should focus on areas of common ground if they are to be sustained over time. Table 9 illustrates shared areas of interest between the pharmaceutical industry and publicly funded RH/FP programs in Russia. Based on this type of analysis, partnerships can be designed to take into account each partner's interests and comparative advantages.

**TABLE 9. PUBLIC/PRIVATE PRIORITIES AND AREAS OF COMMON INTERESTS  
(RUSSIAN MARKET)**

	<b>Pharmaceutical sector priorities</b>	<b>Shared interests</b>	<b>Public sector priorities</b>
<b>General</b>	Sell high-margin products with high growth potential	Increase use of hormonal methods	Decrease reliance on abortion; increase use of modern methods; expand method mix
<b>Target groups</b>	Urban women ages 18-35	Urban women ages 18-35	All WRA
<b>Geographical focus</b>	Increase market share in high-density urban areas	High-density regional urban areas	Maximize access for all population groups, particularly underserved users
<b>Client-directed strategies</b>	Promotion of “star brands” through direct-to-consumer (DTC) and service delivery channels	Promotion of hormonal methods through DTC and service delivery channels	Generic promotion of all modern methods in public service delivery channels
<b>Provider-directed strategies</b>	Recruit “champions” for company brands among prescribing doctors	Recruit champions for hormonal methods among service providers	Strengthen technical capacity and communication skills in the public sector
<b>Collaboration strategies</b>	Work through provider associations and select RH/FP programs	Collaborate with regional authorities, leverage existing programs	Partner with regional and federal authorities in implementation of RH/FP programs

### **Leveraging public sector programs**

USAID supports a range of programs in the region that have a strong RH/FP component. These programs should be leveraged with potential private sector partners. Unfortunately, communication between public sector programs and commercial suppliers is often minimal. The PSP-One project found that contraceptive manufacturers in Russia needed help identifying “champions” in the provider community that could help overcome resistance to hormonal contraception. These companies are also interested in training and educational activities that may have an impact on their market, and opportunities to access more providers and clients. Sharing the goals and approaches of USAID-funded projects with commercial suppliers and demonstrating their impact on contraceptive use can help build trust and foster cooperation.

## Opportunities to leverage donor-funded projects in Central Asia

### Background

Soviet medicine was isolated from the emerging tradition of clinical epidemiology, which by the 1980s became the movement known as EBM. Uptake of modern, evidence-based approaches has improved over the past 15 years as countries have adopted WHO approaches and guidelines. However more work needs to be done to ingrain a culture of EBM at policy and practice levels.

### Approach

In Central Asia, the USAID/ZdravPlus project has worked with ministries of health to improve the content of medical practice through involvement of medical leadership and through multi-specialty and consensus-based development of clinical practice guidelines. EBM centers have been established in Kazakhstan, Kyrgyzstan, and Uzbekistan, and in December 2006 a regional network of these centers was created to enhance collaboration on EBM issues across countries. The project also has begun work to help expand the role of professional associations to introduce self-regulation and increase their ownership of new evidence-based practices and quality improvement. Additionally, ZdravPlus has begun to work with undergraduate and post-graduate medical institutes to revise their curricula to incorporate EBM and to reorient teaching methodologies. These activities have occurred within larger scale efforts to institutionalize family medicine as the underpinning of better primary health care service delivery and to improve the availability, accessibility, and rational use of pharmaceuticals, which is essential to expanding primary health care services.

### Opportunities

While this initial work has focused mainly on the public sector, ministries and EBM centers can be encouraged to include private sector providers and pharmacists in a range of activities. Examples include:

- Invite private providers and pharmacists in the development, review, and implementation of clinical practice guidelines.
- Guidelines can be included as standards of care in contracts between health insurers and public or private facilities.
- Extend independent drug information centers outreach to provide non-biased evidence-based information about a range of pharmaceuticals including contraceptives to private health care providers and private pharmacists, thereby helping balance the information these groups receive from detailing and marketing.
- Include private providers and pharmacists in public and/or NGO training on RH/FP clinical skills, interpersonal communication (IPC)/counseling and contraceptive technologies.
- Introduce EBM and clinical practices into undergraduate and post-graduate medical and pharmacy curricula and residency programs to better prepare future providers and pharmacists – whether they ultimately end up practicing in the public or private sector.

