

Comparative Study of Contraceptive Self-Reliance (CSR) Around the World: Lessons for the Philippines

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Like many other developing countries, the Philippines is preparing for the gradual phase-out of donated contraceptive supplies by the United States Agency for International Development (USAID) and other international non-governmental organizations (NGOs). This comparative study reviews the experiences of countries that have either initiated or completed contraceptive self-reliance programs, assessing the sustainability of strategies, identifying the stakeholders and examining the socio-political and legal environment in which CSR strategies were designed and implemented. This study concludes by extracting lessons and best practices from the experiences of other countries that might inform local government units (LGUs) as they design and implement CSR strategies in the Philippines.

Executive Summary

The Philippine Government intends to respond to the phase-out of external donations through the implementation by the Department of Health (DOH) of a Contraceptive Self Reliance (CSR) strategy, which provides for the gradual replacement of externally donated contraceptives with domestically provided contraceptives. For the Philippines, a country that has decentralized most of its services, this means that the Local Government Units (LGUs) will assume primary responsibility for assuring that sufficient quantities of contraceptives are available for free distribution to those users without means to pay for their contraceptives.

There are three fundamental components of CSR strategies: clients, commodities, and sustainability. CSR requires that LGUs develop the ability to forecast demand, finance, procure, and deliver quality contraceptives to all individuals who need them, when they need them. While CSR is often framed as a technical problem, strategy outcomes are influenced by the political and institutional environment. In other words, the success of CSR strategies are influenced by the actors that design, implement and manage CSR policies and the internal and external environment in which the policies are promoted.

Comparative case studies illustrate the challenges and opportunities surrounding government strategies to increase the financial, institutional and demand sustainability of CSR, to incorporate national and international stakeholders, and to navigate through the socio-political and legal environment. Using a political economy framework, this review identifies and discusses the supply and demand side factors that may affect contraceptive security across countries.

Supply Side Factors

Agents

The issue of contraceptive security requires the involvement of broad set of stakeholders that design, manage and regulate the organizations and institutions that produce, deliver, finance and regulate CS and ultimately the end goal – the rate of contraceptive prevalence. Internal agents are those that directly control CSR reform efforts and the allocation of resources, including the executive branch, the Ministry of Health and local government units. External agents include those actors that may help in the design and implementation of CSR strategies and/or the provision of family planning (FP) goods and commodities, including NGOs, international donors, social mobilization and awareness groups and private sector actors. Recognizing the relationship of the various actors to the government may help policymakers think about how to incorporate different stakeholders into the design and implementation of CSR strategies.

Financial Sustainability

Financial sustainability is a critical component of achieving contraceptive self-reliance. Financial sustainability requires mobilization of public and private financial resources to fund the procurement of the current and anticipated future

demand for quality family planning commodities. Private sector actors will only be able and willing to supply FP products if they can recover their costs. In addition, in low-income countries that have social marketing programs, high levels of cost recovery in the public sector will make the private commercial sector immediately price competitive with the public sector (Winfrey 2000). This means that CSR reform efforts will have to propose pricing and cost recovery strategies that provide incentives to guarantee a stable supply of FP commodities. Achieving financial sustainability requires cooperation between governments, public and private health care providers and suppliers of contraceptives.

Institutional Factors/Infrastructure

Institutional stability relates to the capacity of human resources and health systems (including public and private family planning institutions) to supply FP clients with quality services and contraceptives on a continuous basis (without interruption) wherever they are requested. The importance of institutional stability is reflected in DELIVER's slogan, "NO product, NO program." Efforts to ensure the institutional sustainability of CSR strategies involves cooperative arrangements between government units, public health care providers, resource suppliers and providers of technical assistance and other human resources.

Demand side factors

Preferences

Demand for FP commodities and services is influenced by micro-economic or household factors, including household income and ability to pay (Conteh 2003, Sharma 2005). In order to sustain demand, governments and public and private providers have to be able to provide contraceptives to those individuals who want to use FP services and commodities, but cannot afford to pay for them. Consumers must also have access to their desired commodity mix (i.e. temporary v. permanent, condom v. injectable). For instance, CSR policies that only provide condoms when the preferred method of choice is Oral Contraceptives (OCs) are ineffective and will result in user fall out. In order to meet the objective of sustaining demand and ensure that the limited supply and mix of free contraceptives is available to those who want and need them, governments must segment the market based on income classification (or means test) and work with public and private providers to target the provision of free or low cost commodities to the poorest. This aspect of planning CSR strategies involves close interrelationships between clients, payers (all levels of government), health care providers and suppliers of FP commodities.

Information

Sustaining demand requires that consumers have access to information about FP products and services. Policy makers must dedicate resources and work with public and private sector providers conduct campaigns to raise public awareness about the benefits of FP, educate citizens with accurate information, address concerns related to belief systems and clarify new CSR reforms. Many countries have used health promoters and/or community based distribution systems to

promote and sponsor information, education and communication (IEC) activities and outreach on issue of FP.

In addition, studies have found that higher level of knowledge is associated with greater use of the private sector (Winfrey 2000). Countries like Bangladesh have found that health promoters (promotores) and community based distribution (CBD) systems have a positive relationship with higher contraceptive prevalence rates (CPR). Increasing demand for FP services and products requires collaborative efforts between clients, payers (all levels of government), health care providers and suppliers of FP commodities.

Expectations

Demand patterns are shaped by future expectations about the supply of goods. Sustaining demand for FP services and products requires management of client expectations regarding the availability of and accessibility to FP products and services and their substitutes. Policymakers must work with commercial and public providers to guarantee a stable supply of a mix of FP commodities. Governments must also strive to ensure that FP products and services are widely available, even in rural, isolated, less densely populated areas.

Another factor affecting demand is the consumer's expectation that policies are fair and transparent. In Bangladesh, consumers that felt as though new reform policies were unfair or lacked transparency were likely to discontinue using FP commodities (Bates 2003). As such, policymakers (including LGUs) must guarantee that CSR policies are fair, that goods are equally accessible (even in rural, isolated areas), and publicize new CSR policies to promote transparency.

External Environment

Socio-Political, Legal and Regulatory Environment

Political factors include the constellation of actors in the political system (legislators, presidents, etc) as well as any of those stakeholders that are accountable to the government or who act in the political sphere (donors, policymakers, public administrators and other stakeholders), the effects of political structures (i.e. decentralization), and strength of civil society (including advocacy groups) and the freedom of the press.

Legal factors include the specific national policies, laws and regulations that promote, allow and sustain access to FP commodities and services. Specific political and legal and regulatory factors can constrain the adoption and implementation of CSR. Among these include sales tax, import duties, restrictions on advertising and marketing, laws that restrict cost recovery schemes in public health facilities and protectionist laws that require purchase of locally manufactured products. Governments should work with commercial sector to ease restrictions and increase incentives, including a reduction of unnecessary taxes and tariffs on contraceptives, and reform legal and regulatory barriers.

Governments should also assess laws that restrict financing or allocation of resources and laws that hinder purchase of FP commodities.

Recommendations for the Philippines

- Continue efforts to segment the market and target FP commodities and services to poorest
- Emphasize relationship between CSR and economic development and/or health reform
- Formulate a national committee to promote and sustain CSR
- Develop national stakeholders and support implementation actors
- Reform regulatory environment to ease restrictions on marketing and advertising
- Expand Family Planning coverage by PhilHealth
- Strengthen social mobilization and awareness efforts by a broad range of commercial, NGO, and public sector groups
- Develop media campaign
- Work with private sector to develop creative strategies and partnerships
 - Implement non monetary incentives to encourage commercial sector participation
- Take measures to protect funding for the procurement of FP commodities
 - Analyze how other health and social welfare programs are protected (i.e. vaccination programs, TB/DOTS) and work to protect FP budget in the same way (this could be budget line item)
- Strengthen contraceptive Logistics and Management Information System (LMIS)
- Adopt measures that are sensitive to the particular constraints of the Philippines and realize that there is are many pathways to achieve successful outcomes

The layout of this document is as follows. Section 1 offers a background on the objectives and rationale of CSR. Section 2 provides a brief description on the methodology and data. Section 3 provides a comparative review of the implementation of CSR in other countries. Section 4 summarizes the opportunities and challenges facing policymakers as they adopt CSR. Section 5 reviews the actual and potential national and international stakeholders involved in FP and CSR policies in the Philippines. Section 6 offers recommendations for the design and implementation of CSR in the Philippines.

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List of Abbreviations

APROPO	Advocacy for Population Programs (Peru)
ASCOFAME	Colombian Association of Medical Schools (Colombia)
CBD	community based distribution
CBO	community based organization
CDLMIS	contraception distribution logistic management information system
CIDA	Canadian International Development Agency
CIES	Center for Investigation, Education and Services (Bolivia)
CONAM	Environmental Council (Peru)
CONAPO	National Population Council (Consejo Nacional de Población) (Peru)
CPR	contraceptive prevalence rate
CSM	contraceptive social marketing program
CSR	contraceptive self-reliance
CS	contraceptive security
DFID	Department for International Development, United Kingdom
DHA	district health authority (Romania)
DOH	Department of Health
EU	European Union
FEMAP	Federation of Private Health and Community Development Associations (Mexico)
FP	family planning
FPLM	Family Planning Logistics Management
FPAK	Family Planning Association of Kenya (Kenya)
FNC	Federation of Coffee Growers (Colombia)
FPS	Family Planning Survey
GD MCH/FP	General Directorate of the Maternal and Child Health/Family Planning (Turkey)
GSMF	Ghana Social Marketing Foundation (Ghana)
HSAF	Health and Social Aid Foundation (Turkey)
HSR	health sector reform
ICC/CS	Inter-agency Coordination Committee for Contraceptive Security (Ghana)
ICPD	International Conference on Population and Development
IEC	information, education and communication
INEI	National Statistical Institute (Peru)
INPPARES	Peruvian Institution of Responsible Parenting (Peru)
IOMC	Institute of Mother and Child (Romania)
IPPF	International Planned Parenthood Foundation
IPSS/ESSALUD	Peruvian Social Security Institute (Instituto Peruano de Seguro Social) (Peru)
IUD	intra-uterine device
JICA	Japanese International Cooperation Agency
JSI, Inc.	John Snow International, Inc.

List of Abbreviations (continued)

KEMSA	Kenya Medical Supplies Agency (Kenya)
KIDOG	Advocacy Network for Women (Turkey)
LCS	licensed chemical seller (Ghana)
LGU	local government unit
LMIS	logistics management information system
MCH	maternal and child health
MEXFAM	Mexican Foundation for Family Planning (Mexico)
MINSAL	Ministry of Health (Ministerio de Salud)
MOA	Memorandum of Agreement
MOE	Ministry of Education
MOF	Ministry of Finance
MOH	Ministry of Health
MOHF	Ministry of Health and Family (Romania)
MSH	Management Sciences for Health
MWRA	married women of reproductive age
NFPP	National Family Planning Program (Thailand)
NGO	non governmental organization
NLW	National League of Women (Romania)
NMCI	National Plan for Child Survival and Maternal Health (Bolivia)
NORAD	Norwegian Development Agency
OC	oral contraceptive
PAHO	Pan American Health Organization
PDA	Population and Community Development Association (Thailand)
PeruSHIP	Strengthening Health Institutions Project (Peru)
PHC	primary health care
PofA ICPD	Program of Action of the International Conference on Population and Development (Cairo)
PofA	program of action
POW	program of work
PRES	Ministry of the Presidency (Peru)
PROFAMILIA	Association for the Well-being of the Colombian Family (Colombia)
PROMUDEH	Ministry for the Promotion of Women and Human Development (Peru)
PRSP	poverty reduction strategy
RCHU	Reproductive and Child Health Unit (Ghana)
RH	reproductive health
RNPM	National Promotion of Women (Red Nacional Promocion de la Mujer) (Peru)
SBDS	Basic Insurance Program (Bolivia)
SDA	Salvadorean Demographic Association (El Salvador)
SDP	supply delivery point
SECS	Society for Education on Contraception and Sexuality (Romania)

List of Abbreviations (continued)

SIBASI	Basic System of Integrated Health (Sistema Basico de Salud Integral) (El Salvador)
SMC	social marketing company (Bangladesh and in general)
SNV	the Netherlands Aid Agency
SOMARC	Social Marketing for Change (Turkey)
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
SPO	State Planning Organization (Turkey)
SSK	Social Security Agency (Turkey)
SSSI	Salvadorean Social Security Institute (El Salvador)
SUMI	Infant Maternal Universal Insurance (Seguro Universal Materno Infantil) (Bolivia)
SWAp	Sector-wide Approaches (development assistance)
TFHPF	Turkish Family Health and Planning Foundation (Turkey)
UNFPA	United Nations Family Planning Agency
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

I. Background on Contraceptive Self-Reliance Rationale and Objectives

1.1 Background

Across the developing world, the U.S. Agency for International Development (USAID) has initiated and even completed phase-outs of its donated supplies of modern contraceptives. This move was motivated by USAID's belief that every country should provide its own citizens with this basic health service. In 2004, the Philippine government, in conjunction with its external donors, launched a gradual phase down of foreign donations of contraceptives, which will end in 2008, with the complete phase-out of all donated supplies of condoms, pills and injectables.

