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ASSESSING THE COMMERCIAL VIABILITY OF LONG-ACTING AND PERMANENT CONTRACEPTIVE METHODS

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ASSESSING THE COMMERCIAL VIABILITY OF LONG-ACTING AND PERMANENT CONTRACEPTIVE METHODS

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ACRONYMS

CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
CSI	Egypt's Clinical Service Improvement Project
DHS	Demographic and Health Surveys
FHI	Family Health International
FP	Family Planning
HMO	Health Maintenance Organization
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
LAPM	Long Acting and Permanent Methods of Contraception
NGO	Non-Governmental Organization
NSV	No-Scalpel Vasectomy
OC	Oral Contraceptive
PSI	Population Services International
PSP-*One*	Private Sector Partnerships-*One* Project
SDP	Service Delivery Point
STI	Sexually Transmitted Infection
TL	Tubal Ligation
USAID	United States Agency for International Development
WFC	Well Family Clinic Network

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1. INTRODUCTION

Access to a wide range of contraceptive choices increases couples' rates of adoption and utilization of contraception. Consistent and long-term access to a wide range of contraceptive options is correlated with sustained life-long use, even as the couples' contraceptive needs change (Family Health International 2007). Policy makers, program planners, and service providers have long worked to ensure availability of a variety of family planning methods, including long acting and permanent methods of contraception (LAPM).

Two key questions relevant to increasing LAPM availability worldwide remain:

1. How can LAPM, which require trained providers and clinical settings for administration, be made more widely accessible even in rural or other low-resource settings?

2. How can sustainable LAPM provision be achieved?

1.1 ACCESS

In many poor countries, particularly in Sub-Saharan Africa, weak health systems characterized by challenges of infrastructure, lack of adequate funding and trained staff, and fragmented supply chains make it difficult to provide LAPM on a widespread basis. As a result, significant portions of their populations may not have access to LAPM. In other countries, family planning may be inadequately funded, and public sector family planning services may rely on contraceptives donated by international development agencies. In some countries, such as those with large Muslim populations, religious and political beliefs may prohibit the provision of permanent methods.

1.2 SUSTAINABILITY

As the global demand for family planning services rises, donor funding for family planning has diminished or been phased out in several countries, while local demands for these services have increased. These diverging trends put a strain on the continuation of even current levels of family planning service delivery (FHI 2007; Gribble, Jennings, and Nikula 2004) and jeopardize the public sector's ability to continue and/or increase LAPM provision. In this environment, achieving equity in the use of limited public sector resources and targeting publicly-funded family planning for the poor is increasingly important (PSP-*One* 2008c). The need to consider creative approaches to expanding access to and sustainability of LAPM raises the question: can the private commercial sector be harnessed to address the issues of access and sustainability in LAPM service provision?

1.3 MOVING BEYOND THE ASSUMPTIONS

The interest in increasing commercial sector LAPM provision is based on several assumptions:

- In some countries, commercial sector infrastructure is better able to offer high quality LAPM than public sector infrastructure.

- The commercial sector can reach population segments and geographic areas not as easily reached by the public sector.

- The commercial sector is inherently self-sustaining.

- Consumers perceive that the commercial sector offers higher quality LAPM services and is more efficient, flexible and responsive than the public sector, and therefore a more attractive source for LAPM.

These assumptions have not, however, proved to be universally true. The vast diversity of global markets for LAPM render such generalities insufficient for designing and implementing robust projects to increase private sector LAPM provision. This paper therefore moves beyond assumptions to investigate a central question: under what conditions can the commercial sector play a feasible and sustainable role in LAPM provision?

Addressing this question requires examination of several variables in each family planning "marketplace":

- Socio-economic profile of current and likely LAPM consumers

- Current levels of LAPM use by method, unmet need, and potential demand

- Comparative advantage of commercial provision of the various LAPM methods

- Differentiation by method and by provider type of the current and future LAPM market

- LAPM market segmentation among the public, non-governmental organization (NGO) and private sectors

- Market or other conditions that increase the profit potential of LAPM for private providers

- Role of innovative financing (e.g., health maintenance organizations (HMOs), insurance, vouchers, subsidies) to create or increase the commercial sector's LAPM market share

- Existing, self-sustainable monitoring or supervisory infrastructures to strengthen and maintain the quality of commercial LAPM services

1.4 FOCUS ON THE CONSUMER

In the face of diminished donor funding and constrained public resources for family planning, many studies on the commercial sector's role in LAPM service provision focus on the point of view of donor or governmental agencies (Janowitz, Gmach, and Otterness 2006; Ross, Weissman, and Stover 2009). These studies recommend saving public resources by increasing the role of NGO and commercial sector service delivery and shifting method mix to more cost-effective methods such as LAPM.

To understand what role the commercial sector may play in LAPM provision, however, it is necessary to ascertain – from the consumer's point of view – the advantages and disadvantages of utilizing the commercial sector for LAPM. Program planners typically assume that consumers prefer the private sector for family planning services because of quality, convenience and privacy (Hopstock et al. 1997). With regard to LAPM, however, there are no comprehensive studies that examine how consumers define or rank these characteristics. Notably, there are no data on the monetary value consumers may

attribute to these perceived advantages. To be financially viable, the perceived advantages of commercial sector LAPM providers must attract sufficient revenue. If consumers are not willing or able to pay for the comparative advantages of the commercial sector, the business model will fail. Thus, a focus on the consumer is essential to correctly assess the potential role of the commercial sector in provision of LAPM services.

2. METHODOLOGY

2.1 DEFINITION OF LAPM

Long-acting and permanent methods of contraception are defined in this paper as those methods that provide pregnancy protection for more than one year per "application." They include the intrauterine device (IUD), implants, female sterilization or tubal ligation (TL), and vasectomy.

2.2 DEFINITION OF COMMERCIAL SECTOR

The commercial sector is defined in this paper as private sector, for-profit service delivery outlets (such as private hospitals and clinics); commercial pharmacies and product distributors; and private practices of physicians, nurse practitioners, and midwives. Private provider networks (especially social franchises) are included as well, due to the widespread public sector and donor interest in these service delivery models. We also discuss the differences between donor-supported providers operating in the commercial sector and solely commercial sector providers.

The experience of some national affiliates of the International Planned Parenthood Federation (IPPF), particularly in Latin America, will also be discussed when relevant. Although IPPF strives to cross-subsidize services rather than maximize profit, the business principles used to do so closely mirror the commercial sector's business principles.

2.3 DATA SOURCES

We used quantitative data from existing datasets such as the Demographic and Health Surveys (DHS) of selected countries, analyses of the commercial sector's role in family planning service delivery, and reports, project assessments, evaluations and studies describing private sector LAPM service delivery. Informant recommendations and online searches were used to find key references. We also consulted PSP-*One* papers, primers, and other publications.

We gathered qualitative information primarily through telephone interviews with key informants, including USAID/Washington, D.C. staff, USAID mission staff in selected countries, USAID cooperating/implementing agencies, and program implementers in the field. We conducted a limited number of focus group interviews with women in Honduras, Swaziland, and Jordan.

2.4 ORGANIZATION OF THE PAPER

Addressing the feasibility of commercial sector LAPM provision requires a discussion of the market conditions, policy environment and cultural norms that affect the commercial sector's potential for success. This paper examines four elements in the service delivery environment that are fundamental in shaping the role of the commercial sector in provision of LAPM services:

- Critical mass of consumer demand for LAPM services
- Price as it affects both the provider and the consumer
- Competitive advantages of the commercial sector in provision of LAPM services
- Market segmentation among the public, NGO, and commercial sectors

Section 3 presents brief case studies of selected LAPM service provision interventions. Section 4 reports conclusions, recommendations and lessons learned based on project experience and analysis of available research. Section 5 presents a brief overview of promising future directions for commercial sector LAPM provision.

3. THE FOUR FUNDAMENTALS OF COMMERCIAL SECTOR PROVISION OF LAPM

3.1 CRITICAL MASS OF CONSUMER DEMAND FOR LAPM

A "critical mass of demand" is necessary to generate sufficient sales volume to enable commercial sector providers to make a profit, after covering up-front investments in LAPM training and equipment and recurring costs such as staffing, rent, and client counseling. Market size, a fundamental element in profitability, is a major factor in providers' decisions to include LAPM in their private practices. If the size of the market is small, providers may compensate by increasing the price of LAPM services, which in turn may make the services unaffordable for a majority of prospective clients.

Critical mass not only covers costs and increases profitability; it also allows providers to maintain technical proficiency in LAPM service delivery. A provider who undertakes, during the course of a year, only a few no-scalpel vasectomies, IUD insertions, or tubal ligations (for example) cannot maintain his/her clinical proficiency and confidence.[1] The critical mass of demand can also play a role in establishing LAPM use as a "normative" behavior, which is more likely to attract eligible non-users.

Box 1. Challenges to Growing the Commercial Sector for No-Scalpel Vasectomy in Honduras

The PSP-*One* Project identified an opportunity to increase commercial sector provision of no-scalpel vasectomy (NSV), based largely on the availability of an institutional partner that offered the capacity for ongoing quality assurance. Between 2006 and 2007, PSP-*One* trained nine private doctors on the NSV technique in Honduras, certified an additional three as trainers, and provided all twelve private doctors with NSV kits. The twelve providers work in other sectors in addition to their private practice: nine are contracted by IPPF affiliate ASHONPLAFA to perform subsidized sterilizations; two work in public hospitals; and one works in a social security hospital. PSP-*One* also educated 59 ASHONPLAFA and social security health promoters on NSV and timed the provider training to coincide with the NSV radio campaign carried out by the ACQUIRE project.

According to the most recent Demographic and Health Survey (2006) for Honduras, male sterilization represents only 0.3% of current contraceptive use and only 0.5% of the contraceptive mix for modern methods. Current demand for vasectomy is low, raising concerns regarding the business viability of a private sector initiative for vasectomy services. Since completion of training by PSP-*One*, providers have completed 458 NSV procedures (as of March 2009)—only 7% of which took place in private sector clinics. NSV rates vary widely among providers, prompting concerns about maintaining the appropriate skillset in a low-demand setting. As vasectomy is a permanent or nonrecurring method for each client, a fairly large pool of new adopters is necessary to generate on-going demand.

Despite the low rate of method adoption, providers remain enthusiastic about the service. One of two providers trained in the northern city of San Pedro Sula, has embraced the training and its potential as a family planning

[1] Interview with Irina Yacobson, Assistant Medical Director of Applied Research Department for Family Health International, May 2009.

method. On his own initiative, he has begun training medical students, who spend time in the local hospital as part of their education, in the provision of NSV. The procedure is not addressed as part of routine medical school curriculum. Through this hands-on training, the doctor is improving the technical capacity of future medical providers and broadening the impact of PSP-*One*'s training[2].

The example in Box 1 demonstrates the importance of taking a long-term view of critical mass of consumer demand. Ascertaining the market's potential for a critical mass of consumer demand is of fundamental importance to sustainable LAPM service delivery in the private sector.