## Growing the Whole Market

Several contraceptive security assessments have highlighted the importance of demand in fostering adequate supply. Any substantial increase in the demand for a method is likely to be followed by a quick increase in supply, more product choice, and – if demand arises among previously underserved low-income clients – more affordable prices. Overall increases in demand may translate into higher use of public sector services but are likely to directly influence commercial product supply, since few countries in the region support subsidized commodities.

PSP-One assessments have shown that public and private providers, as well as pharmaceutical companies, agree that lack of knowledge about contraception among potential users is the biggest barrier to modern method use in the EE region. Information and education efforts are needed to turn unmet need into potential demand for modern methods. Low-income women, youth, and rural populations, are especially in need of information and counseling. NGOs such as the Reproductive Health Network in Ukraine, the Business Women's Association of Kazakhstan (BWAK), and various FP associations can be tapped into for

these activities. The ACQUIRE project in Azerbaijan is currently implementing a “whole market” approach by growing demand modern methods, while addressing the supply needs of underserved populations.

### **Romania’s success in growing the RH/FP market**

The success of USAID’s program in Romania demonstrates how a whole market approach can effectively mobilize all the actors – public, private, and NGO – in a FP marketplace to respond to the different FP needs in a country. The Romania strategy contains all the elements of a whole market approach: 1) identifying market segments, 2) using subsidies more effectively, 3) addressing market inefficiencies through demand generation and filling supply gaps, and 4) expanding the private sector’s role. As a result, Romania experienced significant improvement in RH/FP indicators a short period of time. Most notably, modern CPR increased among rural WRA from 20.9 percent in 1999 to 33 percent in 2004. During this same time period, the total abortion rate in rural areas decreased from 2.4 abortions per a WRA to 1.06<sup>1</sup>. There was a similar trend nationally: modern CPR increased from 29.5 percent to 38.2 percent with a subsequent decline in total abortion rate from 2.2 to .08 per WRA.

#### **Background**

In 2001, USAID contracted JSI Research and Training Institute, Inc to implement the Romanian Family Health Initiative (RHFI) with the goal of scaling up integrated FP nationwide with a focus on rural areas. The RHFI built on the experiences and lessons learned from the Women’s Reproductive Health Initiative, another JSI project that integrated FP into primary health care clinics in three districts. In this pilot project, integrating FP into primary care clinics proved to be very successful in reaching rural populations because primary care providers are more accessible to this underserved population group than ob/gyns and FP doctors located in urban-based clinics.

#### **Approach**

Although the RHFI’s seven strategies were designed to address many of the long-standing challenges confronting RH/FP in Romania, the program employed the four components in a whole market approach. Below is an overview of the RHFI approaches as they relate to the whole market approach:

**Targeting subsidies.** As one of the first activities, RHFI identified the population in most need of increased access to RH/FP services. They conducted demographic and health research to identify gaps in coverage, market research to evaluate to contraceptive demand and availability and economic research to determine ability to pay. With this information, they designed the criteria for those groups eligible for free FP products. Because 90 percent of the Romania’s poor population lives in rural areas, the Ministry of Public Health (MOPH) agreed to offer free contraceptives for *all* rural clients through primary care centers, thus simplifying targeting and supply of FP methods.

**Stimulating demand.** The MOPH assumed responsibility for creating demand among the rural population and used a three-pronged approach: IEC/behavior change communication activities, service promotion, and community outreach. RHFI worked closely with the MOPH to time the demand-creation activities to correspond with the scale-up of quality services and availability of products to meet demand, thereby avoiding loss of confidence in the program and the disappointment of the client.