The Philippine Government intends to respond to the phase-out of external donations through formulation and implementation by the Department of Health (DOH) of a Contraceptive Self Reliance (CSR) strategy, which provides for the gradual replacement of externally donated contraceptives with domestically provided commodities for family planning (FP). The public sector will procure contraceptives and make them available for those current users who depend on donated supplies. Of course, for the Philippines, a country that has decentralized most of its services, this means that the Local Government Units (LGUs) will assume primary front line responsibility for assuring sufficient quantities of contraceptives are available for free distribution to those users without means to pay for their contraceptives.

1.2 The Goal and Objectives of Contraceptive Self-Reliance (CSR)

As noted by the POLICY project, there are three fundamental components of CSR strategies: clients, commodities, and long term assurance (or sustainability). The broad goal of the CSR strategy is that governments—LGUs in particular—develop the ability to forecast, finance, procure, and deliver high quality and reliance contraceptives (commodities) to all individuals (clients) who need them, when they need them (long term assurance). In addition, the success of CSR strategies are influenced by the stakeholders or actors that design, implement and manage the policies and the socio-political and legal environment in which the policies are promoted. The specific objectives of CSR are to:

- provide for gradual replacement of externally donated contraceptive commodities with domestically provided supplies (i.e. to serve the replacement market of current users)
- guarantee that the poor of society have continued access to free contraceptives
- reduce unmet FP need
- commit new additional resources for contraceptive procurement
- increase capacity of private sector to provide FP commodities and redesign the relationship between the public and private sectors
- remove operational policy barriers for CSR, and
- design and implement effective service delivery programs that minimize waste and guarantee availability

The objectives of the CSR policy involve two distinct challenges. First, the end of donated supplies of contraceptives implies that the costs of these contraceptives must be financed by resources from national and local governments and households. This requires that CSR strategy achieve two outcomes that are in tension with each other: maintaining (and even increasing) the use of modern method contraceptives among the poor, even as the cost of these contraceptives rises. But the solution is not simply a financial one. An effective CSR strategy requires extensive capacity building of stakeholders and within institutions (through effective delivery and logistics systems) as well as a reconfiguration of the relationship between the public and private sectors.¹

¹ OUTLOOK. 2003. Ensuring Contraceptive Supply Security.

II. Analytical Framework

2.1 Introduction

Given the complexity of the issue of contraceptive self-reliance, it is useful to develop a theoretical framework and diagnostic guide to analyze, identify and assess policies and supportive measures. Again, simple resource mobilization for the procurement of commodities is not the goal of CSR. Rather, it is a means to a desired outcome – namely, the maintenance and possible increase of the contraceptive prevalence rate (CPR). Currently, the CPR, or the proportion of all currently married women of reproductive age (aged 15 to 49 years) reporting current use of any contraceptive method in the Philippines is 49.3 percent compared to 34 percent in the 1980s.²

Like many health outcomes, the utilization rate of contraceptives is influenced by many factors. Modern health systems provide the critical link between the design and development of interventions capable of achieving significant population health improvements and the realization of this improvement. In *Getting Health Reform Right: A Guide to Improving Performance and Equity*, Roberts et al. (2004) presented a framework to argue that health systems' performance can be affected by five "control knobs" or areas of policy action: financing, payment, organization, regulation, and behavior.³

Similarly, the reduction of donor funding (and supplies) will not only affect the financing of FP goods and services, it will affect major stakeholders of the health system, particularly the consumers (clients). In order to develop an effective strategy, LGUs need to have a comprehensive understanding of their health system constraints and opportunities, particularly as they relate to CPR and CSR. With that end in mind, this study presents an analytical tool that can be used by policymakers to examine demand and supply factors, constraints and challenges surrounding long-term sustainability, and the political-legal environment.

2.2 The Micro-foundations of CSR strategy

Most of the studies on contraceptive self-reliance emphasize the technical aspects of the policy. But a comparative analysis of contraceptive self-reliance reform strategies in the developing world suggests that there are other equally important factors within which CRS policies might achieve success. CSR strategies are shaped by the constellation of actors that support family planning and contraceptive security, the degree to which policies provide for the long term sustainability of contraceptive availability, and the socio-political and legal environment surrounding implementation and management.

² Averaged over the 1980s. World Bank Development Indicators 2005.

³ Roberts, M, Hsiao, W, Berman, P and M Reich. 2003.

As such, this report uses a political economy framework to identify the factors that may affect and constraint CSR strategies and outcomes. Diagram A. presents the supply and demand side factors that policymakers should consider when designing and implementing CSR reforms.

Using a political economy framework helps us identify actors who may influence the design, implementation and management of CSR policies. In addition, by assessing both the demand and supply side factors that support reform the political economy helps locate barriers to long term sustainability.

2.3 Supply side Factors

Agents

The issue of contraceptive security requires the involvement of broad set of stakeholders that design, manage and regulate the organizations and institutions that produce, deliver, finance and regulate CS and ultimately the end goal – the rate of contraceptive prevalence. But actors play different roles in the implementation of CSR strategies, which is often a function of the degree of autonomy and accountability they have in relation to the national government. Recognizing the relationship of the various actors to the government may help policymakers think about how to incorporate different stakeholders into the design and implementation of CSR strategies.

Internal Agents

Executive Branch

President

Generally, the national government or executive branch is responsible for shaping the broad policy and reform agenda. Comparative analysis suggests that the success of FP policy reform is determined by the level of support from the executive branch, especially when reforms require a commitment of financial and administrative resources.

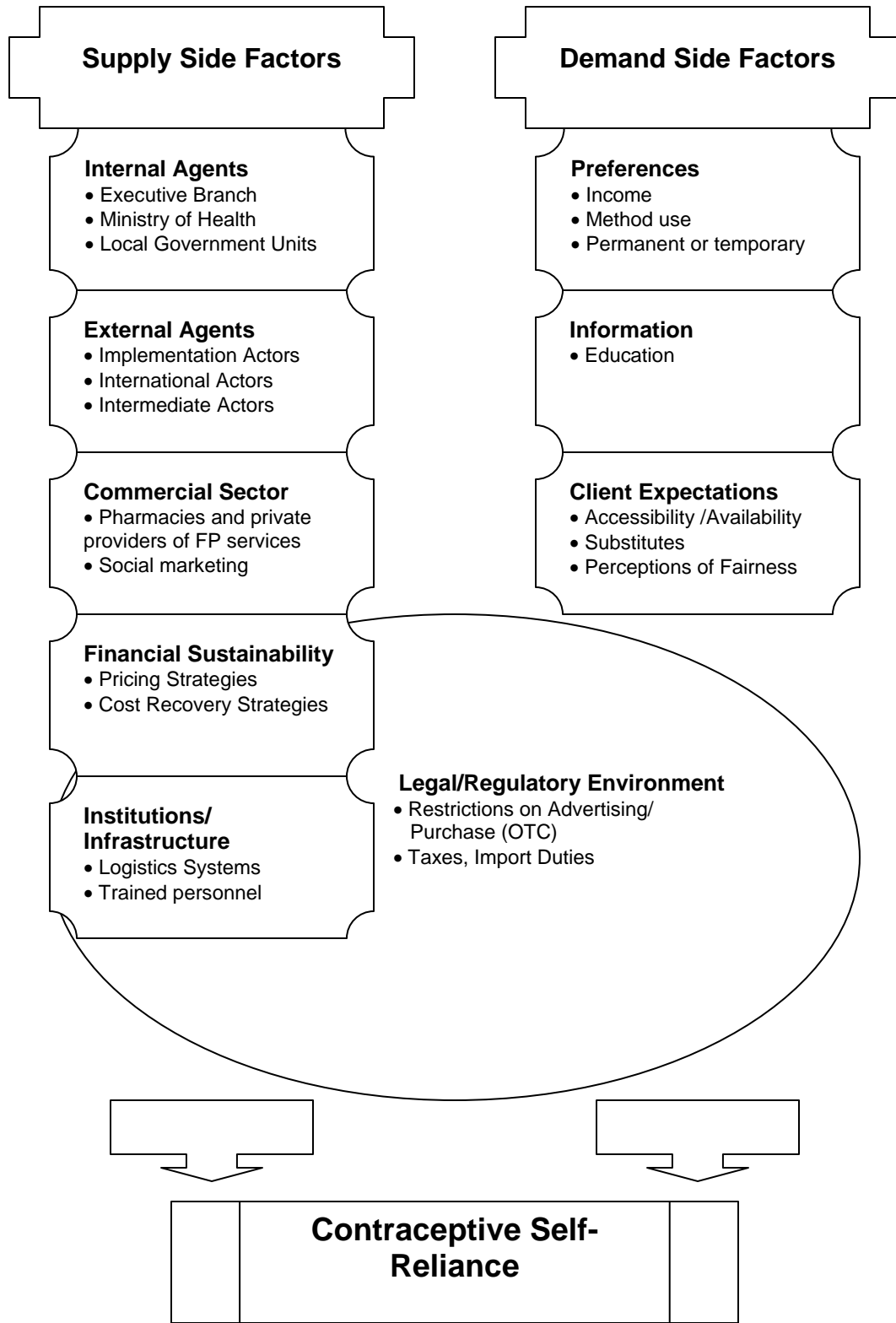
Ministry of Health (MOH)

Generally, the Ministry of Health oversees family planning and public health policies. The responsibilities of the central MOH may be affected by decentralization or other institutional constraints.

Local Government Units (LGUs)

A decentralized country, like Brazil, India or the Philippines, introduces a new set of actors or agents into the policy sphere. Decentralization affects questions of resource allocation, operational control and accountability.

Diagram A. Political Economy Framework of Contraceptive Self Reliance Reform



External Agents

Implementation Actors

These actors – agents of policy change – include those individuals who, as providers of goods, services and resources, have direct control over some aspect of the design and implementation of CSR. They are highly accountable to the national government and are subject to its laws, regulations, and policy directions. Among the group of national implementation actors are: payers (government and private insurers), regulators, private and public sector providers (doctors, midwives) of FP products and services, and local NGOs that operate within the confines of national regulations.

International Actors

International actors may support CSR, but they neither have direct control over policy design nor are they highly accountable to the national government. Because international actors usually participate in at the request of the national government, they have are not highly autonomous from the national government. International actors may include social marketing companies (such as DKT), international donors (such as the United Nations Family Planning Agency or the World Bank) and foundations, and providers of technical assistance services. If international organizations have a local affiliate office (such as the International Planned Parenthood Foundation – IPPF) which is involved with the direct provision of goods and services and subsequently subject to government regulations, etc, then the local affiliate would be included in the category of national implementation actors.

Intermediate Actors

This group of stakeholders enjoys high levels of autonomy from the national government and low levels of accountability. They have no direct control over CSR policy- or the delivery of goods and services so the presence or absence of their support does not affect service delivery. Included among this group are media representatives, communications experts, religious groups (including the Catholic Church) and social mobilization and education/awareness groups (that are not involved with the direct provision of FP commodities and services). While these groups may not have any direct control over CSR policy, the government may want to incorporate their support and participation in FP policy and CSR strategies. In the face of weak executive level or national

Commercial Sector Actors

Donor contributions have not kept pace either with their own commitments or the global demand for reproductive health (RH) supplies, leading to projections of a donor gap of US\$140-210mn for commodities financing by year 2015. It has been noted that commercial sector usually plays an important role in providing contraceptives in low prevalence countries.⁴

⁴ Foreit 2002.

Among the group of external agents, private or commercial sector actors are responsible for the manufacture, distribution and/or sale of FP products (and services).⁵ They are subject to national laws and regulations. The degree of commercial sector participation is sensitive to market structure (i.e. degree of competition), pricing strategies and relationships with the public sector. Among the group of commercial sector agents are: private manufacturers, distributors, resource suppliers (pharmaceutical companies), and social marketing companies (companies which provide health/RH/FP commodities at subsidized prices to rural and low-income clients).

Financial Sustainability

Financial sustainability is a critical component of achieving contraceptive self-reliance. Financial sustainability requires mobilization of public and private financial resources to fund the procurement of the current and anticipated future demand for quality family planning commodities. Commercial sector actors will only be able and willing to supply FP products if they can recover their costs. In addition, in low-income countries that have social marketing programs, high levels of cost recovery in the public sector will make the commercial sector immediately price competitive with the public sector (Winfrey 2000). This means that CSR reform efforts will have to propose pricing and cost recovery strategies that provide incentives to guarantee a stable supply of FP commodities. Achieving financial sustainability requires cooperation between governments, public and private health care providers and suppliers of contraceptives.