3.1.1 HOW IS A CRITICAL MASS OF DEMAND CREATED FOR LAPM?

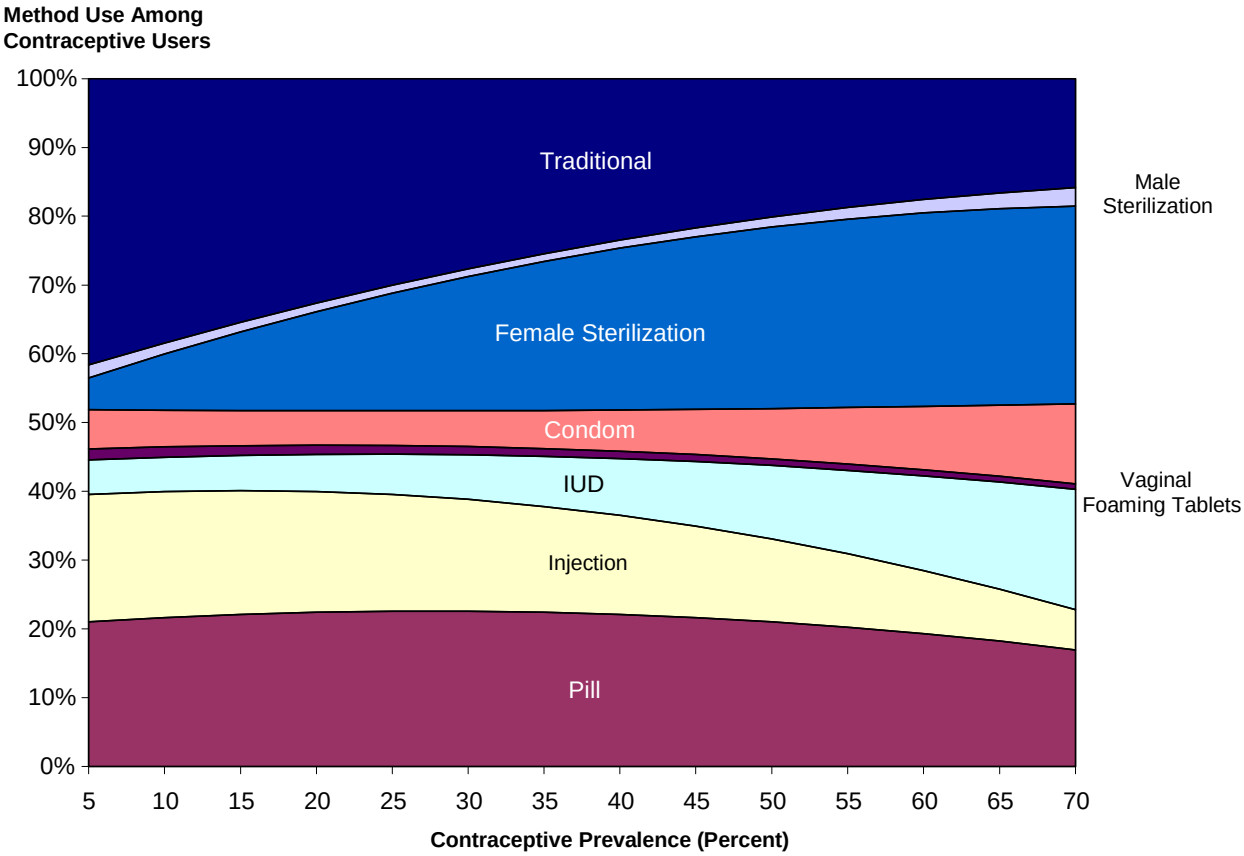
Several research studies in the past decade have assessed national rates of LAPM utilization as the method mix, supply source (commercial vs. NGO vs. public), and contraceptive prevalence change. Generally speaking, as overall contraceptive prevalence increases, long-term methods (sterilization and IUD) comprise a greater share of the contraceptive method mix (Ross, Weissman, and Stover 2009).

Longitudinal data from 200 national surveys (1980-present) also indicate that shifts in contraceptive method mix are similar from country to country (Ross, Weissman, and Stover 2009). Traditional methods are often most popular in countries when the contraceptive prevalence is low. As prevalence increases, traditional method use decreases substantially and long-term methods begin to dominate. Female sterilization is the most popular method in most countries with a high level of contraceptive prevalence (Figure 1), while the IUD dominates in high-prevalence Muslim countries (Figure 2). Thus it appears that growth in LAPM use occurs as a function of overall growth in contraceptive prevalence. Men and women in countries with higher rates of contraceptive prevalence may indeed be more open to LAPM, due to the normative acceptance of modern methods of contraception.[3]

[2] PSP-*One* Interview with Dr. Anibal Hernandez. May 2009.

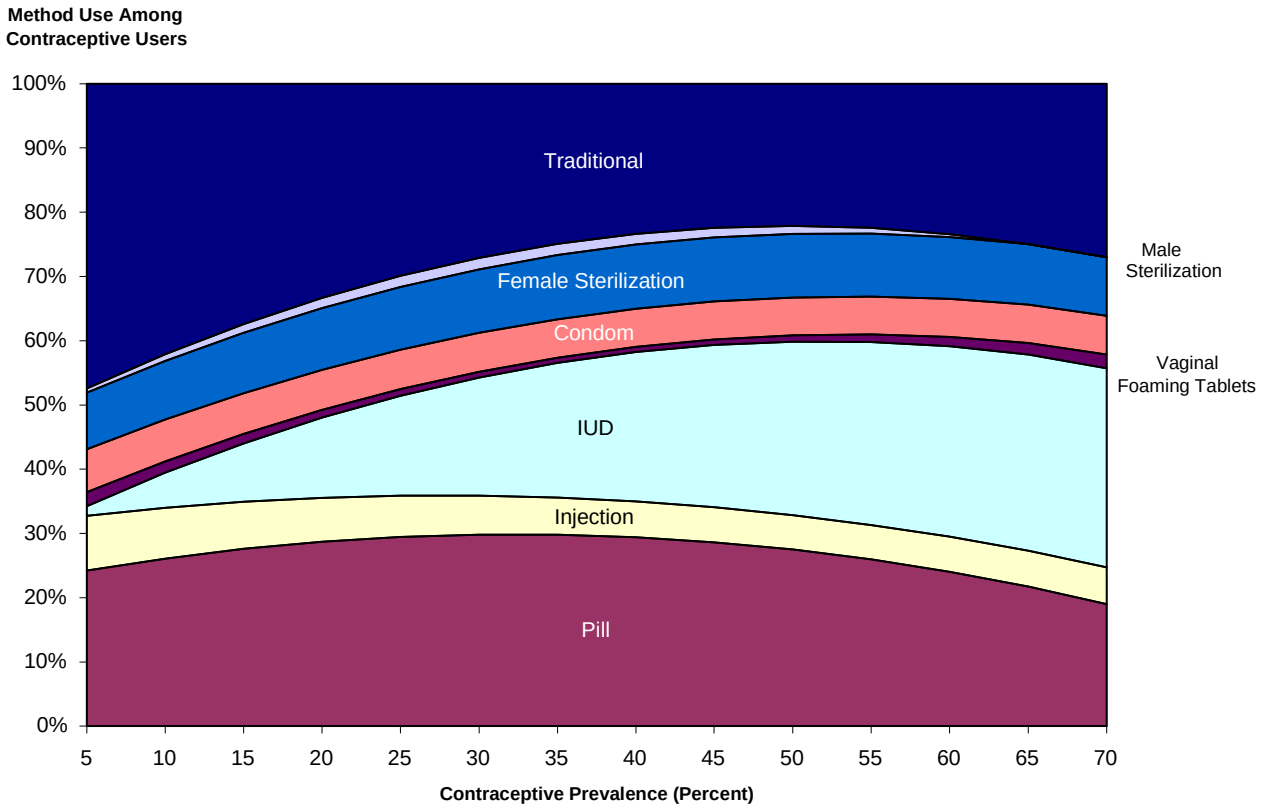
[3] While there is no uniform agreement on what constitutes low, medium, and high levels of contraceptive prevalence, some demographic analysts have suggested he following groupings: less than 20%; 20-39%; 40-59%; and 60% or more (U.S. Census Bureau International Development Database [Accessed November 3, 2009]).

FIGURE 1. CONTRACEPTIVE METHOD MIX IN 74 NON-MUSLIM COUNTRIES, 2008



Source: Ross, Stover, and Adelaja (2005).

FIGURE 2. CONTRACEPTIVE METHOD MIX IN 42 MUSLIM COUNTRIES, 2008



Source: Ross, Stover, and Adelaja (2005).

It appears, therefore, that a critical mass of demand for LAPMs – necessary for sustainable service delivery in the commercial sector – is most likely to exist in countries/markets where overall contraceptive prevalence is high. Historically, however, the commercial sector's share of fulfilling that demand does not grow along with increasing overall demand. Growth in commercial sector share is not an inevitable consequence of increased adoption of family planning. Although the commercial market share for family planning may be high, the absolute size of the market can be quite small (Winfrey et al. 2000). The commercial sector provision of IUD and sterilization services may grow as the use of these methods increases; however, market share may remain static. In some cases, the commercial sector's market share even decreases as method use increases (Janowitz, Gmach, and Otterness 2006). Possible explanations for the limited commercial sector may include the high cost of entering the market for LAPM. Additionally, subsidized prices offered by the NGO sector may attract those consumers who are able to pay.

The concept of critical mass of demand has policy implications for family planning programs. LAPM use tends to increase with overall contraceptive prevalence—an increase which may not be reflected in commercial sector growth due to pricing and other policies. Program planners wishing to create critical mass of demand for commercial sector LAPM must increase both consumer adoption of LAPM and consumer utilization of the commercial sector for LAPM provision. For decades, demand generation for LAPM has relied heavily on public sector and donor-supported communications, education, and

marketing support. Recognizing that consumers do not necessarily turn to the commercial sector for LAPM services, private providers often refrain from investing in category-growing demand generation campaigns.[4]

Commercial sector entities do not usually see the presence of "unmet need" for family planning as an attractive, profitable market. Instead, they invest their marketing resources in growing their own brands or services in the already existing market. As long as the commercial sector views responding to "unmet need" as unprofitable, they will have no incentive to change their marketing approaches. The public sector and donors must thus continue to support demand generation activities for LAPM rather than expecting these costs to be absorbed by the commercial sector.

3.1.2 ESTIMATING DEMAND FOR LAPM

Annex A presents a list of several factors that should be considered in developing an estimate of the potential size of the LAPM market. These factors include: the current number of LAPM acceptors; characteristics of LAPM acceptors at the time of method adoption; trends in overall contraceptive and LAPM prevalence; and laws and regulations affecting the delivery of LAPMs.

The number of current LAPM acceptors helps us to understand whether the level of demand is sufficient to sustain commercial sector participation in LAPM service delivery. However, estimating the number of LAPM acceptors is often problematic, for several reasons. First, data often report the number of current LAPM users, as opposed to recent acceptors of these methods. Second, the characteristics of LAPM users (previous contraceptive use, parity, age, economic and educational status) often are recorded at the time of the survey, and may not reflect characteristics of users at the time of adoption. This makes it difficult to estimate the size of the potential LAPM market. It also renders it more difficult to target marketing efforts toward populations most likely to become LAPM users.[5] In the absence of data on characteristics at time of adoption, characteristics of current LAPM users can be used as a proxy. (See Annex B for a summary of selected characteristics of LAPM and short-acting method users in sixteen countries, based on DHS data.)

3.1.3 POLICIES AND PRACTICES AFFECTING MARKET SIZE

LAPM are often regulated by restrictions at the facility, provider or consumer level. Governments may restrict LAPM to women who meet certain age or parity thresholds, or who have certain medical conditions. Required spousal consent may be another barrier to LAPM use. While some regulations of LAPM are medically necessary (e.g., screening women for medical risk factors that may interfere with LAPM safety), many of these regulations unnecessarily constrain LAPM as an option for population segments that need them most. In addition, provider biases (based on inadequate training, religious or other cultural beliefs) against these methods may further limit access to the services. These factors constrain the size of the overall market, including the share of the commercial sector.

[4] In contraceptive social marketing experience, the manufacturer of an OC brand, for example, that is the well-established market leader with a majority share of the OC market, may sometimes be willing to invest in activities designed to "grow the market" because it can be relatively sure that the majority share of any new business will accrue to its market-leading brand.

[5] Among sterilized females, the number of children born by the mother, age at time of method adoption, and perhaps level of education are characteristics that may have remained the same between time of method adoption and time of survey.

3.2 PRICE

The price charged for provision of LAPM in the commercial sector is important both to the provider and to the consumer.

3.2.1 IMPORTANCE OF PRICE TO THE PROVIDER

Commercial sector providers must be able to recover the costs of providing LAPM services and obtain some level of profit over the long term. With LAPM services, providers may set high prices for the product and offer it to wealthier population segments, or they may set lower prices but increase sales volume by targeting middle and lower income groups. They may also introduce a sliding-fee scale, to recover as much cost as possible from each client based on willingness and ability to pay. Though sliding fees may potentially generate the most revenue, they are exceedingly difficult to implement due to imperfect information about the market.

Commercial providers must also consider the return on investment of spending limited time and resources on the LAPM procedure as compared to other health services. When providers already offer an established set of high-volume and/or highly profitable healthcare services, they may be less inclined to interrupt their practice model and make additional investments to introduce LAPM services. Population Services International (PSI) has found that, because LAPM is time and equipment intensive, some providers have found that they lose revenue by interrupting their normal service model to offer LAPM services.[6]

Costing analysis reveals that subsidies play a very large role in the provision of LAPM services. In Indonesia and Egypt, PSP-*One* estimated the cost of providing implants ($14.10), IUDs ($1.93), injectables ($1.01) and female sterilization ($15.87), using the wholesale cost for the device plus training, equipment, supplies and labor. For implants, the vast majority (74%) of clients from all socioeconomic groups paid far less than the direct cost. However, profit potential for IUDs appeared to be higher: only 8% of clients on average paid less than direct costs.[7] (Details are provided in Annex C.)

A prominent NGO in Sub-Saharan Africa provides another snapshot of an institution's ability to recover costs for LAPM service delivery. The NGO's mission is to provide free services to youth; adult clients, however, are required to pay for services. The NGO recouped approximately half the cost of delivering IUDs ($4.89 out of $9.54) from client fees. Implants, however, have a greater profit potential. A costing study estimates that implants cost the NGO $6.45 to deliver, while paying clients paid an average of $24.45 for implant insertion (Zurita 2009).[8] For a closer look at how cost impacts the work of NGOs, see Box 2.