**Addressing sustainability and supply gaps.** Urban women have access to quality FP services through MOHP services and ample supply of a variety of FP methods through the private sector. To ensure adequate supply of FP services in rural areas, RHFI trained many rural providers in clinical skills, IPC/counseling, and contraceptive technology. In addition, they developed a three-tiered national pull logistics system and tailored the system to the needs of the rural communities. RHFI also worked with the MOPH to secure sufficient funding to purchase the limited supply of contraceptives needed for the rural population.

**Taking into account the private sector’s contribution.** In focusing RHFI’s technical assistance on strengthening the MOPH ability to provide quality FP services and products to those who could not afford to pay them, they acknowledged the private sector’s role in serving urban, more affluent women.

Source: Gasco et al. (2006)

## 5.6 WHAT A MISSION CAN DO: STRATEGIES BASED ON PRIVATE SECTOR POTENTIAL

Table 10 provides a summary of recommended strategies for the three groups of countries described in Section 3 (private sector opportunity ranking). In all countries, the public sector can be expected to fill a similar “stewardship” role. Context differences between these different groups are reflected in the need for demand-building interventions, variations in the public/private mix, and opportunities for public/private partnerships.

**TABLE 10. RECOMMENDED STRATEGIES**

Country's private sector category	Objectives	Strategies
Advanced	<p>Maintain a strong private sector presence</p> <p>Ensure sustained contraceptive security</p> <p>Identify and address the needs of vulnerable populations</p>	<p><b>Whole market approach:</b> Market segmentation to be conducted every 3-5 years to identify supply gaps and monitor ability to pay, changes in the method mix, and changes in sourcing patterns.</p> <p><b>Public/private mix:</b> Private sector likely to ensure sustained product supply of a wide range of methods at different prices. Manufacturers expected to invest heavily in stimulating demand for hormonal methods and innovative products. Low private investment in intrauterine devices (IUDs) and injectables will require public sector intervention. Low-income users may require subsidized products and services.</p> <p><b>Stewardship:</b> 1) Address market and policy barriers to private provision of FP; 2) Make FP a health priority in Ministry of Health (MOH), 3) Allocate public funds to purchase FP methods and target them to population groups; 4) Ensure quality in private sector through: i) policies ensuring quality and safety, ii) strengthening FP clinical guidelines, iii) training public providers; and 5) Monitor private sector prices and quality</p> <p><b>Public/private partnerships:</b> Establish mechanisms for sustained communication between public and private sector entities. Consider joint promotional and training programs (example: Ukraine's' Together for Health project or SOMARC [Social Marketing for Change] Advisory Board).</p>
Intermediate	<p>Grow the contraceptive market</p> <p>Monitor product quality and safety</p> <p>Increase the role of the private sector in reaching underserved groups</p>	<p><b>Whole market approach:</b> Conduct client-focused market segmentation research to identify barriers to use among various population groups. Assess private sector presence and investment on the contraceptive market.</p> <p><b>Public/private mix:</b> The private sector is likely to focus on increasing its nascent consumer base in urban areas. Rural areas, low-income users, and specific methods (IUDs, injectables) may need public sector support. The public sector must also assume the primary role in provider education. The public sector also needs to educate the population on health benefits of FP thereby increasing demand for FP.</p> <p><b>Stewardship:</b> 1) Increase public and policy support for FP; 2) Make FP a health priority in MOH, 3) Allocate public funds to purchase FP methods for low-income users; 4) Address provider bias and misinformation; and 5) Address market and policy barriers to private sector products and services</p> <p><b>Public/private partnerships:</b> Consider partnering with low-cost manufacturer to increase demand for <i>and</i> access to contraceptives among underserved groups (example: through a social marketing intervention).</p>