Institutional Factors/Infrastructure

Institutional stability relates to the capacity of human resources and health systems (including public and private family planning institutions) to supply FP clients with quality services and contraceptives on a continuous basis (without interruption) wherever they are requested. The importance of institutional stability is reflected in DELIVER's slogan, "NO product, NO program." Efforts to ensure the institutional sustainability of CSR strategies involves cooperative arrangements between government units, public health care providers, resource suppliers and providers of technical assistance and other human resources.

2.4 Demand side factors

Preferences

Demand for FP commodities and services is influenced by micro-economic or household factors, including household income and ability to pay (Conteh 2003, Sharma 2005). In order to sustain demand, governments and public and private providers have to be able to provide contraceptives to those individuals who want to use FP services and commodities, but cannot afford to pay for them. Consumers must also have access to their desired commodity mix (i.e.

⁵ The private or commercial sector includes social marketing companies but does not include NGOs like IPPF.

temporary v. permanent, condom v. injectable). For instance, CSR policies that only provide condoms when the preferred method of choice is OCs are ineffective and will result in user fall out. In order to meet the objective of sustaining demand and ensure that the limited supply and mix of free contraceptives is available to those who want and need them, governments must segment the market based on income classification (or means test) and work with public and commercial providers to target the provision of free or low cost commodities to the poorest. Targeting and market segmentation are two of the most important tasks governments can do to move towards CSR. This aspect of maintaining (and increasing) demand involves collaborative relationships between clients, payers (all levels of government), health care providers and suppliers of FP commodities.

Information

Sustaining demand requires that consumers have access to information about FP products and services. Policy makers must dedicate resources and work with public and private sector providers conduct campaigns to raise public awareness about the benefits of FP, educate citizens with accurate information, address concerns related to belief systems and clarify new CSR reforms. Many countries have used health promoters and/or community based distribution systems to promote and sponsor information, education and communication (IEC) activities and outreach on issue of FP.

In addition, studies have found that higher level of knowledge is associated with greater use of the commercial sector (Winfrey 2000). Countries like Bangladesh have found that health promoters (promotores) and community based distribution (CBD) systems have a positive relationship with higher contraceptive prevalence rates (CPR). Increasing demand for FP services and products requires collaborative efforts between clients, payers (all levels of government), health care providers and suppliers of FP commodities.

Client Expectations

Demand patterns are shaped by future expectations about the supply of goods. Sustaining demand for FP services and products requires management of client expectations regarding the availability of and accessibility to FP products and services and their substitutes. Policymakers must work with commercial and public providers to guarantee a stable supply of a mix of FP commodities. In addition, governments must strive to ensure that FP products and services are widely available, even in rural, isolated, less densely populated areas. Another factor affecting demand is the consumer's expectation that policies are fair and transparent. In Bangladesh, consumers that felt as though new reform policies were unfair or lacked transparency were likely to discontinue using FP commodities (Bates 2003). As such, policymakers (including LGUs) must guarantee that CSR policies are fair, that goods are equally accessible (eve in rural, isolated areas), and publicize new CSR policies to promote transparency.

2.5 External Environment

Socio-Political, Legal and Regulatory Environment

The legal and regulatory environment affects both the supply and demand.

Legal factors include the specific national policies, laws and regulations that promote, allow and sustain access to FP commodities and services. Specific political and legal and regulatory factors can constrain the adoption and implementation of CSR. Among these include sales tax, import duties, restrictions on advertising and marketing, laws that restrict cost recovery schemes in public health facilities and protectionist laws that require purchase of locally manufactured products. Governments should work with commercial sector to ease restrictions and increase incentives, including a reduction of unnecessary taxes and tariffs on contraceptives, and reform legal and regulatory barriers. Governments should also assess laws that restrict financing or allocation of resources and laws that hinder purchase of FP commodities.

2.6 Measures of Policy Success

Designing effective policies which support long-term sustainability of the project require that CSR programs and initiatives have clearly articulated goals or optimal strategies. More importantly, CSR strategies must delineate a set of indicators by which policymakers can regularly assess or measure access. Constant, real time feedback is required to achieve sustainability so that policymakers can intervene before health care providers reach stock-outs or before supplies are lost due to waste.

Some indicators of success include:

- **Reduction of Unmet Need.** Unmet need is defined as married women who are not using any method of contraception but do not want any more children or want to wait at least two more years before their next birth. Successful CSR strategies should lower unmet need. This is one of the most widely used measures of performance.
- **Contraceptive Prevalence Rate (CPR).** The proportion of all currently married women of reproductive age (aged 15 to 49 years) reporting current use of any (modern or traditional) contraceptive method. Successful CSR reforms should be associated with a higher CPR. This is the indicator most commonly used to measure success of FP programs and initiatives.
- **Government funding for contraceptives.** This indicator reflects that total combined (federal, state, local) public expenditure on FP commodities. As countries become more self sufficient while sustaining CPR and reducing unmet needs, public expenditure on FP commodities should increase.
- **Commercial Market Share of FP Commodities.** Commercial market share is the percentage of modern contraceptive users who are served by

the commercial sector, relative to other sources of supply. As countries move towards contraceptive self-reliance and target limited provisions to the poorest consumers, wealthier consumers who are currently seeking FP commodities at public health facilities will be shifted to the commercial sector. As the government limits its role, it will provide enabling environment to support the growth of the commercial sector providers of FP commodities and services.

- **Dependence on foreign donors.**⁶ This indicator reflects the level of donated FP commodities received from international agencies and organizations. As countries move towards CSR and rely on the commercial sector, levels of foreign donations should fall.

2.7 Conclusion

The objective of this comparative review is to assess developing countries' experiences with the design and implementation of contraceptive self-reliance – with its dual objective of providing free FP commodities to those with the greatest need and closing the gap on unmet need, – while facing rising financial costs. As discussed above, there are several moving parts that influence the design, implementation and sustainability of CSR strategies, the configuration of which ultimately result in more (or less) successful outcomes. National policymakers must design CSR strategies in such a way that retain the support of powerful actors to promote and sustain CSR, provide for long term sustainability of the provision of FP commodities, reconfigure the private-public relationship, and respond to the challenges and opportunities presented by the external environment. While it is difficult to determine *ex ante* which factors will result in more desirable outcomes (measured as higher CPR), this study uses the loose analytical framework to identify and isolate the micro foundations of CSR strategies.

⁶ While this is a possible performance indicator, this report does not report this figure for any of the country case studies presented here.

III. Methodology

The information presented in this project was compiled using primary and secondary sources. Specifically, the information was analyzed following an extensive review of published and grey literature from project reports, newsletters, policy papers, unpublished conference papers, journal articles and news articles. Much of the information was gathered from leading organizations in policy area of family planning, reproductive health and contraceptive security including, but not limited to, Commercial Market Strategies (CMS), DELIVER, the Futures Group, John Snow Inc. (JSI), the POLICY project, the Population Technical Assistance Project, the United States Agency for International Development (USAID), and the World Health Organization (WHO). In addition, the review was supplemented with interviews and direct correspondence with some of the authors of the POLICY PROJECT reports and studies.

IV. Data

Measuring and comparing the impact of FP programs and CSR strategies is difficult in part because of the poor data on unmet need and CPR, two of the most commonly used performance indicators. CPR is not measured annually, which makes it difficult to assess the impact of specific policy changes. Nor is the DHS survey, from which CPR is derived, carried out in the same year in each country. This makes it difficult to undertake cross-country comparisons.

Data for the less frequently used performance indicators is even more difficult to find in time series or for a large number of countries. For instance, this report presents data on the size of the commercial market, which was calculated prior to the implementation of CSR strategies. Thus, the impact of CSR on the growth of the commercial sector remains unknown, at least for a wide sample of countries.

In this section, data is presented on levels of unmet need, CPR and commercial market share of FP commodities:

- **Levels of Unmet Need.** Unmet need is defined as married women who are not using any method of contraception but do not want any more children or want to wait at least two more years before their next birth. Successful CSR strategies should lower unmet need.
- **Contraceptive Prevalence Rate (CPR).** The proportion of all currently married women of reproductive age (aged 15 to 49 years) reporting current use of any (modern or traditional) contraceptive method. Successful CSR reforms should be associated with a higher CPR.
- **Commercial Market Share of FP Commodities.** This indicator reflects the extent of commercial sector participation in the provision of FP commodities. (The private or commercial sector includes social marketing companies but does not include NGOs like IPPF). As countries move towards contraceptive self-reliance and target limited provisions to the poorest consumers, wealthier consumers who are currently seeking FP commodities at public health facilities will be shifted to the commercial sector. As the government limits its role, it will provide enabling environment to support the growth of the commercial sector providers of FP commodities and services.

CSR should be measured using as many variables as possible. A focus on one particular indicator may be misleading. For instance, the commercial sector in Paraguay serves roughly 60 percent of contraceptive users, with 43 percent of those individuals using pharmacies. The growth of the commercial sector resulted from frequent contraceptive stock outs in the public sector and a hostile political environment that did not support FP. While one of the goals of CSR is commercial sector development, in Paraguay, the unfortunate result has been

high levels of unmet need (27 percent) among the lowest two quintiles as FP products at pharmacies are too expensive for the neediest.

For the sake of comparison, the report presents data on the those countries included in our set of country case studies selected in our cases, as well as other developing countries.

Table 1. Contraceptive Prevalence Rates for married women ages 15-39

Country	CPR WB 1970s	CPR WB 1980s	CPR WB (last year available)	CPR UNFPA (last year available)	CPR UNFPA* (last year available)	Unmet Need DHS (1985-1994)	Unmet Need UNFPA (last year available)
Bangladesh		28.2	54 (1999)	54	43	24% (1994)	15.3%
Bolivia		28.1	58 (2003)	53	27	24% (1994)	22.7%
Colombia	42	57	77 (2000)	77	64	16% (1990)	6.2%
El Salvador	28	47	67 (2003)	60	54	22% (1985)	18%
Ghana	9.5	12.9	25 (2003)	22	13	37% (1994)	23%
Jordan	23	26	56 (2002)	56	41	23% (1990)	11%
Kenya		22	38 (2003)	39	32	32% (1993)	24%
Mexico	38	50.3	70 (2000)	68	60	27% (1987)	-
Morocco	19	31	63 (2003)	50	42	20% (1992)	19%
Peru	25	43.4	69 (2000)	69	50	16% (1991)	10%
Philippines	28	34	49 (2003)	47	28	26% (1993)	19%
Romania	58		64 (1999)	64	30		
Thailand		65	72 (2000)	72	70	12% (1987)	-
Tunisia	34	45.5	66 (2000)	60	51	20% (1988)	39%
Turkey		62.2	64 (1998)	64	38	12% (1992)	10.1%

* Reflects MWRA who use *modern* methods. All other CPR figures reflect both modern and traditional.

Note: UNFPA did not report the data year in which their estimates are based.

Sources: <http://www.unicef.org/pon95/fami0007.html>
<http://www.unfpa.org/profile/tunisia.cfm>
<http://www.inforhealth.org/pr/J43/j43table.shtml>

As Tables 2 and 3 indicate, the size of the commercial market and the oral contraceptive (OC) market vary widely.

Table 2. Commercial Market Sizes, A Cross Country Comparison

Region	Country	Market Share ^a	X	Modern Prevalence	=	Market Size ^b
Latin America	Bolivia 1994	62.0	x	17.8%	=	11.0
	Brazil 1991	38.0	x	53.7%	=	20.4
	Colombia 1995	42.9	x	59.3%	=	25.4
	Dominican Republic 1991	52.7	x	51.7%	=	27.3
	Ecuador 1987	35.7	x	35.8%	=	12.8
	El Salvador 1985	10.4	x	44.3%	=	4.6
	Guatemala 1987	25.9	x	19.0%	=	4.9
	Paraguay 1990	66.4	x	35.2%	=	23.4
	Peru 1991	38.1	x	32.8%	=	12.5
	North Africa/ Middle East	Egypt 1992	54.1	x	44.8%	=
Jordan 1990		44.2	x	26.9%	=	11.9
Morocco 1992		33.4	x	35.5%	=	11.9
Tunisia 1988		22.5	x	40.4%	=	9.1
Turkey 1993		43.4	x	34.5%	=	15.0
Southeast/ East Asia	Bangladesh 1993	15.1	x	36.2%	=	5.5
	Indonesia 1994	28.3	x	52.1%	=	14.7
	Philippines 1993	26.2	x	24.9%	=	6.5
	Thailand 1987	15.5	x	63.6%	=	9.9
Sub Saharan Africa	Burkina Faso 1992	9.6	x	4.2%	=	0.4
	Ghana 1993	47.8	x	10.1%	=	4.8
	Kenya 1993	14.0	x	27.3%	=	3.8
	Niger 1992	4.0	x	2.3%	=	0.1
	Nigeria 1990	40.2	x	3.5%	=	1.4
	Senegal 1992	30.0	x	4.8%	=	1.4
	Tanzania 1992	3.9	x	6.6%	=	0.3
	Togo 1988	26.3	x	3.1%	=	0.8
Zambia 1992	37.9	x	8.9%	=	3.4	

^a Commercial market share is the percentage of modern contraceptive users who are served by the commercial sector, relative to other sources of supply.