[6] Interview with Maxine Eber, Population Services International, April 2009.

[7] PSP-*One* unpublished analysis, Janowitz, B, 2008.

[8] Costing data include all expenditures of the agency (based on financial reports of the board) and include salaries, goods, equipment and projected estimates of depreciation values of infrastructure. These costs cannot be generalized to the commercial sector because they do not include technical assistance and staff seconded by PSP-*One*, USAID and other donors.

Box 2. LAPM Market Entry: No Small Price to Pay

The Well Family Midwife Clinic Network in the Philippines illustrates the costs to providers associated with LAPM and related services.

In the Philippines, the Well Family Clinic (WFC) Network trains midwives to offer comprehensive maternal health and family planning services, including LAPM. In addition to the full range of obstetric services, midwives are trained in interpersonal communications skills, family planning counseling, ambulatory health facility management, reporting and monitoring systems, and business planning. With 15 midwives trained per session, the cost of each training session was $1,573* (in 2003). Each midwife is given the basic equipment and instruments required to provide maternal and child health and family planning services in her clinic – at a cost of approximately $2,443 per clinic.

Midwives are responsible for renovating their clinic structures to meet Well Family quality standards. These renovations were the most expensive component of their participation in the network; midwives reportedly spent from $1,673 to $2,509.

Annual operating costs for each network clinic ranged from approximately $1,673 to $6,692 per clinic (Ravenholt, Perla, and Villaruz 2003). These costs include: direct materials, direct and indirect labor, utilities, cleaning supplies, laundry, rent, communications, office supplies, transportation, ads and promotions, training, insurance, licenses and fees, repair and maintenance.

*Currency converted at www.oanda.com on 01/01/2003 (1 USD=53.65 Philippine Pesos). All dollar figures are USD.

Because the delivery of some LAPM services (particularly sterilization and IUDs) requires significant investments in staffing, equipment and infrastructure, the method may be more attractive to some providers than others. PSI's Women's Health Project has found that, as private providers saw demand for LAPM increase, they realized that adding these services could increase the profitability of their practices.[9]

Still other commercial providers may see the potential in offering LAPM at below-market costs (typically to attract new clients to their practices), cross-subsidizing that service with other more profitable services generated by greater consumer demand. Typically, however, cross-subsidization of services that results in lower prices for LAPM is usually found only in NGO or donor-supported private provider networks, such as IPPF affiliates in Latin America and Friendly Care in the Philippines.

3.2.2 IMPORTANCE OF PRICE TO THE CONSUMER

Ability and willingness to pay for the cost of LAPM has a fundamental impact on a consumer's decision to adopt LAPM from the commercial sector. When commercial sector prices are higher than those of their public or non-profit competition, consumers require a value that is commensurate with the higher price set by the commercial sector.

Not surprisingly, the commercial sector market share for LAPM services is strongly correlated with per capita income and the distribution of wealth (Winfrey, Heaton, Fox, and Adamchak 2000). To sustain

[9] Costing data include all expenditures of the agency (based on financial reports of the board) and include salaries, goods, equipment and projected estimates of depreciation values of infrastructure. These costs cannot be generalized to the commercial sector because they do not include technical assistance and staff seconded by PSP-*One*, USAID and other donors.

large commercial sector participation in family planning services delivery in a country with a high contraceptive utilization rate, *all* economic classes (not just the wealthy) must have some ability to pay for commercial sector LAPM. A powerful measure of broad-based consumer purchasing power is the proportion of national income earned by the poorest quintile of the population (Winfrey, Heaton, Fox, and Adamchak 2000).

Since LAPM require a relatively high outlay of funds at the time of the procedure, they are often cost-prohibitive for the poor. While short-term methods (OCs, condoms or injectables) may be more expensive over time, they are often more affordable to consumers because they do not place heavy burdens on household cash flows.

Several factors influence a consumer's decision to adopt LAPM and whether or not to use the commercial sector to obtain LAPM. The perceived value of commercial sector vs. public sector LAPM, from the client perspective, has not been adequately assessed. Recognizing how much consumers value the competitive advantages of commercial sector LAPM provision is important for correctly targeting services and marketing messages. Price appears to be an important factor, as demonstrated by studies showing that even women able to pay commercial sector prices continue to obtain free or nearly free LAPM services from the public sector. A 2006 study of commercial sector LAPM use trends found that, while the commercial sector share of the LAPM market increased with consumers' ability to pay, it was rarely the dominant provider to the wealthiest consumers. The only exceptions were one instance for female sterilization (the Dominican Republic, discussed below), and two for IUDs (Egypt and Jordan) (Janowitz, Gmach and Otterness 2006).[10] The public and non-profit sectors remained the dominant providers of LAPM services; free public sector services were in fact used primarily by women who could afford to pay commercial sector prices. (Detailed graphs are presented in Annex D.)

Interviews with LAPM service providers in the Dominican Republic[11] provided interesting insight into the reasons behind the predominant role of the private sector in provision of female sterilization in that country. For 20 years, ProFamilia, an IPPF affiliate, has contracted out its female sterilization clients to commercial sector providers. Approximately 90% of all obstetric deliveries in the commercial sector in the Dominican Republic are done by Caesarian section. As multiple Caesarian sections carry health risks for the woman, in the Dominican Republic, three or more Caesarian sections are considered a medical indication for tubal ligation. Consequently, the commercial sector in the Dominican Republic is creating a vibrant market for female sterilization through this routine performance of Caesarian sections.

When there is no cheaper alternative to the commercial sector, women may opt to choose another method rather than pay the commercial price for LAPM. In Kenya, for example, consumer demand for implants is high, but the public sector supply is inconsistent. Rather than receive timely implants from the commercial sector, women prefer to wait for the public sector service and use an alternative method in the meantime.[12] This anecdote suggests that price may be one of the most important variables affecting consumer choice of LAPM source.[13]

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[10] This study investigated the countries where IUD and female sterilization use was more than 9% and where source data were disaggregated between the commercial and NGO sectors. This included 8 countries for IUD data and 10 countries for female sterilization data.

[11] Magaly Caram, Executive Director of ProFamilia; Dr. Dolores Rodriguez, Field Manager, Maternal & Child Centers of Excellence, formerly Surgical Coordinator of ProFamilia.

[12] Interview with Irina Yacobson, Assistant Medical Director of Applied Research Department for Family Health International, May 2009.

[13] Data on the impact of price on LAPM use are sparse. Most studies consider the impact of price on short-term and non-clinical contraceptives, such as condoms and oral contraceptives (Janowitz, B., Measham D., and West, C. 1999). These studies are not generalizable to the LAPM market, due to the high price differential between these methods.

3.2.3 FACTORS AFFECTING PRICE

Several factors affect the price to the consumer for commercial sector LAPM services, including: equipment, training, marketing, and other operational costs to the provider; competitors' prices; the provider type (e.g., midwives vs. physicians); and available health financing options.

Such external factors as adhering to standards of practice and procuring necessary LAPM devices, impact commercial providers' costs of offering LAPM. These factors can be pivotal in encouraging or prohibiting commercial sector provision of these services.

3.2.3.1 STANDARDS OF PRACTICE

Ministries of Health, HMO policy makers, drug authorities and even insurers set requirements for the conditions under which LAPMs may be provided. Standards of practice may prescribe requirements for medical screening of potential users, clinical procedures, facility equipment, staffing and infrastructure, and product (IUD or implant) registration.

Regulations governing LAPM provision are intended to protect the health of consumers. They may, however, unnecessarily constrain the availability of these methods to potential acceptors, especially when they are rooted in out-of-date medical knowledge, subjective biases or financial concerns. Because some regulations require additional time and financial investments, regulations can increase the operational cost of providing LAPM. Laboratory and other required diagnostic tests, for example, inflate the price of commercial LAPM services to consumers. Though such requirements may increase profit-earning potential for the commercial providers, such requirements in effect restrict LAPM service provision to more expensive (or urban) providers, which are beyond the geographic and financial reach of many lower-income potential consumers (see Box 3).

Box 3. A Fine Line: How Facility Accreditation Standards Stunted the Role of Commercial Sector Midwives in the Philippines

After considerable debate, the Philippines National Health Insurance Plan allowed midwives to be reimbursed for providing family planning and LAPM services. The infrastructure requirements for the accreditation, however, were beyond the financial reach of many midwives. Expensive clinic upgrades required to obtain accreditation, such as widened hallways and ambulance access, were irrelevant for the midwives' basic scope of practice, and put accreditation and reimbursement out of reach for the majority of midwife practitioners (Ravenholt, Perla, and Villaruz 2003).

While coverage by an HMO or insurance scheme may expand consumers' access to commercial sector LAPM services by reducing costs to consumers, the costs to the providers of meeting those standards may limit private provider participation. This may be particularly true for private midwives and general practitioners – often the only commercial outlets for LAPM available to rural and lower income women.

LAPM DEVICES

In the case of IUDs and implants, the cost of the device itself often is a significant part of the total cost of service provision. In some countries, lower-priced IUDs and implants have been introduced to the marketplace, in an effort to lower commercial sector prices of some LAPM services. The cost savings have not always been passed on to the consumer, however. In Egypt, for example, some physicians

merely increased their profit margins rather than reducing the price to consumers (Ravenholt 2001). In Kenya, some commercial providers charge clients for IUDs that they obtain free from the public sector. Some observers have suggested that this charge to the client for an IUD procured free may be the only profitable part of a service that has been priced at a level to attract clients.[14]

Resistance within the drug regulatory agency in Egypt to approve a more expensive IUD (designed to attract a wealthier clientele) derailed an opportunity for urban physicians and distributors to market an IUD product perceived as "higher-end." Though the lower priced IUDs were just as safe, the wealthier consumers did not value the public sector brand. The failure to differentiate products diminished the clients' perceived marginal benefit of utilizing the commercial sector (rather than the public sector) for IUD services. Moreover, the profit margins available from sale of lower-priced IUDs was insufficient to allow for active promotion and detailing of IUDS by commercial distributors (Ravenholt 2001).

TYPES OF PROVIDERS

Each type of LAPM service provider (Ob/Gyns, general practitioners, nurse practitioners and midwives) reaches a particular segment of the LAPM market, largely based on prices and geographic accessibility. In the case of IUD delivery, for example, the price of services offered by midwives may be more affordable to lower income women. General practice physicians may be more accessible to rural and lower income women than Ob/Gyns. Ob/Gyns may be most likely to introduce new technologies and lead changes in medical opinion, but their service prices are likely affordable only to urban, higher income women, who may be "early adopters" of newer medical practices.

If health sector regulations exclude one of these categories from the roster of available IUD providers (as has been the case in the past with midwives in some countries in Africa and most countries in Eastern Europe[15]) then appropriately priced LAPM services for important segments of the population, such as rural or poorer women, may not be available in the commercial sector. Absence of one or more provider types from the LAPM commercial marketplace makes it less likely that commercial sector LAPM prices will be accessible to the range of all potential users.

3.2.3.2 PAYMENT OR INSURANCE OPTIONS

Mechanisms for accommodating the price needs of consumers within a commercial sector framework may include a range of approaches that are increasingly common in developing markets: commercial HMOs, private health insurance companies, national health insurance schemes, and public/private partnerships that include voucher programs or contracts for service provision. Whether or not these programs include LAPM services in their benefit/service packages will greatly affect the accessibility of LAPM services in the commercial sector. As mechanisms for financing LAPM service delivery become increasingly prevalent, they may in fact become powerful forces for increased demand for LAPM in the commercial sector.

[14] Ibid.
[15] Ibid.

Box 4. Friendly Care's Journey to Sustainability

Friendly Care, a donor-created and subsidized network of six urban healthcare clinics in the Philippines, was initially established to promote and provide high quality family planning services to middle income consumers who are deterred by overcrowded public sector facilities, yet unable to afford expensive commercial sector prices for healthcare.

To cross-subsidize the costs of its range of family planning counseling and methods (including LAPM), Friendly Care's service package also includes primary health care for families and workers as well as laboratory services. Revenues were insufficient to cover family planning service delivery costs, but with existing high demand, Friendly Care successfully lobbied the national health insurance scheme, Phil-Health, to include vasectomy and IUD services for reimbursement to accredited commercial providers.
Reimbursement began in 2003. To date, Friendly Care is one of 3,779 public and private sector facilities accredited by Phil-Health to offer family planning and other health services. Friendly Care charges the following fees for LAPM services:

- IUD insertion P480 ($10)*;
- No-scalpel vasectomy P4,000 ($82); and
- Tubal ligation P4,000 ($82).