Country's private sector category	Objectives	Strategies
Emerging	<p>Develop the contraceptive market</p> <p>Ensure demand and supply grow together</p> <p>Facilitate private sector investment in the contraceptive market</p>	<p><b>Whole market approach:</b> Conduct client-focused market segmentation research to identify barriers to use among various population groups. Assess private sector supply of products and services.</p> <p><b>Public/private mix:</b> Very limited interest in contraceptive market causes private suppliers to limit product range and investments. Public sector efforts to create demand expected to lead to increased private sector role over time.</p> <p><b>Stewardship:</b> 1) Increase public and policy support for FP; 2) Make FP a health priority in MOH, 3) Address financial incentives that encourage repeat abortions; 4) Increase access to evidence-based information about modern methods; and 5) Address policy barriers to the growth of private sector products and services.</p> <p><b>Public/private partnerships:</b> Consider a large-scale (national-level) program to increase the use of modern methods (example: Red Apple program in Kazakhstan); smaller-scale programs can partner with a manufacturer to ensure product access (example: ACQUIRE project in Azerbaijan).</p>

## 6. CONCLUSIONS

The E&E region presents considerable diversity in terms of income, economic and social development, unmet RH/FP need, and market maturity. Yet, countries in the region share characteristics that are unique to this part of the world, particularly with respect to reproductive behavior, private sector growth and health sector reforms. This paper aimed to present crosscutting findings about the role of the private sector in the region, while pointing out limiting or encouraging factors in specific countries. It also sought to describe trends with regards to market growth, private sector strategies, and socio-economic factors that can help predict future contraceptive security.

Throughout the region, private sector product suppliers play a central role in ensuring access to modern contraceptive methods, though supply gaps are inevitable and must be addressed. In contrast, private doctors and clinics are not significantly involved in the provision of affordable RH services, with the possible exception of Romania. For this reason, the leveraging of private sector effort and investment is most likely to have an impact on product supply rather than on service delivery. However, the private sector generally focuses on consumers with the highest income and education level, until market saturation dictates expanding marketing and distribution efforts to other groups. Understanding market conditions and identifying common goals with private sector suppliers and providers is thus critical to effective public/private cooperation.

USAID missions and implementers of FP programs in the region are advised to look at their own country context as unique. This paper has identified multiple factors, such as method use, the political environment, health systems, provider attitudes, consumer demand, and socio-cultural factors that together create very different conditions from one country to another. This report attempted to provide a broad ranking of countries in the region according to their ability to attract private sector investment in the RH/FP area. This ranking may be useful in predicting opportunities for public/private partnerships, which are determined by the existence of common goals as well as the availability of resources in both sectors. Where private-public partnerships are not feasible, the public sector still has a strong stewardship role to play in complementing the private sector by identifying and addressing equity and access issues among underserved groups.



# ANNEX: COMMERCIAL PRODUCT RANGE IN THE E&E REGION

## Condoms

Condoms are widely available throughout the region at different price levels. Product choice tends to be higher in urban areas and lower in rural areas. It is more common however to find low-price brands in rural areas, because of lower availability to pay. Prices tend to reflect the manufacturer's global reputation, brand image and country of origin. European-made condoms and those made by well-known companies (such as Ansell, Durex and Innotech) fetch the highest prices and are only sold in pharmacies. Some lower-priced brands made in India, China and Russia can be found in kiosks (Central Asia) but in other countries, it may be difficult to find condoms outside pharmacies (Azerbaijan). In Kyrgyzstan, the special status afforded humanitarian aid condoms has allowed products to enter the country without undergoing inspection by health authorities, creating concern about the safety of product supply.

Condom brands are not usually actively marketed by manufacturers but typically imported and distributed through local commercial distributors. Exceptions include the French company Innotech, which promotes its Innotex condoms through country-based sales representatives, local distributors such as FBI in Azerbaijan that advertise in the mass media, and social marketing organizations, such as PSI in Central Asia, which market condoms as part of their HIV/AIDS prevention program.