^b Commercial market size is defined as the percentage of all married women of reproductive age who are served by the commercial sector

Source: Winfrey et al, 2000. Factors Influencing the Growth of the Commercial Sector.

Table 3. Market Size and Shares for Oral Contraceptives: A Global Comparison

Region	Country/ Survey Year	Year 2000 Market Size ^a		Provider Share ^b		
		Projected Prevalence	Projected Users (,000)	Public	Commercial	NGO
South America	Bolivia 1998	3.7	49	19.0	78.1	0.0
	Brazil 1996	20.3	7,462	8.0	89.5	0.9
	Colombia 1995	13.0	989	5.3	92.1	1.0
	Ecuador 1999	10.9	220	18.7	72.9	7.1
	Paraguay 1998			27.0	60.0	13.0
	Peru 1996	6.8	301	58.1	34.3	3.7
Caribbean	Dom. Rep 1996	13.2	193	18.3	64.3	12.5
Central America	El Salvador 1998	9.7	107	49.4	13.1	35.0
	Guatemala 1999	4.9	88	20.7	27.8	43.9
	Honduras 1996	10.8	105	19.1	32.1	41.7
	Nicaragua 1998	13.5	105	53.4	34.3	7.8
Asia and Middle East	Bangladesh 1997	22.2	6,043	67.1	27.6	0.4
	Egypt 1998	11.1	1,339	8.0	88.0	0.4
	Indonesia 1997	19.5	7,510	60.3	12.0	1.8
	Philippines 1998	10.3	1,222	76.4	22.3	0.1
	Turkey 1998	5.6	699	26.0	73.6	0.0
	Yemen 1997	3.6	177	49.3	43.1	2.2
Sub Saharan Africa	Burkina Faso 1999	4.6	122	85.2	8.9	1.0
	Ghana 1998	4.9	202	34.7	53.2	3.1
	Kenya 1998	9.1	510	52.8	30.5	7.4
	Mozambique 1997	2.0	98	70.9	16.0	1.5
	Niger 1998	3.9	85	79.7	18.4	0.0
	Senegal 1997	4.1	74	73.6	17.8	7.9
	Tanzania 1999	6.5	443	79.3	8.6	9.3
	Togo 1998	2.0	22	36.7	46.9	4.1
Zambia 1996	8.4	131	74.9	15.6	6.1	

^a Commercial market size is the % of all MWRA who are served by the commercial sector

^b Commercial market share is the % of modern contraceptive users who are served by the commercial sector, relative to other sources of supply.

Source: Foreit 2002; Paraguay data from Regional Contraceptive Security Feasibility Study, JSI/DELIVER and Futures Group/POLICY.

Note: Commercial providers may include both commercial and subsidized products (i.e. social marketing and/or brands donated to the public/NGO sectors).

V. Comparative Review of Policy Adoption and Implementation in Countries with Experience of Contraceptive Self-Reliance Strategies

More than a dozen countries have initiated contraceptive self-reliance security programs in response to the phase-out of externally donated FP commodities. Some countries, including Peru and Turkey, have completed the phase-out. Others, like Bangladesh, Ghana and Kenya, are in the process. Using the framework discussed above, this section presents a comparative review of CSR policy adoption in these countries, identifying the strategies employed by policymakers and the critical challenges posed to their implementation. Each country case study reviews the external environment, actors, and strategies that promote demand, financial and institutional sustainability. Colombia, Peru, Thailand, Tunisia and Turkey, it is argued, are countries that have had successful experiences with CSR because they continue to serve their traditional clients and show no signs of measurable decline. For the others, it is too early to measure success. For instance, in Kenya, the program continues but depends on other donor support for contraceptives and on USAID support for logistics management inputs.

BANGLADESH

CPR WB 1980s	CPR WB 1999	CPR UNFPA (last year available)	CPR UNFPA* (last year available)	Unmet Need DHS 1994	Unmet Need UNFPA (last year available)
28.2	54	54	43	24%	15.3%

* Reflects MWRA who use *modern* methods

Note: UNFPA did not report the data year in which their estimates are based.

Summary

The case of Bangladesh illustrates that while the national government has made FP and CSR a priority, it has not dedicated sufficient resources to achieving financial and institutional sustainability of CSR. Consequently, Bangladesh's CSR program has stalled. Additionally, the experience of Bangladesh demonstrates the NGO support is important at all stages of design and implementation of CSR strategies.

Bangladesh is a success story in CPR. In 1975, Bangladesh's CPR rate for any method was 7 percent. Recognizing the implications on long-term economic development, the national government made FP a priority during the 1980s. Bangladesh's FP program was designed to comport with conservative Islamic tradition. For instance, field workers delivered contraceptives to individual homes, allowing women to stay within their home, per religious law. It launched a task force and established Bangladesh as one of the first developing countries to incorporate contraceptive security into its overall FP policy. By 2000, this rate

had increased to 54 percent and was almost 60 percent (58 percent) in 2004.⁷ In 1994, unmet need was 24 percent.

Supply Side Factors

Internal Agents

Executive Branch

In launching its CSR program, the government produced a contraceptive security concept paper and organized seminars to raise public awareness. In 2002, the Bangladesh Ministry of Health and Family Welfare sponsored a workshop in which 200 stakeholders (including government representatives, health care providers, and international experts) gathered and developed twenty concrete strategies to attain contraceptive security. A task force grew out of the workshop and outlined and initiated practical steps to implement the strategies. This formal strategy session and subsequent task force helped establish Bangladesh as one of the first developing countries to incorporate contraceptive security into its overall FP policy.

External Agents

International Actors

Prior to health sector reform, twenty-six different donors funded over 100 health programs in collaboration with the government. NGOs continue to play a large role in providing services (and are even encouraging women's economic development through micro-credit programs), evidenced by the fact that more than 80 percent of all contraceptives in public facilities were procured directly by donor agencies. The remaining 20 percent were secured by the government through World Bank (WB) loan credits.

Recently, Bangladesh has tried to promote FP within the larger context of health care reform. These reform efforts have been facilitated by new forms of assistance offered by international donors and financial institutions (such as the World Bank) which provide opportunities to address health care reform. For instance, the mechanism of pooling of funds for sector-wide programs (SWAp) can enable countries to procure substantial quantities of contraceptives. However, new financing mechanisms also bring new challenges. Movement away from direct program with specific targets and allowances support towards a macro-sector focus may mean that RH and FP programs are orphaned. In the absence of earmarked funds, competition over funding priorities may undermine FP financing. While issues concerning CS are prominent in the Bangladesh SWAp and the PRSP provides for the subsidized distribution of OCs as part of poverty reduction strategy, the FP policies are discussed in broad terms. Finally, an emphasis on poverty implies that governments must focus on programs that reduce poverty (so as to achieve goals).

⁷ http://w3.whosea.org/en/Section260/Section1808/Section1935/Section1936_9144.htm

Commercial Sector and Financial Sustainability

Objective: Ensure that private providers of contraceptives achieve financial self-sufficiency

Strategy: Successful cost recovery schemes

As part of its broader FP program and CSR strategy, Bangladesh established the Social Marketing Company (SMC), a privately managed non-profit organization that accounts for 29 percent of the nation's contraceptive prevalence for modern methods. The SMC offers products that are priced low (subsidized to help the poor) or moderately (where the brands break even or even generate minimal profits). The SMC is continuously trying to innovate. For instance, the SMC and Wyeth-Ayers International signed an agreement in 2002 for marketing Nordette oral contraceptives over the next two years. Unfortunately, even after health sector reform, few donors provide any direct procurement of contraceptives. Most donor agencies now pool funding under a single umbrella. The SMC continues to be dependent on donations. Currently, the SMC is exploring ways to segment the market and categorize products so as to maximize cross-subsidies for products intended for the poor. It is also considering plans to directly procure the majority of its FP products and raise prices to cover more of the company's overall costs.

Institutional Factors/Infrastructure

Objective: Procure the country's own contraceptives and guarantee long-term stability of contraceptive supply

Strategy: Improve logistics system and supply chain management

Although committed to FP and CSR, the government of Bangladesh was unprepared to move forward on the technical aspects of CSR—namely the procurement process. Few resources were dedicated to the improvement of the management of the supply chain and related logistics management information systems (LMIS). Briefly, an efficient LMIS can help health program managers improve their systems by reducing commodity costs, enhancing program management, informing policymakers by providing decision making data, providing better customer services, and allowing greater control of contraceptive flows and accountability of donated contraceptives. Not surprisingly, the failure to provide local health managers with technical assistance on the demands and requirements of implementing and managing the procurement system has resulted in stock-outs and waste.

With support from USAID (through DELIVER), Bangladesh implemented the Family Planning Logistics Management (FPLM) project. The initial evaluation confirmed that while stores and warehouses used good warehousing practices, low and inadequate supplies of contraceptives were found. To remedy the shortcomings, the project has provided technical assistance to health managers to carry out the procurement process, a database to track commodity procurements, the creation of manual to explain procurement process, procurement training for shopkeepers and related stakeholders. Currently, Bangladesh is engaged in efforts to improve its supply chain management on a national level, including the creation and systemization of 5-year procurement

cycles and rolling forecasts. In addition, the country is consolidating the supply chain at the higher level, while expanding storage and warehousing units at the local (district) level. While storage conditions have improved, there are still significant barriers, including the absence of a procurement agent and the failure to institutionalize some of the functions.

Demand Side Factors

Preferences and Expectations

Objective: Increase CPR and reduce unmet need

Strategy: Segment the market to determine who can afford to pay and shift them to private sector; shift users from temporary methods to permanent methods

While the government has undertaken several initiatives to raise awareness and maintain demand, including the formation of a working group and a change in service delivery policy, it has not taken steps to ensure in practice that the contraceptive supply remains secure and that demand will be met. A country of 133.3 million, it is estimated that the cost of contraceptives needed annually is US\$30 million and expected to double in the next 15 years. Studies indicate that Bangladesh needs to improve segmentation of family planning market to mobilize more household financing and make more effective use of public subsidies.⁸

Second, the country has not fully developed alternate means of procuring contraceptives, i.e. private sector involvement and campaigns to encourage individuals to switch to more permanent methods of FP options. (Currently, more than 75 percent of contraceptives are for temporary methods.) One of the factors stalling Bangladesh's program is that it is moving from "doorstep" service delivery to clinic-based delivery.⁹ In 1996-97, 35 percent of married women were visited by a FP promoter; in 1999-2000, only 21 percent of women were visited by the promoter.¹⁰

A recent study finds that despite the change in service delivery, women switched to new sources of contraceptive supply (some private) and that overall CPR was maintained. Within two years of the shift away from doorstep delivery service, satellite community clinics became the source of contraceptives for one-third of

8 Schuler, S.R. et al. Reconciling cost recovery with health equity concerns in a context of gender inequality and poverty: findings from a new family health initiative in Bangladesh. *International Family Planning Perspectives* 28(4):196-204 (2002).

9 Interestingly, Bangladesh is moving to clinic based delivery even though recent research indicates that it is more cost effective to do doorstep outreach (because of the demand for services and products). Levin, A. et al. Cost-effectiveness of family planning and maternal health service delivery strategies in rural Bangladesh. *International Journal of Health Planning and Management* 14:219-233 (1999). He notes: While delivering services at a centrally located neighborhood spot reduced travel time for providers, the approach was less cost-effective compared with home delivery of services because clients' attendance was low. Increasing the frequency of outreach clinics and adding immunization to the services offered generally did prove more cost-effective than static clinics, probably because of increased demand for services.

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users, and a steady increase in the use of shops and pharmacies continued. Data suggest that where community clinics are made operational, women will use them and they have not become dependent on home delivery of contraceptives.¹¹

Another survey based study (Bates et al 2003) also found that women were likely to discontinue using FP commodities under the new system when they reported a perceived unfairness of user fees (either because the new policies lacked transparency and/or the criteria used to determine who would receive free/low-cost FP commodities seemed arbitrary (Bates 2003). In other words, the Bangladesh experience indicates that changes in policies must aim for transparent implementation with well-defined criteria.