These fees do not reflect the total cost to Friendly Care of delivering the services. Even with the highest Phil-Health reimbursement level, the auxiliary costs of LAPM—marketing, salaries for field workers and counselors, and administrative overhead—are not covered. However, Friendly Care only charges for services what Phil-Health reimburses. This allows employees to pay nothing for the service, but it does require Friendly Care to rely on donors to subsidize clients who are able to pay only a fraction of the cost of the LAPM service.

Friendly Care has had a long journey toward achieving financial sustainability, but as of April 2009, Friendly Care's clinic operations began covering its costs. Although Friendly Care still relies heavily on donor funds for family planning, in June 2009, its revenue exceeded costs by P1 million ($20,500). That month, approximately 32% of Friendly Care family planning clients were self-paying, 4% of family planning services were reimbursable by Phil-Health, and the remaining 64% of Friendly Care family planning clients received donor-funded or subsidized services.

Although third-party payers are still an important part of Friendly Care's source of revenue for LAPM, the network is working toward becoming financially solvent. To cover all costs associated with LAPM service delivery, Friendly Care managers estimate that annually 7,000 procedures would need to be performed, with each contributing $21 to overhead (or a total of $40 charged for each procedure).

*Currency converted at www.oanda.com on 9/1/09. 1 USD=48.90 Philippines Pesos.

To date, most private health insurance schemes that target middle and lower income groups do not cover family planning benefits. More advocacy to include family planning is needed from consumers, governments and donors. Further, donors must recognize that when they directly fund the provision of LAPM and other FP services, they may at the same time reduce pressure on local insurers to include LAPM in their benefit package (as in Nigeria and Ghana).

When designing benefit packages, insurers weigh the projected demand and use for the product among the risk pool, alongside the cost of providing each benefit. Social insurance could play a large role in

ensuring sustainability of LAPM in the private sector by including LAPM in their benefits packages. Insurers may in fact benefit from the cost-effectiveness of LAPM compared to short-acting methods: annual costs tend to be lower for LAPM than for short-acting methods (Table 1). Though there seems to be strong potential to increase affordability of LAPM for consumers, it is not yet clear what overall impact inclusion in these programs will have on commercial LAPM provision.

TABLE 1. ESTIMATED ANNUAL COSTS PER FAMILY PLANNING METHOD, 2006

Short Acting Methods	Cost Range	LAPM	Cost Range
Pill	$2.28-$3.73	Norplant	$6.57-$6.80
Injectables	$2.70-$4.40	Female Sterilization	$1.20
Condom	$1.60-$4.22	Male sterilization	$0.67
Spermicides	$3.84-$8.00	IUD	$0.41-$0.47

Source: Gribble, Jennings, and Nikula 2004.

Monitoring providers' experience over time will be critical to understanding how insurers can impact the use of commercial sector LAPM. Several questions remain: How many insurers include LAPM in their benefit packages? How many commercial sector providers are offering LAPM services through these schemes? How many consumers are using commercial sector facilities to obtain LAPM through these schemes?

A number of potential challenges have also begun to emerge. Some providers are opting out of providing LAPM because the insurance or voucher reimbursement is insufficient to cover costs. Cash-flow limitations caused by long reimbursement delays can also deter providers from offering the service (Rosen 2000). Solving these challenges may well be a worthy investment. Accreditation and reimbursements tied to quality control mechanisms may position insurance schemes to incentivize affordable, high quality LAPM administration.

3.3 COMPETITIVE ADVANTAGES OF THE COMMERCIAL SECTOR

In the competition for patronage, commercial sector LAPM providers must offer consumers competitive advantages over public sector and non-profit LAPM providers.[16] Different segments of the population place different values on each of these commercial sector attributes, and consumer perceptions often determine consumer choice. Although understanding consumer needs is critical, very little information currently exists about consumer desires with regards to LAPM. Without this understanding of the consumers' needs and wishes, the commercial sector cannot be more responsive, flexible and attractive than its public sector counterpart.

Ultimately, for the commercial sector to become profitable, it needs to know which attributes to emphasize to attract a viable market share. Commercial providers, donors, and public sector program planners must learn what consumers most value in LAPM service delivery, and what service attributes they are willing to pay for in the commercial sector – they must focus on the consumer to better

[16] Competitive advantages for sources of LAPM service delivery may include: convenient location; convenient hours of operation; consistent availability; affordability/price of the service; affordability/price of service-related elements (like transportation to the outlet, ancillary tests, follow-up, and necessary devices); status conveyed by using the ou let; minimal wait times; availability of useful information; support for method decision-making; privacy; respect shown to the consumer; reputation for reliability and quality of care; familiar providers or type of providers; or any other service delivery elements that may be desirable or important to the consumer.

understand how to best involve the commercial sector. These questions have not been sufficiently explored in the LAPM context. For example, even though recent evidence reveals that consumers will pay for greater privacy safeguards when receiving treatment for sexually transmitted infections (STI), there is no evidence to indicate how much consumers will pay for perceived attributes of commercial sector LAPM.[17] Box 5 discusses perceptions of care provided by IPPF affiliate ASHONPLAFA in comparison to the public sector.

Box 5. Putting a Price Tag on Safety: An Enhanced Challenge for the Commercial Sector

PSP-*One* asked 33 current oral contraceptive users in Honduras how they would choose a provider if they were one day to undergo a tubal ligation, which accounts for 24.6% percent of modern method use in urban areas of Honduras (Honduras Ministry of Health, National Institute of Statistics (INE), and Macro International 2006).

Participants were recruited for focus groups in community centers, place of employment, and through referral by participating friends and family members. All 33 women surveyed were from the middle and lower-income quintiles; they lived or worked in the urban areas of Tegucigalpa and its surrounding neighborhoods, or San Pedro Sula.

The women discussed "safety" as an important factor in their decision to seek care at ASHONPLAFA, the IPPF affiliate in Honduras. One participant stated, "I would go to ASHONPLAFA because it is safer. You know what happens and they keep things sanitary…if at a health center a person has problems they send them to ASHONPLAFA." Another woman added, "I think that, personally, I have more faith in ASHONPLAFA because it is dangerous to go just any place."

Respondents estimated that the cost of tubal ligation ranged from 500 Lempiras ($26*) to 1500 to 2000 Lempiras ($78 to $104). In reality, ASHONPLAFA charges 2,500 Lempiras ($130) for the procedure. Given that the average gross national income in Honduras is estimated to be $1,700, the price of even this heavily subsidized procedure constitutes a very significant percentage of the average household's resources.

When faced with the actual price, many women in the focus groups said that they would have to save for the procedure. One woman stated that she would ask the doctor for a recommendation for a less expensive but reputable surgeon. For these women, the commercial sector was not mentioned as a viable option, presumably because LAPM costs would be even higher than at the subsidized NGO. Furthermore, since most of the lowest income women rely on the free services from the public sector, the commercial sector was not considered as a viable option.

*Currency converted at www.oanda.com on 9/1/09. 1 USD=19.24 Honduran Lempiras.

The challenge commercial providers face in demonstrating their competitive advantage over alternative practices may be even larger than anticipated. Demographic and Health Survey (DHS) analyses of the use of commercial versus non-profit and public sector sources for family planning products and services reveals that consumers often have difficulty distinguishing among these sources (Janowitz, Gmach, and Otterness 2006; Ross, Weissman, and Stover 2009). Lack of specificity in DHS survey questions may have caused some of this confusion; nevertheless, there are a multitude of marketplace factors that can contribute to consumer misunderstanding of commercial versus non-profit LAPM service providers. This lack of clarity may signal that market segmentation is not being practiced: providers are not marketing distinct service models to attract specific target groups; and they are not effectively

[17] Interview with Irina Yacobson, Assistant Medical Director of Applied Research Department for Family Health International, May 2009.

highlighting to consumers the attributes that could garner increased willingness to pay (for example, quality, provider type, convenience, or supportive counseling).

Dual practices (where public sector providers work in the commercial sector during off-hours) further blur the line between commercial and public sector services. Limited public vs. private brand distinction is another concern: in some cases, such as Egypt's public sector Gold Star clinics, the public sector has been able to utilize the sort of aggressive marketing techniques usually used by the private sector to bolster their brand and win consumer trust (see Box 6).[18]

Box 6. One Step Forward and One Step Back: When Gilding the Public Sector Bruises the Commercial Sector

Egypt's public Gold Star Network has received significant investments, technical assistance and a mass media promotional campaign from USAID to emphasize the premium quality of the network. In the public sector clinics, IUD consumers in recent years have paid only the cost of the IUD device (2 Egyptian Pounds (L.E.), or $0.36*) to have it inserted. In contrast, commercial sector practitioners have charged from 7 to 12 times this amount (L.E. 15-25, or $2.70 to $4.50).

The investments in improved quality and visibility for Gold Star have resulted in a declining market share for private sector IUD providers, from 56% in 1988 to 34% in 2005. Physicians who work in both the public and private sectors may be tempted to purchase an IUD for 2 L.E. in the public sector (presumably under the name of a fictitious client), to be used in their private practices, where they charge their clients a "commercial" price (Ravenholt 2001).

*Currency converted at www.oanda.com on 9/1/09. 1 USD=5.57 Egyptian Pounds.

Although enhanced quality of the public sector is clearly a positive development, lack of clear differentiation between the sectors makes expanding overall access through market segmentation unfeasible. When higher income groups perceive no significant difference among public, non-profit and commercial services, they are unwilling to pay a commercial sector price.

An analysis of public sector family planning investments found that in middle-income countries, strong public sector investment impedes the growth of the commercial sector as a source of family planning products and services (Winfrey 2000). For low-income countries, however, the correlation is negligible. Whether this correlation holds also for LAPM specifically is not known.

In countries where a significant number of LAPM consumers have chosen the commercial sector, there has been little research documenting which elements of the commercial model were considered by consumers to be competitive advantages, garnering increased willingness to pay. Little is known about how consumers make the decision to adopt LAPM in either the public or private health sectors.

[18] Longitudinal data from DHS surveys in Egypt demonstrate the trends of private sector (commercial and non-profit) market share for IUD services. From 1988 to 2005 the percentage of IUD users seeking services from the private sector declined significantly and steadily: 1988 (55.6%), 1992 (52.8%), 1995 (55.1%), 2000 (36.1%), 2005 (33.7%). DHS surveys do not distinguish between private non-profit and commercial sector sources.

A number of external factors are likely to influence this decision-making process: availability of accurate information; the experience of friends and family; availability of effective counseling; and referrals and recommendations made by other knowledgeable providers, such as Ob/Gyns or pediatricians. The extent to which the commercial sector provides unique decision-making support is not clear. There is no information regarding the distinction among the commercial, public and non-profit sectors in terms of their ability to provide this supportive decision-making environment.[19]

3.3.1 THE COMMERCIAL SECTOR AND LAPM ACCESS

Two basic market realities drive commercial sector LAPM service delivery. The commercial sector works where and when it is profitable; and areas that are densely populated and accessible (and that can supply jobs and capital) are more likely to have a population that is able to pay for commercial LAPM services. In the absence of incentives, LAPM service providers are unlikely to significantly increase service to hard-to-access segments of the population or to the very poor.

Sub-Saharan Africa, with generally low contraceptive prevalence and weak public sector infrastructure, is a case in point. Despite promising gains made in short-term contraceptives (e.g., OCs and condoms) – delivered via commercial sector pharmacies, shops, and traditional healers – the commercial sector for LAPM is no more accessible than is the public sector in many rural areas. In rural areas, approximately half of health services are provided through the private sector, but only about 15% of these services are obtained from clinics and hospitals where LAPMs would be provided.

With specialist physicians concentrated in urban and wealthier areas, regulations that require LAPM to be administered by such specialists will effectively limit LAPM as an option for remote and lower income areas that are served primarily by midwives and nurses. This was the case also with implants, during their introductory period in many countries. Commercial sector LAPM provision, though accessible to consumers living in more densely populated areas, may not greatly expand access to consumers living in less-populated or remote areas.

Normative practices, such as cultural taboos against male physicians treating female patients, may further limit consumer access to IUDs, even in urban and wealthier areas, and add to consumers' costs to access the service (Box 7).[20]

[19] Ibid.

[20] PSP-*One* compiled qualitative data from Jordan in partnership with its network of community health workers (CHW), who between 2005-2009 have visited more than 1 million women to promote family planning, cervical and breast cancer screening. Visits occur every two to six months, depending on need, thereby building a rather strong rapport between the health workers and he clients. In June 2009, the CHWs discussed perceptions and factors influencing the prior or potential decision to adopt an LAPM method. Among the 66 adopters, 50 women had used IUDs, one woman was using implants (recommended by a family member) and 15 had received a tubal ligation. Sixty-three respondents were *potential adopters*, defined by PSP-*One* as women with more than three children who had expressed during earlier visits an interest in limi ing future births.