**Table 1. Condom Brands Sold in Kazakhstan<sup>3</sup>**

Brand	Country	Minimum price per condom (US\$)		Brand	Country	Minimum price per condom (US\$)
Banana	India	0.07		Macho Man	India	0.15
Chica	N/A	0.36		Magnum	N/A	0.44
Close Fit	N/A	0.36		Masculan	Germany	0.44
Control	Spain	0.47		Reflex	Russia	0.50
Context	Russia	0.42		Sico	Germany	0.33
Desire	India	0.08		Sitabella	N/A	0.62
Durex	UK	0.62		2 To Tango	India	0.17
Horoscope	Chinese	0.24		Ultra 2	Germany	0.81
Favorite	Germany	0.10		Vie Tex	N/A	0.36
Innotex	France	0.42		Vizit	Germany	0.33
Lifestyles	Belgium	0.83				

<sup>3</sup> Source: *Contraceptive Security In The Central Asian Republics: Kazakhstan, Kyrgyzstan, And Tajikistan*. Joint report by PSP-One and the DELIVER projects. 2006.

## Oral contraceptives

The OC supply in former soviet republics is influenced by global product introductions, trends in the Russian market, local cultural preferences, and purchasing power. Pharmaceutical companies generally hope to create a market similar to Western Europe and Russia, with a focus on low-dose innovative formulations. Health providers today tend to favor the newest and most expensive brands, even though safe and effective low-dose OC brands are also available. “High-dose” pills containing 50 mcg or more of estrogen are no longer found in most EE markets but were often the only option for women in Soviet countries. Memories of pills, which tended to produce undesirable side effects, appear to reinforce industry-induced bias against older formulations. The following major types of OCs are currently available, mostly over the counter:

Monophasic combined pills provide a fixed combination of ethinylestradiol (an estrogen) in doses of 20-50 mcg and a progestin. The most commonly found OC formulation worldwide is ethinylestradiol 30mg/levonorgestrel 0.15mg. It is marketed under more than 40 brand names and is recognized as safe and effective by the international medical community (International Planned Parenthood Federation, 2002). In the EE region, two brands are based on this formulation: Schering’s Microgynon and Gideon Richter’s Rigevidon, which is the most widely distributed of the two and the lowest-priced brand on the market (as low as US\$1.00 per cycle). Doctors and pharmacists however often consider them “old” and of inferior quality.

Monophasic pills containing newer progestins such as gestodene, desogestrel are known as “third generation” OCs. These and even more recent formulations with the progestins drospirenone and dienogest tend to receive the bulk of promotional investment because they offer high margins for the trade. Despite their high prices and a slightly increased risk of thromboembolism, these newer formulations are very popular in developed markets. For example, Yasmin (sold in EE under the brand Yarina), which contains drospirenone, is now the world’s best selling OC brand and is heavily promoted in Russia and other post-soviet countries.

Multiphasic (Biphasic and triphasic) pills provide different doses of progestin and estrogen throughout the cycle. Their overall hormone dosage is low, and according to manufacturers, provide a better match for the body’s natural menstrual cycle than monophasic pills. These OC formulations are especially popular in developed markets (USA, Canada, Western Europe) but have been moderately successful in the EE region.

Progestin-only pills (POP formulations) contain a low, uninterrupted daily dose of a progestin and no estrogen. They are recommended for women who are breastfeeding or who cannot take combined pills. This formulation is not widely available in the region and some countries (Azerbaijan) do not have a POP on the market. There are currently three brands of POP in the region, Exluton (Lynestrenol 0.5 mg) and Cerazette (Desogestrel 0.075 mg) marketed by Organon, and Microlut (Levonorgestrel 0.03 mg), made by Schering. The availability of these formulations varies greatly from one country to another, and is usually limited to urban areas.

The following table provides a list of oral contraceptive brands available in Russia, Kazakhstan and Azerbaijan. Because Russia is a more developed market, product choice is greater but prices are also higher.