BOLIVIA

CPR WB 1980s	CPR WB 2003	CPR UNFPA (last year available)	CPR UNFPA* (last year available)	Unmet Need DHS 1994	Unmet Need UNFPA (last year available)
28.1	58	53	27	24%	22.7%

* Reflects MWRA who use *modern* methods

Note: UNFPA did not report the data year in which their estimates are based.

Summary

The case of Bolivia demonstrates that even in a country in which the political will to support FP and CS has been absent, it is possible to promote and adopt FP and CSR policies. While Bolivia does not receive external donations of FP commodities from USAID, it received, until 2004, donations from the U.K.'s Department for International Development (DFID) and the Canadian International Development Agency (CIDA). It is nearing the end of the phase-out of externally donated contraceptives. Unmet need (based on DHS data) was 24 percent in 1996.

Bolivia's current commitment to improve RH and FP services is a significant departure from the 1970s when FP clinics were closed and the FP component of the MOH's maternal and child program was eliminated. Throughout the 1970s and 1980s, quiet attempts were made by private clinics and NGOs to supply contraceptives. Nevertheless, the incidence of abortion rose. In 1989, a momentous "Workshop to Fight Against Abortion" was held with the support and participation of the Catholic Church, leftist labor interests, women's organizations and the political parties. Soon after, the government moved to insert an FP component into the National Plan for Child Survival and Maternal Health (NMCI)

11 Centre for Health and Population Research. 2003. Use of Family Planning Services in the Transition to Community Clinics in Abhoynagar: 1998-2002.

and approve the provision of voluntary FP services (thus making it possible for FP clinics to reopen). The government consolidated RH and FP policies in the 1990s, with the backing of legislation that emphasized participatory government and decentralization. The public sector created new mechanisms for financing health services and working with the private sector to deliver health care services. In 1998, the government-run Basic Insurance Program (SBDS) included provisions for FP. In 1989, the CPR for all methods was 30.3 percent; by 1998, the rate had climbed to 48.3 percent, but only 25 percent for modern methods.¹² As a reflection of its commitment, Bolivia has a line item for the purchase of contraceptives in its national budget.

Supply Side Factors

External Agents

Implementation Actors

PROSALUD is a nonprofit organization that manages an innovative network of high-quality, low-cost, client-focused services which target the unmet needs of Bolivia's low-income populations. Established in 1985, PROSALUD was the result of a public-private partnership to establish and operate primary health care services in Santa Cruz. The goal of this collaboration between the public and private sectors was to improve access to basic health services and increase their quality while decreasing costs and inefficiencies. Financial sustainability was the product of good management and a strategy of cross-subsidization, through which those who can afford to pay for services subsidize services for those who cannot. Fees for curative services also subsidize free preventive services, and revenues from clinics in better-off areas help support clinics in poor areas. Initially, PROSALUD faced many obstacles, the first of which was gaining the participation of the community. In 1985, the USAID-funded Self-Financing Primary Health Care Project that was the precursor of PROSALUD failed because it had not been able to reach an agreement with a group of rural and urban cooperatives that were intended to be the target population. USAID has provided PROSALUD with donated commodities; it will continue to provide donations through 2008.

Financial Sustainability

Objective: Ensure that private providers of contraceptives achieve financial self-sufficiency

Strategy: Successful cost recovery schemes and social marketing

The Center for Investigation, Education and Services (CIES), the leading nonprofit institution offering RH services and education in Bolivia, has prioritized outreach to rural and low-income women. In addition to the clinics and mobile units that it currently runs, CIES opened a set of "social pharmacies" in 2000. Prior to launching the project, CIES conducted a market study on which segments of the population to target, how to promote its strategies, which medications to provide, and what quantity to purchase for maximum profit and

¹² These figures differ from those reported in Table 1 because Table 1 figures are averaged over 1980s and 1990s.

efficiency. CIES reports that the pharmacies are already covering its operational and financial costs.

In a similar effort to achieve financial sustainability, the national government intends to begin charging municipalities for contraceptives and condoms for the purpose of establishing a revolving fund at the national level for future purchases of contraceptives. Municipalities can use funds from the Infantil Maternal Universal Insurance (Seguro Universal Materno Infantil --SUMI) to purchase commodities.

COLOMBIA

CPR WB* 1970s	CPR WB* 1980s	CPR WB* 2000	CPR UNFPA (last year available)	CPR UNFPA* (last year available)	Unmet Need DHS 1990	Unmet Need UNFPA (last year available)
42	57	77	77	64	16%	6.2%

* Reflects MWRA who use *modern* methods

Note: UNFPA did not report the data year in which their estimates are based.

Summary

Colombia has completed the phase-out and as such, no longer receives USAID donated FP commodities. This case study demonstrates the importance of diversifying resource bases and encouraging private providers (NGOs) to provide contraceptives. It also illustrates that CSR can be achieved even in the absence of support from the national government and Catholic Church if a broad range of civil society actors support it. Unmet need was 16 percent in 1990 (based on DHS data).

Sharing many similarities with the Philippines, Colombia country has never had an official population policy or consistently strong support from the government. And the Catholic Church has always opposed artificial methods of birth control. But, civil society has long recognized the importance of universal health care and has successfully lobbied for it. Health sector reform has led to more financial resources for health care, decreased donor dependence, broad-based support for health promotion and preventive care, and special attention to underserved groups. The support for health care reform extended to FP services. Private physicians, who serve about 10 percent of Colombia population in general health and contraception, have been very supportive of FP. Scientific medical associations and professional unions supported and defended FP programs when necessary. The commercial sector manufactured contraceptive products locally. And the communications media promoted the development of FP and sex education programs. In 1965, the CPR for all methods was 27 percent; by 1997, it was 74 percent and 78 percent in 2000.

Supply Side Factors

External Agents

Implementation Actors

Many observers claim that Colombia's success in the increase of CPR (70 percent) has to do with Association for the Well-being of the Colombian Family (PROFAMILIA), a private non-profit association affiliated with the International Planned Parenthood Foundation. PROFAMILIA became Colombia's most effective private sector program, serving a larger proportion of the country's population (70 percent) than does any other private organization in the world.

PROFAMILIA began as a clinic based organization to provide FP services, but over time it tested various strategies for improved service delivery. The clinic model evolved to provide better service to Colombia's large rural population (48 percent of total). In 1970, working with Federation of Coffee Growers (FNC), PROFAMILIA established the first rural Community Based Distributors (CBD) program, the first of its kind in the world. Because of link to FNC, family planning was seen as a part of integrated rural development. Rural field workers became full-time employees of PROFAMILIA and contraceptives were distributed by volunteers. PROFAMILIA later launched an urban CBD which depended on (female) shopkeepers. It also started a contraceptive social marketing (CSM) program, in addition to its mobile services and targeted outreach to males. PROFAMILIA changed the role of providers: non-medical CBD workers and paramedical personnel were permitted to provide OCs to women without a medical prescription.

PROFAMILIA maintains extensive coverage by providing direct services and managing service contracts with other institutions and commercial outlets. The market is segmented by ability to pay and other factors, and supplies are provided through many outlets, such as PROFAMILIA centers, private physicians, drugstores, and whole sale distributors. Extensive technical and financial assistance has enabled PROFAMILIA to expand its program and service delivery coverage. By emphasizing high quality services and goods, PROFAMILIA has stimulated demand for its programs. Innovative strategies in service delivery were combined with market strategies such as radio announcements and green flags outside service delivery locations and distribution points so that clients would know where to obtain FP information and services.

Intermediate Actors

Among the factors that contributed to the achievements in FP programs was the commitment made by a number of key Colombian institutions. Among them was the Colombian Association of Medical Schools (ASCOFAME). The deans of the medical schools of ASCOFAME set up the Division of Population Studies. From this base, the first FP services were initiated, along with the first demographic research and program evaluation studies. Teaching hospitals also played an

important role in developing FP service programs in 1960s and 1970s. Although student unrest curtailed FP activities during the 1970s, medical schools reintroduced courses on FP in the 1990s. The leaders of ASCOFAME, in concert with a number of private U.S. organizations (the Ford and Rockefeller Foundations) and U.S. universities supported training that produced a cadre of well-trained, committed Colombian professionals. This multidisciplinary team of sociologists, economist, lawyers, communications experts, physicians and nurses understood the serious population problems facing the country. Experts have commented that the investment in human resources during the first decade of family planning and population activities proved to be one of the most important contributions to the successful Colombian story.

Financial Sustainability

Objective: Achieve Financial sustainability

Strategy: Target services, expand product line, and diversify resource base

PROFAMILIA started another non clinical approach to service delivery through its contraceptive social marketing (CSM) program which involved the marketing, distribution and sale of contraceptives at subsidized prices to pharmacies, supermarkets, and other commercial outlets. By the 1980s, as contraceptive knowledge expanded, PROFAMILIA saw its profits tumble, the result of the the higher cost of acquiring contraceptives, the MOH's assigned selling price of certain "drugs" and the government's ban on the sale by non-profit organizations of donated products to wholesalers. In response to the challenge, PROFAMILIA reevaluated and came up with a community marketing approach in which it purchased pills from local distributor at wholesale price and then resold them, using the CBD promoters as its new sales force. The advantage for the pharmaceutical company was to broaden its market through PROFAMILIA's clinics and CBD network. In 1981, PROFAMILIA switched from employing its own sales staff to contracting with independent wholesalers, who were already wholesalers of other pharmaceutical products so that it could reduce costs.

PROFAMILIA has been successful in the areas of cost recovery, cost effectiveness and sustainability. During the 1990s, PROFAMILIA experienced a transition both in terms of its client population and the nature of its services. It was increasingly serving a more middle class population and offering a diversified range of reproductive health services. The transition was fueled by the need to become self-sustaining in anticipation of a substantial reduction in external assistance. Fortunately, PROFAMILIA has a strong record of financial solvency. From the outset, its service policies were informed by market segmentation analyses and targeting. To cover its costs, PROFAMILIA has charged fees for services (using some of the funds to cross-subsidize products for the poor), has developed an effective system for tracking "real" costs of services (by method, clinic and program or delivery strategy), and has strictly defined performance measures and assessed progress.

EL SALVADOR

CPR WB 1970s	CPR WB 1980s	CPR WB 2003	CPR UNFPA (last year available)	CPR UNFPA* (last year available)	Unmet Need DHS 1985	Unmet Need UNFPA (last year available)
28	47	67	60	54	22%	18%

* Reflects MWRA who use *modern* methods

Note: UNFPA did not report the data year in which their estimates are based.

Summary

In 1998, the US announced that it was phasing-out donated contraceptives to El Salvador. Subsequently, the U.S. has dedicated considerable resources helping the country's MOH build the capacity to forecast, finance and procure products. While the financing piece remains unresolved, this case study shows that considerable resources must also be expended on building political support, developing stakeholder capacity, and establishing the physical infrastructure necessary to support product availability. It also shows that health promoters (promotores) can help achieve demand sustainability. The CPR was 47 percent in 1988, 60 percent in 1998 and 67 percent in 2003. Estimates using DHS data show unmet need at 22 percent.

Political will has been an issue in promoting and sustaining FP and CSR strategies. MOH has consistently encountered difficulties getting adequate public resources. A commodities procurement agreement was signed by the MOH and UNFPA in February 2004, but when a new president (Saca González) was elected four months later, the MOH and key ministry personnel were replaced and it is unclear whether the new administration will implement the agreement and other contraceptive security initiatives.

Supply Side Factors

External Agents

Implementation Actors

Despite budget constraints which affect the availability of certain essential drugs in the country, the MOH has taken several steps to ensure contraceptive security. These include: the establishment of a new position of Manager of Women's Health within MOH; an agreement with UNFPA to procure contraceptives; and public resources to cover 10% of El Salvador's contraceptive requirements.

The three key stakeholders in El Salvador's family planning strategy are: the MOH, the Salvadorean Social Security Institute (SSSI) and the Salvadorean Demographic Association (SDA). The SSSI and the SDA are responsible for 17 percent and 16 percent of RH commodity distribution. Each agency has approached the phase-out in distinct ways. With USAID support, the MOH initiated decentralization in four specific administrative areas: supply management, human resources, maintenance and financing. USAID has strengthened the MOH contraceptive logistics system by training personnel,

contributing to a 29 percent increase in community-based contraceptive distribution by MOH rural health promoters.

The SSSI provides medical care to insured workers in El Salvador. While SSSI has been able to maintain financial sustainability, high product costs limit the SSSI's ability to assume a larger portion of FP market (although its share of the FP market did grow by 2 percent between 2001 and 2002). Both MOH and SSSI purchase contraceptives from local distributors and laboratory representatives. An affiliate of the IPPF, the SDA provides low cost FP services to lower middle class Salvadoreans. With contraceptive support from USAID which will enable it to generate income to cover 85 percent of operating costs, SDA's network of health outlets ("Profamilia") and its CBD program (CBD) will continue providing family planning services to rural women and extending family planning services to new users.