Box 7. Beyond Quality and Convenience: The Premium on Propriety – Jordanian Women Travel to Receive IUDs from Female Providers

In Jordan, qualitative research among 66 current LAPM adopters and 63 potential adopters revealed much about the value placed on the attributes of LAPM service providers. Method preference had little impact on women's choice of provider or facility. Of importance to women was the facility's proximity to home, the cost of the procedure, and the presence of female staff. One 45-year-old mother of six had her IUD inserted at a United Nations Relief and Works Agency clinic and chose that facility because it was *"close to home…. I don't pay transportation…there is a midwife for fitting the IUD, not a male doctor."* In keeping with religious norms, many women reported traveling to a clinic that was farther from their home to receive services from a female practitioner.

Other factors important to Jordanian consumers included quality, convenience and efficiency. Overall, women had a positive impression of private sector provision of LAPM. One woman who intends to use an IUD in the future indicated that she will seek care in the private sector because, *"…a private doctor will administer more care for ladies. There is no overcrowding at a private doctor's clinic like the public sector." Another commented that, although she had never received care from a private source, she believed that "definitely the service is better and faster."*

3.3.2 SUPPLY CHAINS FOR THE COMMERCIAL SECTOR

Service providers offering IUD and implant insertions can be only as effective as their supply chains. A consistent, reliable pharmaceutical and medical product supply chain is critical for the commercial sector to be able to provide access to LAPM. In some countries, such as Egypt or Kenya, the commercial distribution system does not reach or is not affordable to all commercial LAPM providers. Egyptian commercial providers who also practice in the public sector have de facto informal access to IUDs at below market prices (Ravenholt 2001). In Kenya, a public-private arrangement allows commercial sector providers to obtain IUDs free of charge from the public sector. This arrangement is not without problems, however. To access the supply, Kenyan physicians must apply for a service delivery point (SDP) number; this cumbersome process is often a deterrent to commercial providers.[21] Those who do manage to secure the SDP number are challenged by the public sector's common supply interruptions, caused by a fragmented distribution system and weak procurement and inventory handling.

3.4 MARKET SEGMENTATION

Segmenting the market allows marketers to tailor services and promotional messages to specific target groups, such as those who are most likely to want/need the services or those who are most likely to be able to pay for those services. Market segmentation strategies require knowledge of the critical determinants affecting a consumer's choice to adopt LAPM and to utilize the commercial sector.

[21] PSP-*One* compiled qualitative data from Jordan in partnership with its network of community health workers (CHW), who between 2005-2009 have visited more than 1 million women to promote family planning, cervical and breast cancer screening. Visits occur every two to six months, depending on need, thereby building a rather strong rapport between the health workers and he clients. In June 2009, the CHWs discussed perceptions and factors influencing the prior or potential decision to adopt an LAPM method. Among the 66 adopters, 50 women had used IUDs, one woman was using implants (recommended by a family member) and 15 had received a tubal ligation. Sixty-three respondents were *potential adopters*, defined by PSP-*One* as women with more than three children who had expressed during earlier visits an interest in limiting future births.

Targeted segments for the LAPM commercial market may include women who wish to limit or cease having more children and couples with the ability to pay (either through their own means, or with subsidies or insurance) for the procedure. Knowing the key target market's characteristics is critical to most effectively craft marketing messages to reach them. Literacy, available transportation mechanisms, ability to pay, beliefs about LAPM, perceptions about the private health sector and potential size of the segment must all be considered in targeting campaigns to reach segments of the population most likely to adopt LAPM.

Segmenting the market according to the ability of potential consumers to pay for LAPM services is a rational scheme for ensuring that all contraceptive needs are met for all members of the consumer market in a price-appropriate way: public resources are focused on the underserved and poor, and each provider type can focus its service delivery efforts on a well-defined consumer target group. Such a scheme, when arrived at collaboratively by the public and private sectors, maximizes the potential of the health system by preserving free and subsidized LAPM services for those without the ability to pay, while allowing the commercial sector to be sustained by earning the patronage of the clientele who can pay. Common instruments for effectively segmenting the market by ability to pay include vouchers for services and transportation (which must not be overlooked as an additional cost and time barrier to potential adopters); providers may also target free services geographically, to lower income areas.

If done successfully, segmentation of the market by ability to pay has several advantages. It can improve equity (wealthier women may cross-subsidize the poor, or free up public sector resources to be used on lower income groups); improve the distribution of resources in the health system; and enhance financial sustainability of the public and private sectors. In contrast, universal access to free or reduced-price services may diminish the market for NGO and commercial sector services and be ultimately unsustainable.

For LAPM in particular, the sustainability of the commercial sector depends on market segmentation, because it cannot successfully compete if similar quality goods and services are made available to all consumers through the public sector for free or at heavily subsidized prices (Box 8).

Box 8. Small Markets and Strong Competition: LAPM Provision in Swaziland

A prominent NGO in Swaziland has a reputation for providing the highest-quality family planning services in the country, providing reproductive health services, including STI treatment, male circumcision, and the full range of family planning methods. Interviews with female clients suggest that providers at this NGO clinic "listen to concerns." In contrast, respondents suggest that the public health sector has long waits, inexperienced service providers, and a general sense that "nobody cares." Several clients expressed the idea that free services offered in the public health sector translated into lower quality.

On the other hand, many clients could afford commercial doctors, but they prefer to get family planning services in particular from the NGO clinic (even if they receive other health services in the private commercial sector). For LAPM in particular, the commercial sector would be hard-pressed to compete with organizations like the NGO for a small piece of a small market, given the low current acceptability of LAPM (just 1.9% of urban family planning users have an IUD and 8.2% of urban women have undergone a tubal ligation). (Source: PSP-*One* qualitative interviews, May 2009).

3.4.1 THE ROLE OF DONOR-SUPPORTED PRIVATE PROVIDER NETWORKS IN MARKET SEGMENTATION

In settings where the public sector does not or cannot provide good quality LAPM services, or where a critical mass of demand does not exist to support a robust LAPM commercial sector, family planning and reproductive health advocates have attempted to stimulate provision of services in the commercial sector through donor-supported private provider networks, sometimes called "social franchises." Donor-supported provider networks are often initiated to resolve one or more commonly occurring challenges in the LAPM marketplace, as presented in Table 2. Different aspects of private provider networks are presented in Boxes 9, 10 and 11.

TABLE 2. RATIONALE FOR IMPLEMENTING PRIVATE PROVIDER NETWORKS

Common Service Delivery Gaps Addressed by Private Provider Networks	Role of Donor Support
Lack of market segmentation/Absence of lower-priced services in the commercial sector	Subsidies allow commercial providers to compete with the price of services offered by the public and NGO sectors
Lack of critical mass of demand for LAPM	Coverage for the cost of demand-generation activities
Uneven quality of LAPM services in the commercial sector	Pay for the cost of provider training and quality assurance monitoring
Uneven geographic access to LAPM service delivery outlets	Fund or facilitate the establishment of service delivery outlets in underserved or unserved areas.

Box 9. Changing Provider Biases through New Practice Models: PSI's LAPM Programs Generate a Critical Mass of Demand[22]

PSI has created a network of LAPM providers in 21 countries across Africa, Asia, and Central America. Many countries have adopted a creative approach to fostering a critical mass of demand, sufficient to persuade providers to offer LAPM services and consumers to adopt LAPMs, in settings where the prevalence of IUDs and implants is low.

Through one widely used approach, by organizing and promoting campaigns called "clinic event days," the project concentrates method demand into a one- or two-day period, during which participating private, public, and NGO sector network providers may serve as many as 50 LAPM clients in a single day. Community mobilizers conduct targeted communication activities among women leading up to the event day. Because clients know that the LAPM services they want will be readily available at the announced time of the clinic event day, they come from surrounding areas to the network facilities.

To address cost barriers, PSI and its affiliated providers have adopted different pricing and reimbursement models, such as voucher systems, to reach the poor while ensuring that private providers are reasonably compensated for the additional time and skill required for LAPM provision. Since LAPM procedures require a higher level of patient attention, as well as sterile equipment and bed space, many providers prefer to set aside a few days for LAPM service provision only. This frees up the clinic to perform other non-invasive and simple, non LAPM services on

[22] Correspondence with Maxine Eber, Senior Technical Advisor, Reproductive Health Department, PSI, July 2009.

other days. Many providers find this to be a more efficient use of clinic time and resources.

Clinic event days have the potential to convince providers of the business viability of LAPM provision, while also generating additional demand for the methods through the positive experiences of event day clients and word-of-mouth promotion. PSI has found that in addition to training providers, on-the-job supervision is essential in building provider skills, confidence, and motivation to offer LAPM services, especially when reinforced by on-going supervisory visits by Clinic Support Teams. Ensuring that potential clients are aware of the full range of family planning options, so they may make an informed choice, is also critical to the success of this approach.

Box 10. In India, A Rapidly Expanding Provider Network Responds to Unmet Need for Products, Services, and Quality Training[23]

Janani, a multi-donor funded network of 620 family planning retail outlets supported by DKT-International, was established in Bihar, India, in 1996. At that time, one-quarter of couples in Bihar had no access to family planning services. However, demand and willingness to pay for family planning services were so small for most private providers that they could not even earn enough from them each month to pay for a cup of tea.

Community outreach efforts, supported by Janani's partnering Rural Medical Practitioners and coupled with Janani's branded provider network, created a base for sales of Janani's Butterfly brand of oral contraceptives and condoms and also for family planning services provided by the network's 144 Surya and affiliated medical clinics. Currently, Janani delivers care through clinics, family planning outreach activities at government facilities, and social marketing of contraceptive and post-abortion care products.

A recent partnership with the government brings clinics a $35* reimbursement for each female sterilization provided. As of November 2009, each Janani clinic provided on average 10 tubal ligations daily, with plans to expand service delivery to an average of 30 procedures each day.

Since 1996, Janani has provided family planning services to more than 12.5 million couples. The average cost of protecting a couple for a year is approximately $2 per couple. Recently, however, Janani's business model has changed. With support from the Government and donors, its mandate has shifted away from cost-recovery toward rapid scale-up of services. Still, Janani runs efficiently drawing upon historical efforts to achieve a cost-effective operation.

Janani has become a partner of the Ministry of Health and Family Welfare, Government of India. The organization not only fills a gap in LAPM product and service provision, it also trains new cadres of rural outreach workers and clinical providers to make family planning methods and procedures more accessible.

*Currency converted at www.oanda.com on 9/1/09. 1 USD=49.31 Indian Rupees.

Loose provider networks may already exist in the form of local or national professional associations. The presence of these associations has facilitated communication with and recruitment of potential participants in some provider network LAPM interventions. Under the informal aegis of such professional associations, a newly initiated provider network may also gain early credibility among consumers as well as providers. Donor-supported provider networks in a particular geographical area have also been formed, with outside technical assistance from private sector clinic operators or private practitioners. In some cases, USAID has provided the funds and technical assistance to create a new

[23] Interview wi h Preeti Anand, Deputy Director, Janani, June 2009.

private sector clinic-based network organization, like Egypt's Clinical Service Improvement project (CSI) and the Philippines' Friendly Care.

Subsidizing costs of service provision by private practitioners through a donor-supported network may serve a useful purpose in expanding access to LAPM services. Nevertheless, making the case for the effectiveness and efficiency of networks as a mechanism for expanded access to LAPM would require an analysis of the return in services delivered measured against the investment costs (training, monitoring and supervision, product supply, promotion). Such detailed information does not appear to be readily available for most of the existing donor-supported provider networks.

Box 11. Moving beyond Proof of Concept:
Building An Evidence Base For Provider Networks

Donors have long supported private provider networks to expand access to family planning and other health services, and many of these networks are beginning to yield some exciting results. But what are the comparative advantages of provider networks as compared to donor investment in either NGOs or the public sector? Are provider networks a wise use of funds, or is it too early to tell?

In Pakistan, the Greenstar model has shown that it can dramatically scale up availability of LAPM services for the poor. In 2008, Greenstar reached 700,000 women through free clinic days. Of those, 80% adopted a family planning method; 20% of these women adopted IUD and another 5% adopted a tubal ligation. Greenstar has filled a large service gap both in training and service delivery. Although Greenstar is donor-subsidized, it provides 30% of the country's family planning services, the majority (74%) of which are provided to the poor.[24]

The comparative cost advantage of operating through donor-supported networks (versus the public sector or existing NGOs) has not been assessed. Aside from a few exceptions like Janani, the cost per client has not been ascertained (or has not been shared in the public domain). Understanding the characteristics of donor-supported networks also requires further research. Not all social networks are able to determine whether the targeted clients are poor or lower income, or whether the wealthier are receiving the bulk of these subsidized services.