**Table 2. Oral Contraceptive Brands Sold in Russia, Kazakhstan and Azerbaijan<sup>4</sup>**

Combined OCs	Formulation	Manufacturer	Minium price per cycle (USD)		
<i>Microgynon</i>	Levonorgestrel 0.15 mg + EE 30mcg	Schering	5.50	3.98	N/A <sup>5</sup>
<i>Rigevidon</i>	Levonorgestrel 0.15 mg + EE 30 mcg	Gideon Richter	1.24	1.35	0.90
<i>Marvelon</i>	Desogestrel 0.15 mg + EE 30 mcg	Organon	9.39	11.28	4.60
<i>Regulon</i>	Desogestrel 0.15 mg + EE 30 mcg	Gideon Richter	4.03	2.63	9.00
<i>Mercilon</i>	Desogestrel 0.15 mg + EE 20 mcg	Organon	10.97	14.29	N/A
<i>Novinette</i>	Desogestrel 0.15 mg + EE 20 mcg	Gideon Richter	4.82	4.29	3.69
<i>Femoden</i>	Gestodene 0.075 mg + EE 30 mcg	Schering	11.91	6.24	6.9
<i>Logest</i>	Gestodene 0.075 mg + EE 20 mcg	Schering	10.37	7.52	5.77
<i>Lindynette20</i>	Gestodene 0.075 mg + EE 20 mcg	Gideon Richter	PNA <sup>6</sup>	4.51	N/A
<i>Jeanine</i>	Dienogest 2 mg + EE 30 mcg	Schering	14.66	9.77	7.60
<i>Yarina</i>	Drospirenone 3 mg + EE 30 mcg	Schering	16.77	13.53	7.40
<i>Diane 35</i>	Cyproterone acetate 2 mg + EE 35 mcg	Schering	N/A	8.27	6.00
<i>Triquilar</i>	Lev. 0.05/0.075/0.125mg + EE 30/40/30mcg	Schering	7.24	3.38	
<i>Tri-Regol</i>	Lev. 0.05/0.075/0.125 mg + EE 30/40/30 mcg	Gideon Richter	2.19	1.35	2.00
<i>Trisiston</i>	Lev. 0.05/0.075/0.125 mg + EE 30/40/30 mcg	Jenapharm	5.47	2.48	N/A
<b>Progestin only OCs</b>					
<i>Exluton</i>	Lynestrenol 0.5 mg	Organon	15.19	12.78	N/A
<i>Cerazette</i>	Desogestrel 0.075 mg	Organon	16.77	N/A	N/A
<i>Microlut</i>	Levonorgestrel 0.03 mg	Schering	6.97	N/A	N/A

<sup>4</sup> Sources: Assessment Of Commercial Partnership Opportunities In Russia. PSP-One report. February 2007; Contraceptive Security In The Central Asian Republics: Kazakhstan, Kyrgyzstan, And Tajikistan. Joint report by PSP-One and the DELIVER project. 2006; The Private Sector Contribution To Contraceptive Security In Azerbaijan. PSP-One report. September 2006.

<sup>5</sup> Not available in country

<sup>6</sup> PNA: Price not available

## Emergency Contraception

Emergency contraception is widely available in the region, in part because Gedeon Richter, the Hungarian manufacturer of worldwide brand leader Postinor 2, has a long-time presence in post-soviet markets. Escapelle, a newer formulation also made by GR is scheduled for introduction in all EE markets. No other contraceptive manufacturer is currently manufacturing or marketing EC.

**Table 3. Emergency Contraception Brands Sold in Russia, Kazakhstan and Azerbaijan**

Emergency contraception	Formulation	Manufacturer	Minimum cost		
			Russia	Kazakhstan	Azerbaijan
<i>Postinor 2</i>	Levonorgestrel 0.75 mg	Gedeon Richter	5.65		3.35
<i>Escapelle</i>	Levonorgestrel 1.5 mg	Gedeon Richter	7.35	N/A	N/A

## Injectables and new methods

Injectables and new hormonal methods represent a very small percentage of the contraceptive market but for different reasons: Depo-Provera, which was introduced in public sector programs in the 1990s, has fallen out of favor in most EE countries and is only infrequently prescribed by health providers. In contrast, new methods of delivery (patch, ring) are growing in popularity in spite of low sales volumes. These methods are just being introduced in certain countries (Kazakhstan, Ukraine).