Institutional Factors/Infrastructure

Objective: Procure low cost contraceptives and develop budgets that accurately forecast needs

Strategy: Provide stakeholders with technical assistance and strengthen CBD logistics and management systems

After announcing its phase-out plan, the U.S. dedicated considerable resources to help El Salvador's MOH, which uses CBD, build the capacity to forecast contraceptive demand, finance and procure products. Given El Salvador's size, it does not have a problem with the transportation and delivery of contraceptives. But the public health system, divided into three networks, is surprisingly complex. Within each network are 28 regions or SIBASIs (Sistema Basico de Salud Integral) which are divided into sub-regions. Each SIBASI manages their portion of the national contraceptive procurement budget and is responsible for managing their stocks and reporting product usage to the MOH. One of the issues impeding CSR is that the MOH does not have a standard budget allocation method. Consequently, in order to define a procurement strategy, the MOH had to consolidate and align the budgeting requirements of finance, procurement and essential drug divisions. With PRIME II sponsored technical assistance, MOH has implemented a contraceptive logistics and information system, which includes a logistics manual, training of personnel, monitoring and supervising of the implementation of the system, and the development of two new performance management indicators to assess ``contraceptive security.

Demand Side Factors

Information

Objective: Ensure continued use of FP methods and fulfill unmet need

Strategy: Raise public awareness and provide information, services and goods through promotores

The private sector accounts for only one-fifth of FP services in the country. The MOH covers 47 percent of country's contraceptive needs, (equivalent to the percentage of Salvadoreans living below the poverty line). Central to MOH's

program is its health promoter (promotores) program that uses CBD. El Salvador initiated its promotores program in the 1970s to expand primary health care (PHC) services to poor and rural populations. MOH uses health promotores as full time salaried health care workers who conduct outreach home visits. USAID has consistently supported MOH promotores; a recent study found that USAID technical support has contributed to a 29 percent increase in CBD by rural health promotores.

NGOs, such as ADS, have also used promotores in their efforts to extend services to marginalized rural communities. However, in 1996, due to shortages in funding, the ADS promoter program was redefined. The ADS program now uses a strategy based on distribution posts in which the promoters provide services at their community locations, based on increased client accessibility. To conclude, a recent study suggests that the potential role of health promoters in sustaining demand is not insignificant: FP use was higher among women who were exposed to health promoters.

GHANA

CPR WB 1970s	CPR WB 1980s	CPR WB 2003	CPR UNFPA (last year available)	CPR UNFPA* (last year available)	Unmet Need DHS 1994	Unmet Need UNFPA (last year available)
9.5	12.9	25	22	13	37%	23%

* Reflects MWRA who use *modern* methods

Note: UNFPA did not report the data year in which their estimates are based.

Summary

Though Ghana never entered a formal contraceptive phase-out program, it no longer receives significant contraceptive donations from international agencies. The case of Ghana illustrates the importance of forming national, multi-stakeholder, multi-agency committees involving the highest levels of government to promote and sustain CSR strategies. It also highlights some of the innovative programs that private sector stakeholders have devised to achieve financial sustainability. Unmet need was 37 percent in 1994 (using DHS data).

Supply Side Factors

Internal Agents

Executive Branch and Ministry of Health

The environment in Ghana is very supportive of family planning. The President has actively promoted family planning, linking it to economic development and better access to services and quality of life. In the early 1990s, the government completed a six-year bilateral agreement to lower fertility through maternal and child health. One of the components was contraceptive procurement through the Contraceptive Procurement Project. In 1994, Ghana legislated the formation of the National Population Council to manage the population and family planning

agenda. Substantial resources were dedicated to sponsoring information and education activities. Efforts were also undertaken to develop a coordinated public-private sector family planning campaign. Supporting strategies included mass media and interpersonal components at the national and regional levels. The efforts seem to have influenced the desired end goal: the fertility rate has decreased from 5.5 percent in 1993 to 4.4 percent in 2003, and the CPR has doubled from 10 percent to 19 percent (although the some report 14.3 percent).

With assistance from international donors (DELIVER, USAID), Ghana was one of the first developing countries to incorporate contraceptive security into its overall FP policy. To implement its plan for contraceptive security, the Ghana Ministry of Health (GMOH) set up a national working group, the responsibility for which was charged with the MOH's Reproductive and Child Health Unit (RCHU). As a first step to deal with the shortages, the GMOH (GMOH) convened a workshop in 2002 that brought together the stakeholders, including Ministry representatives, donors, non-governmental agencies (NGOs) and technical agencies. The discussions raised public awareness and established consensus among different issues.

Out of the workshop emerged the creation of the Inter-agency Coordination Committee for Contraceptive Security (ICC/CS), which is responsible for developing a national strategy, monitoring the progress of other stakeholders, developing partnerships and channels of collaboration, and coordinating with the other partners involved in the process. The other goals are to help improve the availability of affordable and high quality contraceptive products and services, strengthen public-private partnership in the supply and delivery of contraceptives and help to implement reliable and efficient distribution networks. Membership of the ICC/CS is comprised of the Public Health Division of RCHU, the supplies directorate, private manufacturers and distributors, and other partners. In 2003, the ICC/CS created a core technical group whose mandate is to carry forward the issues identified in the workshop, promote collaboration and communication, and integrate the national CS strategy into the GMOH's program. While Ghana has driven the CSR program initiative, it has received support from the Summa Foundation, USAID, the Gates Foundation and technical assistance from USAID, MSH and CMS.

Efforts to achieve support FP were done in concurrence with broader health sector reform. Ghana signed onto a five year, sector-wide assistance health sector program of work (SWAp POW) (2002-2006) which is supported by a number of donors, including the U.K.'s Department for International Development (DFID), the Norwegian Development Agency (NORAD), the World Bank, the Netherlands Aid Agency (SNV), EU, USAID and the Japanese International Cooperation Agency (JICA). Unfortunately, these assistance programs have their set of challenges. Although Ghana has encouraged donors to pull funds into the health fund, FP continues to receive earmarked funding both within and outside of pooled funds. This limits the flexibility of the government to invest in

logistics systems or related services which support FP service delivery and procurement. While the SWAp POW includes efforts to expand and support RH, it provides too few details. For instance, while the SWAp sets out a target of doubling the CPR by 2006, it fails to provide strategies or steps for achieving this goal. Similarly, the PRSP set out priorities without assessing the country's available resources to carry out the program tasks.

Financial Sustainability

Objective: Provide low cost, high quality FP commodities to the poor and achieve financial solvency

Strategy: Launch commercial products to diversify and support cross-subsidization programs

Outside of Latin America, only two countries show commercial market share greater than 50 percent: Egypt and Ghana. In Ghana, prices in pharmacies and public sector outlets are similar. In Ghana, commercial outlets are dominated by GSMF products which are priced to compete with the public and NGO sectors. GSMF International (previously known as the Ghana Social Marketing Foundation) is the largest non profit, private sector supplier of contraceptives (and other health related products, including oral rehydration salts and insecticide bed nets) in Ghana. GSMF sells an estimated 50 percent of all condoms and 33 percent of all OCs, targeting low-income individuals and communities. GSMF International relies on mass media advertising and promotions to create brand awareness and generates demand through commercial outlets and through Ghana's CBD program.

Based on USAID and CMS recommendations for achieving self-sustainability, GSMF was encouraged to diversify its product line and launch a commercially priced product. With financing from the Summa Foundation, GSMF was able to import condoms and packaging materials. Recently, GSMF International branched off to form a subsidiary, GSMF Enterprises Limited, whose objective is to operate a franchise of licensed chemical sellers (LCSs) so as to optimize the efficiency of the pharmaceutical supply chain. The franchise model, designed to be sustainable, will harness the potential of existing LCSs to improve drug access in rural and peri-urban communities, and improve on the quality of drugs and services at lower retail prices (thereby improving local competition). Outputs include policy formulation (based on data on drug consumption and public health issues and stronger referral systems).

Demand Side Factors

Information

Objective: Ensure stable supply of contraceptives to current users and potential users

Strategy: Support and strengthen CBD system

While more than 60 percent of users obtain contraceptives from the private sector, Ghana continues to struggle with a financing gap in securing adequate supplies for the remaining 40 percent. By 2006, it is estimated that this funding

gap could reach US\$ 8 million. One of the critical factors contributing to the financing shortfall is that Ghana has yet to segment the market so it continues to provide free commodities to clients who could afford to move to the private sector.

Another factor affecting demand sustainability is inadequate levels of training and outreach. Ghana's FP strategy relies extensively on community-based distribution. CBD health outreach promoters work on a volunteer basis, compensated only through 30-50 percent commission on contraceptive sales. In addition to non-clinical FP commodities, most CBDs carry first aid drugs which increases their value for the client. Recent evaluations suggest that many CBD workers have insufficient materials and training to provide information, education and communication (IEC) adequately. Generally, the level of FP knowledge of health providers at referral points is weak.

JORDAN

CPR WB 1970s	CPR WB 1980s	CPR WB 2002	CPR UNFPA (last year available)	CPR UNFPA* (last year available)	Unmet Need DHS 1990	Unmet Need UNFPA (last year available)
23	26	56	56	41	23%	11%

* Reflects MWRA who use *modern* methods

Note: UNFPA did not report the data year in which their estimates are based.

Summary

Currently the Jordanian government finances 100 percent of its contraceptive commodity requirements through donor support. The phase-out of FP commodities is expected to begin in the next 2-5 years. Nevertheless, Jordan is already undertaking steps to strengthen contraceptive security. The case of Jordan demonstrates the need to support the physical infrastructure required to implement and sustain SSR and to remove legal and regulatory barriers that impede financial sustainability. Unmet need (based on DHS data) was 23 percent in 1990.

Supply Side Factors

Financial Sustainability

Objective: Encourage private sector participation and secure low-cost commodities

Strategy: Reduce legal and regulatory barriers that increase cost of products

In Jordan, the private sector plays an important role. The commercial market serves 36 percent of modern users while public facilities serve 34 percent. Public hospitals provide free care and do not charge user fees. The non-profit sector has FP clinics that serve 30 percent and are financed by donors and user fees. Recent trends, however, indicate increasing pressure on limited resources. While absolute number of commercial users doubled over 1990 and 2002, the

percentage of people seeking FP commodities from public facilities has increased. Specifically, the public sector market share for pills increased fourfold at the expense of commercial sector. Concerted efforts to promote social mobilization by the National Population Commission concerned by the impact on the private sector and pressure on resource constraints led to the 2002 removal of two policy barriers to commodity availability and private sector participation. First, the Minister of Finance and Minister of Industry and Commerce and General Director of Customs issued a decision exempting all modern contraceptives from duties and tariffs. Second, the council of ministers decided to exempt all modern contraceptives from sales tax.

Institutional Factors/Infrastructure

Objective: Improve forecasting, management and delivery of contraceptives and foster ownership in system across all levels

Strategy: Restructure management logistics system and expand training to larger group of stakeholders

In 1996, Jordan's MOH requested that its contraceptive logistics system assessment be studied. MOH was concerned that recent disruptions and stock-outs would undermine gains in FP. In particular, the CPR rose from 27 percent in 1990 to 41 percent in 2002. And a comparative analysis of public sector users in Bangladesh, Egypt, the Philippines, Cambodia and India indicated that Jordan is doing a better job in terms of targeting limited public sector resources. The external assessment found Jordan's logistics system to be weak and without a strong management structure to oversee decision making and performance. Local health personnel also expressed concern that the system was informal and lacking in direction and guidance. Moreover, the confusion about the ordering and distribution process had led to recurring stock-outs

Following the evaluation, Jordan MOH held a one week design workshop and invited health care workers from all levels (including midwives, representatives from IPPF) to participate and provide suggestions as to how to improve the current system. The outgrowth of the meeting was a new system (which included a central information systems component) better designed to meet the needs of MOH. A core group of stakeholders were trained and step by step manuals were developed. Recruited senior logistics officers were retained by the MOH so that the logistics system would seem like an integral part of MOH and not simply a project activity. Political support for the enhancement of the logistics system became stronger after policymakers saw that a strong logistics system significantly improved FP programs and contraceptive availability.

KENYA

Country	CPR WB 1980s	CPR WB 2003	CPR UNFPA (last year available)	CPR UNFPA* (last year available)	Unmet Need DHS 1993	Unmet Need UNFPA (last year available)
Kenya	22	38	39	32	32%	24%

* Reflects MWRA who use *modern* methods

Note: UNFPA did not report the data year in which their estimates are based.