A number of important questions require further exploration to shed light on the contribution of donor-supported provider networks to LAPM service delivery in the commercial sector. Limited data exist on how these networks affect the number of LAPM services provided or new geographic areas covered, and how many previously un- or under-served clients have been reached. There is little knowledge about what happens to the commercial, public, and non-profit sectors with respect to availability, quality, and pricing of LAPM services when private provider networks exist in the same marketplace. Finally, there have been few studies which document the health impacts of private provider networks at the population level.

There are additional questions that would help develop an understanding of the social franchise model. To what extent have the management and administration costs of the network been offset by client revenue? How can a private network program create a sustainable funding base? What, if any, are the prospects for financial break-even or profitability status? How have previously donor-supported networks performed, after donor support has been withdrawn? What are the prospects for continued donor support? Have family planning services such as LAPM been neglected or diluted by the need to add more services to sustain the network? Is there competition between services offered and the service mix? What activities are cost-effective means of increasing clients for network providers? These questions begin the discussion regarding the role of the social franchise model, raising more questions and illuminating additional gaps in knowledge.

[24] Personal communication, Dana Tilson, Country Representative, Greenstar Pakistan, July 2009.

In rural Africa, use of donor-supported provider networks as a mechanism for expanded access to LAPMs may be additionally complex. Healthcare coverage – whether by public or private providers – may be inadequate. If there is a private nurse or midwife in a given area, then she likely attends to all health needs in her catchment area, directly or through referral. In most cases, she does not have training in LAPM provision; and, according to anecdotal reports, she may not feel a need to expand her business through training for a new service because she is already as busy as she can be or cares to be.[25] Without the competition of other service providers in the same geographic area, private practitioners are unlikely to be interested in learning new skills and adding new services to their practices in order to attract new clients and gain new business.

[25] Interview with Irina Yacobson, Assistant Medical Director of Applied Research Department for Family Health International, May 2009.

4. CONCLUSIONS AND RECOMMENDATIONS

This section summarizes the most salient conclusions regarding the four fundamental elements of commercial sector LAPM service provision: critical mass of demand, price, competitive advantages, and market segmentation. These conclusions, based on experience to date, may be useful for LAPM program planners, implementers and evaluators.

4.1 CONCLUSIONS

Many recent studies of LAPM service delivery in the private sector have focused on the cost-efficiency of LAPM versus supply methods – that is, on the need to save public sector resources in the face of declining donor support by increasing the method mix share of LAPM. A focus on the LAPM consumer appears to have been overlooked.

Growth in overall prevalence of contraceptive use typically does lead to increased LAPM use. This trend, however, does not necessarily translate to greater commercial sector market share. A multitude of factors influence a consumer's decision to utilize the commercial sector, including ability and willingness to pay, adequacy of LAPM supplies and equipment, trained personnel and flexible practice models. Commercial providers must also be convinced of the feasibility and business sense of providing LAPM, which may be a revenue-losing effort, particularly during its initial introduction.

4.1.1 CRITICAL MASS OF DEMAND

A critical mass of demand is necessary to sustain meaningful commercial sector participation in LAPM service delivery. Demand must be enticing to new commercial providers to justify upfront investments in equipment, new practice models and staff training. A critical mass of demand is also necessary for trained providers to maintain their clinical skills in the procedure. Lessons from the PSI model show that promotional launches can be useful in enhancing acceptance of LAPM among both consumers and providers.

Low demand cannot sustain commercial sector LAPM service provision except through significantly increased prices for the service, or through donor subsidies or other support of service delivery costs. Critical demand is most likely to occur in countries with higher contraceptive prevalence rates (CPR).

Marketing campaigns for demand generation may be primarily financed by NGOs or the public sector. Commercial sector entities are unlikely to invest in LAPM demand generation activities due to concerns about low returns on their investments. Revenue generated through branded LAPM services has still not been able to cover the cost of the devices, let alone the costs of marketing to attract new clientele. As greater LAPM adoption is easier to achieve in countries where higher contraceptive prevalence has laid the foundation, some rethinking of LAPM strategies and assessment criteria may be appropriate in low-prevalence countries, as in Sub-Saharan Africa, for example.

4.1.2 PRICE

The cost-efficiency over time of LAPM versus supply methods is an important issue for public sector providers and donor agencies. For consumers, however, a key concern is the immediate cash-flow impact of price payable at the time of product purchase or at the time of service delivery.

Continuing widespread use of the public sector in most countries for LAPM services – even by women in upper economic quintile groups – appears to indicate that the price of those services is a deciding factor in the consumer's choice of source.

Financing schemes that lower the price of LAPM services to the consumer may make LAPM provision a cost-effective tool for providers, and generate demand for services in the commercial sector. These include HMO and insurance capitation plans for healthcare services; government-subsidized vouchers for commercial sector services; and national health insurance benefits.

Profitability prospects for providers are at least as important to the success of commercial sector LAPM intervention as a mechanism for ensuring quality of care.

4.1.3 COMPETITIVE ADVANTAGES OF THE COMMERCIAL SECTOR

Too little is known about the comparative advantages of the public and private sectors in supporting the consumer's LAPM decision-making process: under what circumstances, for example, is a potential LAPM consumer most likely to adopt a LAPM? Further, little is known about the relative value to the consumer of the service characteristics offered by the commercial sector.

LAPM commercial sector project design and implementation needs to be based on market-specific knowledge of consumer needs and expectations as well as on consumer perceptions of the advantages and disadvantages of commercial sector LAPM service delivery.

The penetration into rural areas of commercial pharmacies, shops, and stores that provide such contraceptive methods as OCs and condoms cannot be taken as a predictor of the potential penetration of commercial sector providers of LAPM services.

The majority of donor-funded LAPM service delivery interventions in the private sector are not grounded in an assessment of the marketplace for LAPM or of the needs and preferences of potential consumers. Rooted in the desire to improve access to and utilization of key health services, they often embrace a more supply-driven approach.

4.1.4 MARKET SEGMENTATION

Few, if any, country markets for LAPM services are segmented among the public, NGO, and commercial sectors according to the ability of consumers to pay for the services. But commercial sector providers of LAPM services cannot usually compete successfully in such an undifferentiated market, where free or heavily subsidized LAPM services of good quality are made available through the public sector. Although subsidization of LAPM can immediately improve access in the short-term, it has been shown to erode the commercial market in the long term.

Extending LAPM services to remote areas does require incentives from donors or from the public sector. Donor-supported, branded provider networks have been useful in bringing lower-priced LAPM

services to underserved areas, while promoting demand for their use. However, it is still unclear if these social franchises can be more than de facto NGOs, or if they may actually become financially viable.

Unquestionably, provider networks have increased the adoption of LAPM in the locales where they operate. Whether these new services have made a mark on CPR trends, however, has not been adequately documented. Meanwhile, the progress social franchises have made toward reaching financial sustainability is uneven, and is not always an explicit objective. Social franchises that have calculated family planning impact and operational costs, such as Janani in India, do not disaggregate LAPM from short-term methods. This further clouds our understanding of financially sustainable models.

Finally, because market segmentation is rare in practice, it is unclear what clients who have the ability to pay for LAPM services will do, if the subsidized services are not available to them.

4.2 RECOMMENDATIONS

The following recommendations are suggestions for increasing the efficient and effective involvement of the commercial sector in LAPM services delivery.

4.2.1 LAPM PROJECT DESIGN

In countries where demand for contraceptives in general is very low, donors may be best positioned to invest in demand generation campaigns for contraceptives in general and for LAPM specifically. They can also advocate including LAPM in national health insurance schemes, HMO capitation plans and public-private partnerships (e.g., vouchers, shared equipment, provider training). These strategies strive to expand the market size while preserving a role for the commercial sector to fill the expanded need.

All donor-funded projects involving LAPM service delivery by commercial sector providers should be based on a thorough analysis of the competitive environment and should include an assessment of the profitability prospects for providers (costs, volume, price).

Programs should further explore the potential for expanding LAPM services in the commercial sector through midwives and female general practitioners – culturally acceptable service providers who are likely to be affordable to lower income consumers. This may require some advocacy for task shifting to enable midwives or nurses to have a greater role in offering LAPM services to consumers.

These frontline practitioners are more accessible than physicians (particularly in remote and rural areas). Empowering nurses and midwives to provide more services, through supportive supervision and increased training, can benefit consumers, the commercial sector and the overall health system.

4.2.2 POLICY

Changes in government policies and practices can lower costs for commercial sector practitioners to provide LAPM services. Reducing unnecessary operational costs can generate a cost savings that can be passed on to the consumer. Possible mechanisms include:

- tax relief[26] for commercial providers offering public health and family planning services (including LAPM)
- subsidies for land leases or discounted land purchases to incentivize commercial sector clinics
- increasing the availability of low-cost credit for the health sector
- offering free or discounted utilities for clinics
- creating shared training opportunities for medical staff
- implementing vouchers and national health insurance reimbursements for LAPM services
- including the commercial sector in government-negotiated discounts for supplies, equipment and medical devices

4.2.3 DOCUMENTATION AND EVALUATION

Market share alone is not an adequate indicator of commercial sector LAPM program effectiveness. More refined indicators or an assessment tool would enable programs to better demonstrate the impact of the various public-private and commercial sector models of scaling up services.

Comprehensive assessment would document: costs per LAPM procedure; the impact on CPR; and the financial viability of various models. A central clearinghouse should be established to track progress, compile lessons learned, and enable project implementers, donors, and stakeholders to better incorporate those findings into their work.

Existing social franchise efforts can provide useful guidance regarding effective marketing campaigns, harnessing economies of scale, promoting creative approaches to policies and health financing, and more generally assessing impact in relation to costs/investments. However, programs need more opportunities to share these lessons globally and to build on each other's challenges and successes.

4.2.4 FUTURE RESEARCH

Studies of potential and current LAPM consumers are needed, in order to help practitioners, program designers and implementers identify the specific attributes of commercial LAPM service provision that consumers value most, and to understand consumers' decision-making processes in adopting LAPM. This knowledge can help providers attract new clients, inform targeted marketing strategies, and help the commercial sector deliver the attributes that consumers are willing to pay for, without investing in aspects that are not relevant for consumer needs.

Market segmentation strategies should be further investigated, to understand how to incentivize consumers who have the ability to pay to utilize the commercial sector. This approach has the potential to greatly expand access and grow the commercial market. Research is also needed to study the

[26] Tax relief may include granting "tax holidays," or tax-free income for monies earned for LAPM and other closely-related public health services. If the internal tax bureau does not have adequate systems to apply targeted tax deductions for public health services, the government may consider offering full tax holidays to a limited number of facilities fulfilling specific requirements. These may include provision of a set number of LAPM and other public heal h services, particularly in areas that are impoverished and remote.

behavior of upper-income potential LAPM users, in countries where they do not have access to free or subsidized LAPM in the public sector: Do they turn to the commercial sector for LAPM, or do they instead choose short term contraceptive methods?

Research is needed also to analyze the cost of providing LAPMs across the range of private sector provider types, and to analyze the impact of third-party payment schemes (such as HMOs, private insurance plans, and national insurance schemes) on the volume of participating providers' delivery of LAPM services.

4.3 LOOKING TO THE FUTURE

The recommendations outlined above can be used to inform the next steps in maximizing the potential of the commercial sector in LAPM service delivery. Understanding the competitive environment for the commercial sector can help LAPM service providers develop viable business models, and can inform the approach of governments and donors in designing policies to strengthen the commercial sector's role in LAPM service delivery.

Practitioners and program designers need to be mindful of the difficulties of targeting countries with low overall contraceptive prevalence. A more efficient strategy is to target countries where modern family planning methods are acceptable and more frequently used, as a way of attaining the critical mass of demand to support a high-quality, sustainable commercial sector LAPM market.

Though LAPM are more cost-effective than short term methods over the long term, the high upfront costs present a significant barrier for many consumers. Providers also face some initial barriers to market entry: they require training, supplies, and changes in practice models in order to incorporate LAPM.

Social insurance can be a powerful instrument in growing the commercial sector LAPM market, by addressing both provider and consumer cost barriers. Provider involvement in HMOs or other insurance schemes can ensure reimbursement for costs incurred, encouraging a higher quality of service in commercial sector LAPM provision. Capitation schemes incentivize providers to promote LAPM services that have a high initial cost, but yield significant cost savings over time. In addition, HMOs and other insurance schemes may have built-in structures for training and for monitoring LAPM service delivery quality, reducing the need to establish independent supervisory and training systems that may be difficult to sustain. Private provider networks also have the potential to contain costs. These service delivery models need to be carefully assessed to determine the return on investment.