**Table 4. Injectable Contraceptive Brands Sold in Russia, Kazakhstan and Azerbaijan**

Injectable contraceptives	Formulation		Minimum cost per month		
			Russia	Kazakhstan	Azerbaijan
<i>Depo-Provera</i>	Medroxyprogesterone acetate 1ML	Pfizer	2.50	0.60	N/A
Trans-dermal patch				Average cost per month	
<i>Ortho-Evra</i>	Norelgestromin 6mg+Ethinyl estradiol 0.75mg	Janssen Cilag	15.00	4.32	N/A
Vaginal ring				Average cost per month	
<i>NuvaRing</i>	Etonogestrel+Ethinyl estradiol	Organon	7.50	N/A	N/A

## Spermicides

Although topical contraceptives are not a dominant method in the EE region, they are popular in certain countries (Ukraine, Kazakhstan) and are easily available in urban areas. The most widely represented brand is Pharmatex, manufactured by Innotech, which includes ovules, spermicidal cream, tablets, tampons and capsules. A Russian brand of vaginal suppositories, Kontraceptin T, and two monoxynol-based spermicide brands: Patentex (German) and Lady can also be found in some urban pharmacies. Their availability tends to decrease drastically in rural areas.

**Table 5. Brands of Topical Contraceptives Available in Kazakhstan<sup>7</sup>**

Brand	Manufacturer	Country	Minimum price
Pharmatex vaginal capsules (6)	Innotech	France	5.1584
Pharmatex ovules (10)	Innotech	France	6.656
Pharmatex cream (18 applications)	Innotech	France	6.656
Pharmatex tampons (2)	Innotech	France	6.656
Kontraceptin T vaginal suppositories (10)	Nigfarm	Russia	5.3248

<sup>7</sup> Source: Contraceptive Security In The Central Asian Republics: Kazakhstan, Kyrgyzstan, And Tajikistan. Joint report by PSP-One and the DELIVER project. 2006

### Intra-uterine devices

The range of IUDs varies throughout the region but the lowest-price CopperT Cu is usually easily found in pharmacies that cater to health providers. These copper-bearing devices are the most widely used worldwide. They include Organon's Multiload Cu 375, Schering's Nova-T, and the TCu 380A, made by Finishing Enterprises. At least five different types of IUDs are produced in Russia by Simurg Medical Enterprise but little is known about these products as they are not used in the public sector or sold in Western markets. The most expensive IUD on the market is Mirena, which is sold at an average retail price of US\$ 250.00. Mirena is the only IUD actively marketed by a pharmaceutical manufacturer in the region. The Russian market probably has the widest product range in the region (see table 6).

**Table 6. Brands of Intrauterine Devices Available in Russia<sup>8</sup>**

Brand	Manufacturer	Country	Price (US\$)
Yunona Bio T	Simurg Medical Enterprise	Belarus	1.897
Gain T 200	Ortho Pharmaceutical	Canada	N/A!
Copper T Cu 380A	Finishing Enterprise	USA	N/A
Nova T Cu 200-Ag	Lieras	Finland	10.62
Nova T Cu 200-Ag	Schering AG	Germany	10.16
Fincoïd 350	Fexsima	Finland	11.38
Multiload Cu375	Organon	Netherlands	22.76
Multiload-Cu 250	Multilan	Switzerland	43.63
Mirena	Schering AG	Germany	257.99

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<sup>8</sup> Source: *Assessment Of Commercial Partnership Opportunities In Russia*. PSP-One report. February 2007



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