Summary

Although USAID has completed the phase-out of external donations to Kenya, the country still relies heavily on technical assistance and contraceptive donations from other international donors. Kenya faces significant cultural barriers to family planning. Children are an important asset to the older generation and provide security for the future. A review of Kenya's experience illustrates the critical role that NGOs can play in building on national government support and furthering the CSR program. In addition, Kenya's experience with CSR demonstrates once again the importance of the design of FP commodity distribution and delivery systems. Kenya has also emphasized outreach but has relied more on private voluntary organizations to complement services. Unmet need was 32 percent in 1994 (using DHS data).

Supply Side Factors

Internal Agents

At the end of the late 1980s, Kenya had the highest fertility rate in the world. Recognizing the constraints on the country's resource, that national government made family planning a high priority, so much so that the President promoted the idea in his speeches and required the MOH to provide family planning services at all government hospitals. The MOH and the National Council on Population and Development organized a network of government and non-government organizations (including churches, women's groups, FP groups) that provide family planning services to the public. Efforts to raise awareness involving donors and other stakeholders led to a major commitment of resources from the Kenyan government. As a result, Kenya now boasts one of the biggest FP programs in Sub-Saharan Africa. While there has been some success -- Kenya's CPR (for all methods) has increased from 33 percent in 1993 to 38-39 percent in 2003, --- the rate has been stagnant over the last few years. Unmet need remains high -- some 32 percent.

External Agents

Implementation Actors

One of the organizations participating in the network of public and NGO organizations was the Family Planning Association of Kenya (FPAK). During the 1990s, public awareness of the issue of FP and contraceptive security increased. FPAK, which began in 1962 as a volunteer based effort, pioneered the family

planning movement in Kenya, promoting the provision of sexual and reproductive health services within the context of reproductive rights and the empowerment of young people. FPAK also took the lead in transforming Kenya's family planning program from a vertical, Nairobi-based model to a more community-based, participatory one, reaching the local and regional levels. That made the program one of the first in the world to experiment with community-based distribution of contraceptives. Currently, Kenya has the oldest family planning program in Sub Saharan Africa and the largest CBD program in Africa. CBDs continue to play a key role in the provision of non prescriptive services, counseling and referring client for clinical services.

Financial Sustainability

Objective: Improve efficiency of procurement systems so as to achieve financial sustainability

Strategy: Decentralize decision making to local levels

As part of an effort to achieve contraceptive self-reliance, the parastatal agency, Kenya Medical Supplies Agency (KEMSA), mandated that decisions on health commodity requirements would be made at district level, instead of central level. KEMSA, then, would then sell commodities to all health facilities. Unfortunately, the shift in KEMSA's role from providing contraceptives based on requested needs (pull system) rather than allocated proportions of the total supply (push system) has encountered several difficulties. The biggest is that the government has not provided the necessary resources to support the restructuring and reorganization. Consequently, KEMSA is on verge of collapse, thus threatening Kenya's long term efforts to procure its own commodities. There are several strategies the government could pursue at this time: capitalize KEMSA and help it become competitive on market to secure its position as the main supplier of health commodities for the public sector in Kenya; privatize or outsource the management of the company.

Institutional Factors/Infrastructure

Objective: Maintain logistic information system that accurately forecasts demand, manages stocks, delivers contraceptives in timely fashion, and monitors performance

Strategy: Re-design and improve logistics system to address failures in system performance

As the phase-out rolled out, Kenya's contraceptive logistics system was revealed to be fractured and crisis-driven supply schedules, resulting in condom stock-outs. An analysis indicated that the supply chains for each of the different health commodities varied in coverage, availability of information and commodities, and logistics system performance. While FP commodities were generally maintained in fully supply with relatively good supervision and information systems, some problematic issues were identified within these vertical programs. Among these were as poor inventory control at the service delivery point (SPD), poor reporting for reproductive health commodities and high wastage rates of some medicine. To avoid further stock-outs, USAID intervened and currently supports Kenya's

contraceptive security efforts with logistics management systems. Evaluative studies find that the contraceptives logistics support provided by USAID has been critical in increasing effectiveness of other donor support.

MEXICO

CPR WB 1970s	CPR WB 1980s	CPR WB 2000	CPR UNFPA (last year available)	CPR UNFPA* (last year available)	Unmet Need DHS 1987
38	50.3	70	68	60	27%

* Reflects MWRA who use *modern* methods

Note: UNFPA did not report the data year in which their estimates are based.

Summary

Mexico has successfully completed the USAID phase-out of donated contraceptives. This case study illustrates the important role the media can play in building support for CSR and pressuring the government to reform relevant policies. Unmet need was 27 percent in 1994, unchanged from 1987 levels.

Supply Side Factors

Internal Agents

Executive Branch

Among the factors which contributed to Mexico's success were: high demand, political willingness and commitment towards the FP program during and after the phase out process. When the phase-out started, the CPR rate was 63.1 percent in 1992; in 2004, it hovered at 70 percent. At the outset, five key national public agencies were partners to the phase-out agreement which ensured that the transfer of procurement tasks would be institutionalized. Aiding the process, Mexico designated a single USAID contact person for the management and oversight of their phase-out agreements which facilitated rapid transmission of information regarding potential stock-outs or problems.

External Agents

Intermediate Actors

Mexico's experience with CSR illustrates the critical role media representatives can play in building support for CSR and pressuring the government to implement or reform relevant policies. As stated above, like many countries, Mexico's laws favored purchase of domestic products which, often times, prevented providers from securing the lowest- cost FP product. This meant that state governments were finding it difficult to achieve financial sustainability while providing free contraceptives to the most poor. This precarious situation facing state governments was highlighted by a Mexican official at a meeting in Istanbul in May 2001. A Mexican journalist, attending the meeting, sent news bulletins from Istanbul about Mexico's plight and the implication it had CS. The story was carried by print and broadcast media in Mexico, raising awareness of the

problem and the significant savings that could be realized if states could procure their commodities in the international market. In July 2001, just two months after the conference, federal health authorities declared contraceptives a national security item, thereby releasing them from the “Buy Mexico” regulations.

Institutional Factors/Infrastructure

Objective: Manage stocks of contraceptive and delivery to supply distribution points

Strategy: Decentralize decision making and incorporate NGOs into logistics and distribution system

From 1992 to 1998, the USAID-funded Family Planning Logistics Management (FPLM) provided technical assistance in logistics to the Mexican Foundation for Family Planning (MEXFAM) and the Mexican Federation of Private Health and Community Development Associations, which are the two main NGOs providing FP and RH services in Mexico. Central offices managed contraceptive procurement for their clinics, affiliates, pharmacies, and outreach programs. Prior to the intervention, an evaluative study indicated that there was waste in product (people forgot to look at dates) and that staff members were not adequately trained. As part of this project, personnel at the regional and central offices were trained on basic aspects of logistics systems, and concepts and applications of logistics monitoring.

While NGOs were receiving training in logistics system, the government was trying to reconfigure the distribution system. Specifically, the MOH initiated a shift in warehousing and distribution responsibilities from the central office to local vendors. But, in the absence of sufficient training and financing, some regions stopped ordering contraceptives. In sum, the government may want to consider involving NGOs in the logistics system and that decentralization may hinder the efficient operation of logistics information and management systems.

Socio-Political, Legal and Regulatory Environment

In Mexico, 70 percent of FP services are provided through public sector sources. After USAID support ended, the government found itself paying three times more for IUD s and nine times more for OCs. Decentralization, in part, was the culprit behind supply failures (and higher prices). Efficient delivery and communication suffered from the lack of capacity at national and local levels and inadequate coordinating systems. Decentralization of health services only exacerbated the complex RH programs. The other reason for the higher prices was the “Buy Mexico” regulations (and associated high production costs) which made it difficult for public sector providers to purchase contraceptives from foreign suppliers. This resulted in state governments paying nearly twice as much for contraceptive as they would have if they had purchased commodities on international markets. (NGOS like MEXFAM and FEMAP, while not subject to “Buy Mexico” rules, were also paying high prices due to their low volumes and lack of direct access to international suppliers.)

Early in 1990, Mexican government learned from USAID about the phase out plan for contraceptive donations. There were some factors that made a difference: In 1994, a regulation for the provision of FP services was issued by the Secretariat of Health. A widespread media strategy not only focused on maintaining the CPR, but also expanding the services to a number of other high priority population groups.

MOROCCO

CPR WB 1970s	CPR WB 1980s	CPR WB 2003	CPR UNFPA (last year available)	CPR UNFPA* (last year available)	Unmet Need DHS 1992	Unmet Need UNFPA (last year available)
19	31	63	50	42	20%	19%

* Reflects MWRA who use *modern* methods

Note: UNFPA did not report the data year in which their estimates are based.

Summary

Morocco no receives financial support from USAID to purchase contraceptive commodities. Currently, Morocco is using a portion of WB credits to purchase commodities. The review of Morocco's experience illustrates that despite constraining factors, logistics management information systems (LMIS) can be successfully deployed. That said, implementation and sustainability require considerable political and financial resources. And extra care has to be taken to design a country-tailored program so as to secure buy-in from significant stakeholders. Unmet need was 20 percent in 1992.

Supply Side Factors

Internal Agents

Executive Branch and Ministry of Health

Morocco has a strong FP policy. The Royal Family sponsors FP campaigns. Similarly, the government has been willing to dedicate resources and place priority on FP activities. A multi-sectoral population/FH committee created a five-year plan that clearly outlined roles and responsibilities for the private sector in the family planning market. Within MOH, the FP division and members of the Population Directorate instigated the design and development of a logistics management information system (LMIS) to get better data and indicators for decision making related to FP initiatives.

Institutional Factors/Infrastructure

Objective: Deploy efficient procurement system

Strategy: Train all relevant personnel and develop ownership of logistic management information system and tailor system to local context

John Snow, Inc/Family Planning Logistics Management (JSI/FPLM) began working with Morocco in the 1980s after the national FP program requested USAID assistance to improve its logistic systems so as to avoid waste (expired

commodities). Deployment of LMIS began with a design workshop in 1993 in which representatives from lower and higher levels attended and help customize the system to the local environment. Training and implementation occurred over the next three years, and was supported by the development of a curriculum, manuals and training strategy and certification of trainers. LMIS is now helping reduce costs and the Moroccan government is using extra savings to purchase commodities. The critical factor contributing to the efficient performance of Morocco's LMIS was that the initial design and implementation of the system were tailored to the local context (including geographic constraints (remote versus accessible, rural versus urban). After extensive training and revamping of the supply chain, management personnel and users within the system were able to accept the LMIS as their own. As a result of the MOH's strong FP policy, LMIS has received senior management support. Strong political support is crucial to the success of the LMIS and eventually CSR.. In sum, significant external support – funding and technical expertise – are critical components to ensure the initial success of a logistics system.

PERU

CPR WB 1970s	CPR WB 1980s	CPR WB 2000	CPR UNFPA (last year available)	CPR UNFPA* (last year available)	Unmet Need DHS 1991	Unmet Need UNFPA (last year available)
25	43.4	69	69	50	16%	10%

* Reflects MWRA who use *modern* methods

Note: UNFPA did not report the data year in which their estimates are based.

Summary

Peru has officially completed the USAID phase-out of donated contraceptive supplies. The phase-out was accomplished amidst a background of a long standing national government support and generally high levels of awareness and support for FP services and commodities. The Peruvian experience illustrates the power of advocacy and interest groups in driving CSR and the importance of setting up national committees to promote CSR. Unmet need was 16 percent in 1991 (based on DHS data).

Peru has a history of strong support for FP programs. As early as 1980, the Peruvian government created the National Population Council (Consejo Nacional de Población, CONAPO) whose long standing role was to coordinate national family planning efforts and to encourage the active participation of NGOs, universities and donors in the population programs. The FP budget increased under both Garcia and Fujimori regimes. In late 1990s, however, after more than a decade of strong government leadership in FP, support eroded. While renewed interest in FP and health sector reform has grown over the last few years, opposition from religious and political leaders continues. Peru's CPR continues to rise from 46.0 percent in 1986 to 54.7 percent in 1991 to 69 percent in 2000.

Supply Side Factors

Internal Agents

Executive Branch and Cabinet Ministries

Since 1995 the government has started to reform the health sector, with an emphasis on expanding coverage to the poor. In 1995, the Peruvian government amended the 1985 Law on Population by including male and female sterilization as an acceptable family planning method to be provided by public services. (By the late 1980s, female sterilization, however, became a very sensitive issue on the part of the Church and women's NGOs.) The government undertook the decentralization of health services, which was supported by several laws, including the Law on the Modernization of Social Security which introduced new forms of health services, for those under the Instituto Peruano de Seguro Social (IPSS/ ESSALUD) involving the private sector.