Strategies should be further explored to reduce operational cost to providers (e.g., low-cost credit and tax holidays). Mechanisms like vouchers, contracting out services, and national health insurance schemes can facilitate commercial LAPM delivery to the poor, if public or donor funds are available to support them.

Policy makers should focus on the competitive advantage of each provider type in a given market in fulfilling three strategic objectives: raising awareness for LAPM; referring potential adopters to clinics; and providing quality services. Empowering key medical practitioners to deliver LAPM is a crucial step in enhancing the viability of the commercial sector. Task-shifting policies that enable nurses and midwives to be trained to administer LAPM can increase accessibility of LAPM to lower income and remote areas, where physicians are in short supply. In countries where cultural norms restrict female examination by a

male provider, female practitioners, midwives, and nurses should be positioned to offer LAPM to potential consumers.

ANNEX A. VARIABLES AFFECTING THE VIABILITY OF COMMERCIAL SECTOR PROVISION OF LAPM SERVICES

The table below presents an overview of variables that affect the viability of commercial sector LAPM services. Assessment of many of these variables would require quantitative or qualitative research.

TABLE 3: VARIABLES THAT AFFECT THE VIABILITY OF COMMERCIAL SECTOR LAPM SERVICES

Size of LAPM market	▲ number of current acceptors ▲ characteristics of current acceptors (age, parity, education, contraceptive history) at time of method adoption ▲ geographic accessibility to commercial sector providers ▲ ability to pay commercial prices ▲ projection of future potential acceptors/LAPM market
Factors in consumer selection of source (ranked if possible)	▲ price ▲ amount charged by service provider ▲ payment options (insurance, HMO, voucher, etc.) available to consumers ▲ quality ▲ referrals (personal or institutional) ▲ counseling ▲ geographic accessibility ▲ privacy ▲ relationship with provider ▲ media impact ▲ other relevant consumer wants/needs
Legal/regulatory issues	▲ legal methods ▲ allowed providers ▲ required conditions for method provision ▲ religious/cultural constraints

Costs to provider of commercial sector LAPM provision	▲ training ▲ staff (clinical and counseling) ▲ facilities ▲ equipment ▲ recurring supplies ▲ promotion/advertising/client educational materials
Income to provider	▲ price to consumer ▲ volume (number of methods provided) ▲ alternative payment schemes (HMO, insurance, voucher, etc.) available to providers
Quality assurance mechanisms	▲ availability for commercial sector ▲ cost to establish (who pays?) ▲ cost to maintain (who pays?)
Competitive environment	
Public sector conditions	▲ quality ▲ accessibility (point of service delivery location and market segmentation) ▲ price and subsidies ▲ donor support ▲ referral network and counseling ▲ media budget
Nonprofit sector conditions	▲ quality ▲ accessibility (point of service delivery location and market segmentation) ▲ price and subsidies ▲ donor support ▲ referral network and counseling ▲ media budget
Commercial sector conditions	▲ number/type of LAPM providers ▲ access to required/necessary clinical facilities ▲ method biases and/or preferences of providers ▲ geographic distribution of providers ▲ access to media for advertising/promotion ▲ quality ▲ price ▲ referral network and counseling

ANNEX B. SELECTED CHARACTERISTICS OF CONTRACEPTIVE USERS AT TIME OF SURVEY[27]

TABLE 4. GEOGRAPHIC DISTRIBUTION OF FAMILY PLANNING USERS BY METHOD TYPE AND COUNTRY

Country	Location	LAPM (%)	LA (%)	PM (%)	SAM (%)	Traditional methods (%)
Africa						
Ethiopia	Urban	72.8	69.2	79.4	33.1	62.0
	Rural	27.2	30.8	20.6	66.9	38.0
Ghana	Urban	59.0	58.0	60.0	54.5	52.2
	Rural	41.0	42.0	40.0	45.6	47.8
Kenya	Urban	30.7	40.3	21.7	31.1	23.6
	Rural	69.3	59.7	78.4	68.9	76.4
Nigeria	Urban	70.9	75.7	52.6	51.0	46.2
	Rural	29.1	24.3	47.4	49.0	53.8
Senegal	Urban	75.6	87.0	50.0	71.8	79.3
	Rural	24.4	13.1	50.0	28.2	20.7
Uganda	Urban	24.2	44.3	19.8	31.9	18.3
	Rural	75.8	55.7	80.2	68.1	81.8
Asia						
India (Uttar Pradesh)	Urban	28.0	55.6	25.9	45.1	23.0
	Rural	72.0	44.4	74.1	55.0	77.1
Pakistan	Urban	41.0	38.1	41.8	50.6	47.9
	Rural	59.0	61.9	58.2	49.5	52.1
Philippines	Urban	58.5	46.9	62.8	52.0	56.9
	Rural	41.5	53.2	37.2	48.0	43.2
Latin America/Caribbean						
Dominican Republic	Urban	69.3	86.3	69.3	70.2	85.1
	Rural	30.7	13.7	31.7	29.8	14.9

[27] Data were analyzed by he USAID-funded RESPOND Project (EngenderHealth) from the most recent Demographic and Health Surveys for each country except Ecuador. Ecuador data came from the 2004 Ecuador Reproductive Heal h survey and were analyzed by the PSP-*One* Project.

Country	Location	LAPM (%)	LA (%)	PM (%)	SAM (%)	Traditional methods (%)
Ecuador	Urban	65.1	66.5	64.6	63.3	57.7
	Rural	34.9	33.5	35.5	36.7	42.3
Honduras	Urban	61.9	69.8	59.7	50.2	44.0
	Rural	38.1	30.2	40.3	49.8	56.1
Peru	Urban	78.2	89.0	72.0	72.5	61.2
	Rural	21.8	11.1	28.0	27.5	38.8
Other Regions						
Egypt	Urban	46.3	46.7	33.3	38.4	73.2
	Rural	53.7	53.3	66.8	61.6	26.8
Jordan	Urban	87.4	87.8	85.3	86.5	84.7
	Rural	12.6	12.2	14.7	13.5	15.4
Ukraine	Urban	68.2	68.2	68.3	79.9	66.7
	Rural	31.8	31.8	31.8	20.1	33.3

LAPM: Long-acting and permanent methods
LA: Long-acting methods
PM: Permanent methods
SAM: Short-acting methods

TABLE 5. MEAN PARITY, BY METHOD TYPE AND COUNTRY

Country	LAPM	LA	PM	SAM	Traditional methods
Ethiopia	4.6	4.3	5.0	3.9	2.7
Ghana	4.8	4.3	5.2	2.8	2.8
Kenya	4.5	3.2	5.7	3.2	3.7
Nigeria	5.2	4.5	7.6	2.8	3.3
Senegal	4.9	4.2	6.6	3.8	3.7
Uganda	6.4	4.6	6.8	3.8	4.8
India (Utter Pradesh)	4.4	3.0	4.5	3.4	4.1
Pakistan	5.7	4.6	6.0	4.4	4.6
Philippines	3.8	3.2	4.1	3.0	3.3
Dominican Republic	3.5	1.9	3.6	1.7	1.8
Honduras	4.0	2.7	4.3	2.7	3.5
Peru	3.5	2.3	4.2	2.3	2.8
Egypt	3.2	3.1	5.1	3.4	2.8
Jordan	4.9	4.6	6.9	3.9	4.1
Ukraine	1.6	1.6	2.1	1.0	1.6
Ecuador	3.5	2.5	3.9	2.4	2.8

LAPM: Long-acting and permanent methods
LA: Long-acting methods
PM: Permanent methods
SAM: Short-acting methods

TABLE 6. WEALTH DISTRIBUTION, BY METHOD TYPE AND COUNTRY

	Africa						Asia			Latin America/Caribbean				Other Regions		
	Ethiopia	Ghana	Kenya	Nigeria	Senegal	Uganda	India (UP)	Pakistan	Philippines	Dominican Republic	Ecuador	Honduras	Peru	Egypt	Jordan	Ukraine
Wealth distribution of LAPM users																
Poorest	3.64	5.59	4.33	6.28	4.21	8.36	19.26	14.87	9.92	15.36	18.11	8.85	5.52	13.57	14.28	9.76
Poorer	0	15.25	10.7	8.04	8.9	9.39	22.69	14.2	18.42	21.16	20.72	14.5	14.36	17.83	18.66	24.3
Middle	6.21	21.08	16.41	9.13	14.8	12.79	19.04	20.47	22.45	22.3	20.2	21.77	21.4	20.57	19.77	20.17
Richer	6.64	22.24	29.29	22.41	22.71	25.04	20.48	22.96	24.99	21.47	20.9	26.28	30.1	23.66	24.23	19.25
Richest	83.51	35.83	39.27	54.14	49.38	44.42	18.53	27.49	24.22	19.71	20.1	28.6	28.62	24.37	23.06	26.52
Distribution of users by wealth quintile																
Poorest																
LA	2.88	4.01	2.61	3.27	1.54	0	1.53	6.96	9.95	1.55	11.5	5.51	1.97	52.7	33.15	22.06
PM	0	3.3	7.97	0.74	9.27	12.05	43.38	46.33	11.57	61.57	32.58	24.17	10.01	2.04	5.41	0.66
SAM	93.89	64.04	58.27	61.67	86.04	63.93	9.84	27.46	44.87	35.63	32.44	48.65	44.33	45.13	33.88	40.74
Trad	3.23	28.65	31.16	34.32	3.15	24.02	45.25	19.25	33.61	1.25	23.48	21.68	43.69	0.12	27.56	36.54
Poorer																
LA	0	5.4	4.91	4.25	7.13	0.66	1.28	7.77	10.9	3.28	13.78	5.83	3.74	60.69	37.17	29.88
PM	0	5.78	9.46	0.78	6.53	7.94	43.42	28.8	17.41	65.51	33.48	31.79	15.88	2.32	6.76	1.83
SAM	98.36	67.04	62.57	54.87	80.01	72.38	18.35	38.16	42.38	28.91	34.37	46.47	41.1	36.46	28.98	42.62
Trad	1.64	21.77	23.05	40.1	6.33	19.02	36.95	25.27	29.3	2.31	18.38	15.9	39.29	0.53	27.09	25.67
Middle																
LA	0.68	8.19	5.46	2.54	6.66	1.3	1.94	9.62	8.76	2.49	15.46	8.84	6.83	63.94	38.15	27.51
PM	0.86	6.65	11.96	1.52	5.18	8.04	44.1	27.95	22.51	65.83	32.89	38.02	16.45	1.99	4.27	0.84
SAM	94.61	60.24	62.98	70.72	82.87	64.37	20.08	35.62	37.1	28.14	33.82	43.37	45.66	33.36	26.77	49.49
Trad	3.84	24.92	19.6	25.23	5.29	26.28	33.88	26.81	31.62	3.54	17.83	9.77	31.05	0.71	30.82	22.16
Richer																
LA	1.34	4.85	10.65	4.79	6.84	1.81	2.99	5.57	8.92	4.96	14.9	12.47	13.43	65.74	43.74	21.6
PM	0	6.53	13.01	1.23	4.42	11.08	41.14	27.19	25.25	61.63	35.61	36.5	14.97	2.43	7.36	1.04
SAM	95.84	61.8	59.51	64.18	82.48	64.25	30.31	39.61	35.98	27.66	30.18	41.94	44.83	29.87	26.94	56.99
Trad	2.82	26.82	16.83	29.79	6.26	22.86	25.55	27.63	29.86	5.74	19.31	9.08	26.77	1.96	21.96	20.37
Richest																
LA	4.32	7.39	15.91	5.55	14.72	3.09	7.58	9.78	4.31	6.08	15.99	14.46	13.44	68.51	42.37	21.65
PM	2.67	7.13	8.7	1.33	2.58	8.36	31.77	22.26	32.44	59.69	38.61	39.63	17.54	2.24	9.24	0.76
SAM	83.19	62.81	62.23	63.77	75.84	71.65	39.7	40.75	33.5	29.28	30.95	34.31	45.95	24.75	25.14	58.18
Trad	9.82	22.67	13.15	29.35	6.86	16.9	20.94	27.21	29.75	4.94	14.45	11.6	23.06	4.51	23.25	19.41

LA: Long-acting methods, PM: permanent methods; SAM: short-acting methods; Trad: Traditional methods

TABLE 7. LAST SOURCE OF CURRENT METHOD BY METHOD TYPE AND COUNTRY (%)

L

	Africa						Asia			Latin America/Caribbean				Other Regions		
	Ethiopia	Ghana	Kenya	Nigeria	Senegal	Uganda	India (UP)	Pakistan	Philippines	Dominican Republic	Ecuador	Honduras	Peru	Egypt	Jordan	Ukraine
LA Users																
Religious/Voluntary	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Govt. Clinic/ Pharmacy	55.0	84.3	54.2	67.4	72.5	78.9	44.1	34.5	78.6	53.3	40.9	57.8	81.2	63.6	36.6	93.8
Govt. Home/ Community Delivery	16.5	1.1	0.0	0.0	8.9	0.0	0.0	24.1	1.1	5.6	0.0	0.0	3.2	3.2	0.5	0.0
NGO	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	20.8	0.1	6.4	1.8	0.0	0.0
Priv. Clinic/ Delivery	28.6	14.7	45.8	32.6	12.0	21.1	55.9	39.5	18.3	40.0	35.1	42.0	8.4	31.4	60.8	4.8
Priv. Pharmacy	0.0	0.0	0.0	0.0	6.6	0.0	0.0	0.6	0.0	0.0	1.2	0.0	0.0	0.0	1.7	0.4
Shop/ Church/ Friend	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.3	0.0	0.2	1.0
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	1.7	0.1	0.5	0.0	0.3	0.0
Don't know	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.3	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.0
PM Users																
Religious/Voluntary	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Govt. Clinic/ Pharmacy	91.1	70.1	54.1	56.3	86.5	75.7	71.1	70.4	75.9	58.6	51.6	46.4	84.9	26.2	67.8	100.0
Govt. Home/ Community Delivery	5.3	0.0	0.0	0.0	1.9	0.0	19.6	2.4	0.0	0.3	0.0	0.0	1.9	0.0	0.0	0.0
NGO	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	16.0	0.1	1.3	0.5	0.0	0.0
Priv. Clinic/ Delivery	3.6	29.9	45.8	43.7	10.6	24.3	9.0	26.0	23.1	40.7	30.0	53.0	9.5	73.3	32.2	0.0
Priv. Pharmacy	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Shop/ Church/ Friend	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	1.0	0.5	0.8	0.4	2.4	0.0	0.0	0.0
Don't know	0.0	0.0	0.0	0.0	1.1	0.0	0.1	1.2	0.0	0.0	1.6	0.1	0.0	0.0	0.0	0.0

ANNEX C. COST OF SERVICE PROVISION: INDONESIA[28]

The direct costs of providing LAPM in Indonesia were calculated based on the wholesale cost for the device, training, equipment, supplies and labor. Estimated direct costs for injectables and LAPM were:

Injectables	$1.01
Implants:	$14.10
IUD:	$1.93
Female Sterilization:	$15.87

TABLE 8. DISTRIBUTION OF PRICES PAID FOR SELECTED CLINICAL METHODS OBTAINED FROM THE PRIVATE SECTOR IN INDONESIA BY WEALTH QUINTILE

Method and Price	Wealth Quintile					Total
	Lowest	Second	Middle	Fourth	Highest	
	%	%	%	%	%	%
Injectables (DMPA)						
Free	1	1	2	3	2	2
Less than $1.01	39	37	29	18	12	24
Greater than or equal to $1.01	60	62	69	79	86	74
Total percent	100	100	100	100	100	100
N	350	539	689	793	817	3188
Implants						
Free	11	14	8	19	15	14
Less than $14.10	79	81	85	71	53	74
Greater than or equal to $14.10	9	5	8	10	32	12
Total percent	100	100	100	100	100	100
N	50	61	32	36	27	206
IUDs						
Free	27	49	36	17	10	16
Less than $1.93	46	8	14	13	5	8
Greater than or equal to $1.93	27	43	50	71	85	76
Total percent	100	100	100	100	100	100
N	22	55	80	152	545	854

[28] PSP-*One* analysis; B. Janowitz, unpublished 2008.

Method and Price	Wealth Quintile					Total
	Lowest	Second	Middle	Fourth	Highest	
	%	%	%	%	%	%
Female Sterilization*						
Free	30			31	18	24
Less than $15.87	27			12	8	14
Greater than or equal to $15.87	43			56	74	62
Total percent	100			100	100	100
N	62			51	148	261

ANNEX D. WEALTH AND SOURCE CHARACTERISTICS OF FEMALE STERILIZATION AND IUD USERS IN SELECTED COUNTRIES[29]

IUD Client Profile

FIGURE 3. COLOMBIA, IUD SOURCE BY INCOME, 2000

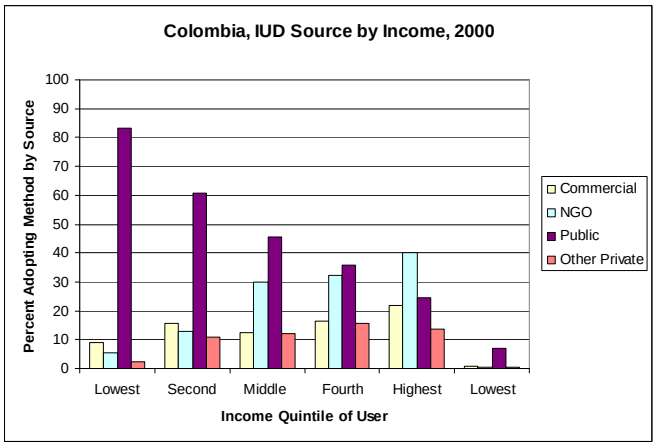
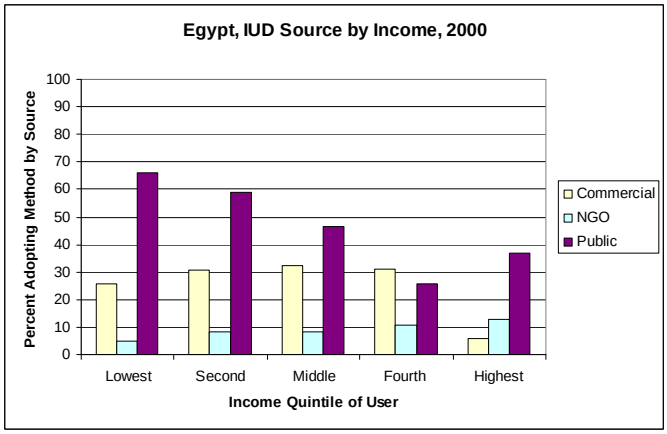


FIGURE 4. EGYPT, IUD SOURCE BY INCOME, 2000



[29] Janowitz, Gmach, and Otterness (2006).

FIGURE 5. JORDAN, IUD SOURCE BY EDUCATION, 2002

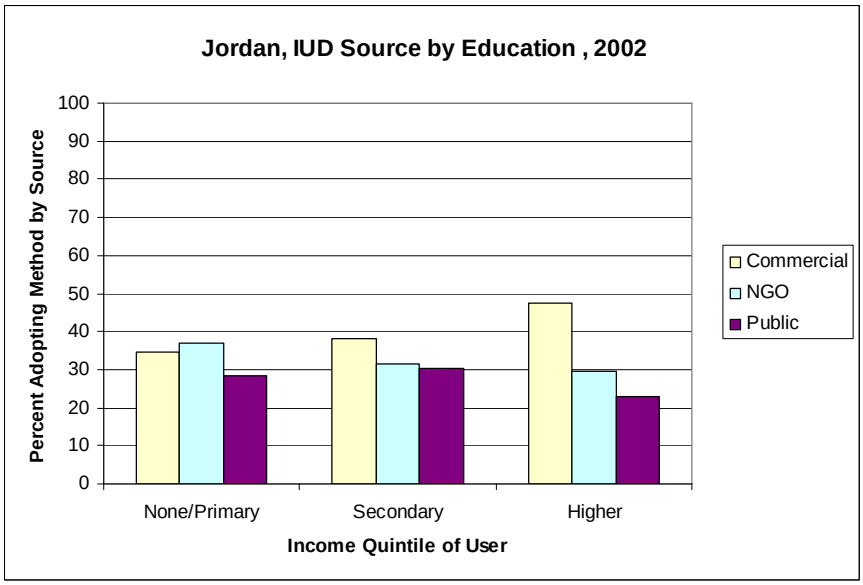
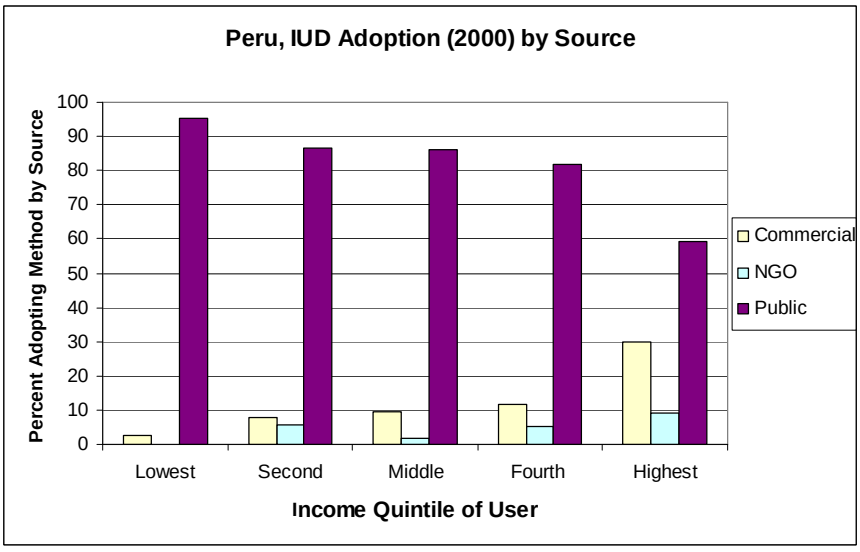


FIGURE 6. PERU, IUD ADOPTION (2000) BY SOURCE



Female sterilization client profile

FIGURE 7. COLUMBIA, FEMALE STERILIZATION SOURCE BY INCOME, 2000

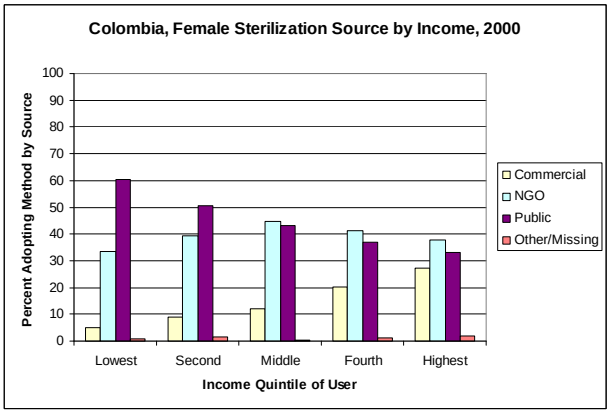


FIGURE 8. DOMINICAN REPUBLIC, FEMALE STERILIZATION COURSE BY INCOME, 2002

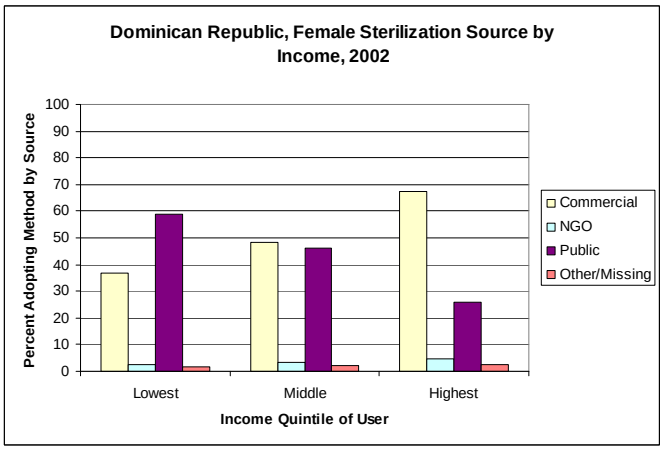
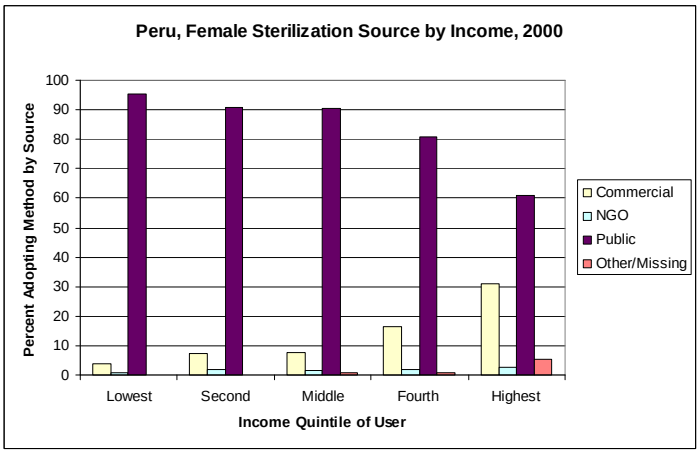


FIGURE 9. PERU, FEMALE STERILIZATION SOURCE BY INCOME, 2000



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