In February 1996 the government adopted the National Program of Reproductive Health and Family Planning 1996-2000, with the aim to improve RH through the provision of high-quality RH services. In 1996, the functions of the National Population Council (CONAPO) were transferred to the Ministry for the Promotion of Women and Human Development (PROMUDEH), which took over the functions of other agencies (e.g. the National Population Council) concerning population. Out of PROMUDEH emerged COORDIPLAN, which has the responsibility of coordinating, monitoring, evaluating and promoting the plans and programs in the field of population, family planning and reproductive health, in particular the National Population Plan 1998-2002. COORDIPLAN consists of the vice-ministers of the Ministry of Health, PROMUDEH, Ministry of Education, Ministry of the Presidency (PRES), Ministry of Regional Development and the presidents of the Peruvian Social Security Institute (IPSS), the National Statistical Institute (INEI) and the Environmental Council (CONAM). The COORDIPLAN works through the National Office of Popular Cooperation for local level promotion of RH services. This is done by collaborating with local health care promoters and community based organizations (CBOs).

External Agents

Implementation Actors

In Peru, NGOS are playing a vital role in Peru to educate current and potential clients about their right to high quality reproductive health and other services. The involvement and empowerment of clients through civil society and actual consumer inputs in health service design and delivery is helping to make clients more aware and more demanding. National support of family planning has been assisted through the efforts of non profit and social mobilization organizations. USAID SHIP, Care-Peru has developed and trained local networks of promotores and participates in several RH projects. The IPPF affiliate, Peruvian Institution of Responsible Parenting (INPPARES), offers contraceptives marketed at low cost through the clinics next to the provision of a whole range of RH services. Special family planning brigades provide services in remote under-served communities in Peru. INPPARES markets drugs and contraceptives and promotes Norplant in

collaboration with Leiras Pharmaceuticals (Finnish). The NGO APROPO (Advocacy for Population Programs) promotes FP and the social marketing of contraceptives. In addition to its own brands that were introduced with success on the commercial market, other contraceptives (Depo-Provera and Microgynon) have been promoted.

NGOS are playing a vital role in Peru to educate current and potential clients about their right to high quality RH and FP services. The involvement and empowerment of clients through civil society and actual consumer inputs in health service design and delivery is helping to make clients more aware and more demanding. Movimiento Manuela Ramos, a Peruvian national NGO, works with 200 CBOs around the country to foster and support the improvement of reproductive health services. Active since 1979, Centro Flora Tristan provides IEC services and expertise for institutional strengthening and capacity building in reproductive health in the form of social mobilization and awareness, workshops on reproductive health, capacity building, training of interneers from other regional NGOs, research and sensitization of media workers on women's (RH) rights and work on the politico-cultural barriers in RH. In these activities Centro Flora Tristan co-operates with PROMUDEH, the Congress' Commission for women, the National Police of Peru, the judiciary and municipalities. Workshops are realized in collaboration with NGOs, MINSA and the district municipalities. Flora Tristan is member of the Consorcio Mujer: a network of NGOs working in RH, such as Cendoc Mujer, CESIP, Manuela Ramos, Centro Amauta-Cusco, Centro Ideas-Piura and CEPSCO-Tarapoto.

Established in 1990, Red Nacional Promocion de la Mujer (National Promotion of Women --RNPM) is an advocacy network for the promotion of women's rights, including those pertaining to RH. By 1999, RED Mujer consisted of 800 representatives of a variety of civil society organizations and government agencies, local governments, municipalities, labor unions, women's self help groups, Catholic Church groups and academics. The local groups and regional committees identify, monitor and evaluate policies and women's needs, which are reported to the Red Mujer's general assembly, which in its turn formulates an social mobilization strategy. The RED Mujer is funded by CIDA, the UNFPA, the Ford Foundation, the Netherlands, USAID-POLICY project in 1998 (advocacy), the European Union, and the Pan American Health Organization (PAHO). With the assistance of POLICY, the Red Nacional por la Promocion de Mujer (RNPM or the national network for the promotion of women) formed and strengthened 24 departmental/provincial branches to advocate for women's issues under decentralization. The focused interventions involved technical assistance and training using a CSR mobilization and advocacy tool kit that includes an advocacy training manual, policy analysis tools, contraceptive security research and advocacy success stories.

Despite the government's commitment to CS, evaluative studies suggest that there have often been conflicts between the government and the NGOs. For

instance, there has been government resistance to the amount of donor support that the NGO has received. Further tensions resulted during the sterilization campaign. The NGOs have found that the most successful collaborations took place at the local and regional level, where agreements with specific time frames and actions were signed.

International Actors

Peru has received generous support from international donors which has assisted its CSR and FP programs. UNFPA's Fifth Peru Cooperation Program (1997-2001), was aimed at further development and strengthening of activities in the fields of IEC on reproductive health and sexual rights, improved access and quality of reproductive health services and capacity building aimed at incorporating population issues in national development policies and programs. Moreover, the program supported the process of decentralization through strengthening the regional population councils by way of capacity building, training and IEC activities.

To foster and monitor the implementation of the ICPD Plan of Action in Peru, UNFPA initiated the creation of the "Tripartite Table of Follow-up and Implementation of the Program of Action" of the ICPD conference in 1997. This ad hoc consultative body, a unique initiative in Latin America, consisted of 24 representatives of the government, national NGOs, universities and international donor agencies (multi- and bilateral) was formed to co-ordinate and evaluate the implementation of the ICPD Program of Action, to identify constraints and set priorities and to serve as a forum for the exchange of information.

Financial Sustainability

Objective: Diversify resource base and promote private sector participation

Strategy: Promote availability of commodities in commercial outlets

Since 1996, the National Family Planning Program (under MOH), has received direct funding from the national budget. In other words, there is a direct budget line item for the National FP Program, making it independent from other programs and on the need to consult with other MINSA programs for its budgetary allocations. (That said, although family planning still receives the larger share of funds, MINSA has recently prioritized other areas (i.e. maternal mortality, HIV/STDs.) In 2004, Peru financed 80 percent of its contraceptive needs and hopes to provide for 100 percent in 2005. MINSA procures its contraceptives through the UNFPA which buys them at low cost in the U.S. Donor supported social marketing subsidized the advertising but not the prices of contraceptives. Since 1989, brand name advertising has been permitted for contraceptives by special dispensation. Brand name television advertising of social marketing products increased their share among commercial brands.

Commercial Sector Participation

During the 1980s, the commercial market share of FP commodities was greater than that of the public share. The government created conditions which

supported commercial sector development. Distribution channels and competitive conditions supported commercial sector activity. The private company Shering Inc., one of the market leaders in Latin America, has been active in social marketing of contraceptives in Peru for several years. Economic liberalization (i.e. removal of price controls) in the 1990s produced a substantial increase in the commercial share, coincident with a large increase in the number of retail outlets. Other restrictions were also lifted. Brand name promotion was permitted for contraceptives by special dispensation. Donor supported social marketing subsidized advertising but not the prices of contraceptives.

In 1995, the executive branch took measures to expand the FP program, introducing injectables and promoting tubal ligations. Free methods had always been available at public entities, but the program launched an aggressive campaign – including frequent public statements by the President to promote availability of free FP commodities and services at public facilities (Foreit 2002).

However, following the government's aggressive campaign to advertise the free provision of contraceptives in the mid 1990s, the rise in the share of the commercial market came to a halt and has been partly reversed. Over decade 1986-1996, commercial outlet share of pill users in Peru rose about 20 points then fell by the same amount returning to 38 percent by 1996 (Bulatao 2002). Commercial outlet share of injectables fell 70 percent over a decade to 12 percent by 1996. Shering Inc. has discontinued its social marketing partnerships with Peruvian NGOs such as APROPO and INPARRES. Given the pressure on the national government resources over the long term, greater efforts need to be made to create conditions which make it attractive, once again, for the private sector to participate.

Institutional Factors/Infrastructure

Objective: Strengthen contraceptive management system

Strategy: Streamline and coordinate systems among different levels of government and across all stakeholders

MINSAs Family Planning Public Sector Support program aims at developing a sustainable contraceptive management system to avoid wasted commodities. Diverging from the experiences of other countries, Peru's FP logistics management project, FPLM, subcontracted with PRISMA, a local non profit acting as a third party grantee to provide technical assistance and training to MOH. In a country with significant geographic and communication constraints, the model successfully built logistics expertise at both the regional and national levels. Training and supervision were a worthwhile investment and were effective so that eventually regional and central stakeholders could manage the system without a need for PRISMA. USAID provided the Peruvian government with financial assistance to contract PRIMSA and John Snow, Inc. provided additional technical assistance for further design and management of the contraceptive distribution system.

Despite the implementation of a contraceptives logistics system, Peru faces other institutional constraints. One of the problems with the Peruvian health system is its complexity and the mis-utilization of health services due to cultural constraints and duplication of efforts (e.g. public clinics, ESSALUD (national insurance) clinics, private institutions offering same services in the same locations). Within MINSA, the monitoring system is still underdeveloped, which impairs effective forecasting, budgeting and planning. Currently, the health budget is drawn up annually according to national priorities and past trends in allocations rather than real expenditures. In addition, the different programs remain vertical and are not fully integrated, with each having its own supervision, IEC, and program agenda. Current plans to reform the health sector further comprise the ability to integrate the vertical programs under one office. In order to more efficiently use resources, MINSA must integrate programs and reduce vertical nature.

Demand Side Factors

Preferences and Expectations

Objective: Provide stable supply of affordable FP commodities and services

Strategy: Improve market segmentation so as to better target limited public sector resources

Family planning remains a national priority, which has translated in a large share of total government funding. However, it is not clear whether the country can sustain its current level of provisions. For one thing, the public system is overburdened in Peru. Beginning in 1996, the government, which operated 87 percent of total health service establishments, began an aggressive marketing campaign to promote availability of contraceptives which had always been free in public outlets. This has greatly increased demand for public services while reducing demand for and market position of NGOs and private providers more difficult as they lost clients and income. In 2000, 79 percent of Peruvians sought health care services from public sector health facilities. This is a dramatic change from the 1980s when 75 percent of users acquired their contraceptives from the private sector. As of 2003, the commercial market was less than 30 percent. Most of the increased demand has been for injectables, which are currently only provided by public facilities. Shering Inc. is currently negotiating the marketing of the new contraceptive CycloProvera, in partnership with MINSA.

Evaluative studies suggest that Peru needs to do better market segmentation. Most studies indicate that a significant numbers of users could afford to buy their commodities in the private sector.

Moreover, the Peruvian government has so efficiently committed resources to the issue that it has crowded out or stifled private sector development. As part of the efforts to shift users from the public sector to the private sector, CATALYST created a pilot network, RedPlan Salud that provides incentives for private providers to increase sales of FP products. The pilot – based loosely on a franchising model-- involved training midwives and providing them with discounted INPPARES and commercial products brands and other supports.

Midwives then visited their clients and took FP products to them directly. Pharmaceutical companies have an incentive to participate in order to enhance availability and sales of commercial brand contraceptives at a discounted price. Follow up studies indicated that this pilot succeeded in shifting some clients away from public sector to private sector.

ROMANIA

CPR WB 1970s	CPR WB 1980s	CPR WB 1999	CPR UNFPA (last year available)	CPR UNFPA* (last year available)
58		64	64	30

* Reflects MWRA who use *modern* methods

Note: UNFPA did not report the data year in which their estimates are based.

Summary

In anticipation of a phase out of public sector contraceptives that were purchased under an expiring health loan, the government of Romania approved public sector funding for contraceptives and the provision of free commodities to vulnerable population sectors in 2000. The Romanian experience highlights the important roles that champions and networks can play in promoting the issue of contraceptive security and influencing the policy process.

Beginning in 1992, international donors helped pressure the government to establish family planning clinics. In 1998, USAID POLICY intervened to lend support on a multisectoral policy dialogue on which FP/RH services would be covered by health insurance. Once key FP/RH services were identified, the Coalition for Reproductive Health in Romania (Coalition) conducted advocacy events to promote the support of the public and national and local leaders for health insurance coverage of FP/RH services, access to these services in rural areas, and continuity of the family planning clinics. Despite the urgency of improving access to FP/RH services, the government did not issue any national FP/RH policy until after 1998. Health sector reform, the 1997 approval of the health insurance law, and decentralization—provided opportunities for FP/RH policy changes. The government soon approved a series of policy measures that provided for the inclusion of selected FP/RH services in the health insurance basic benefits package. In 1999, as policy and program initiatives focused on improving access to services, the FP/RH community in Romania became concerned about depleting stocks of public sector contraceptives that were purchased under an expiring health loan.

Supply Side Factors

Internal Agents

Executive Branch and Ministry of Health

Becoming more receptive to FP/RH issues, the MOH originally planned to procure contraceptives for all women using contraception. Government-wide budget cutbacks in 2000, however, reduced allocations for health programs. Soon a team of stakeholders was assembled. The team consisted of senior officials of the Ministry of Health and Family (MOHF), NHIH, Ministry of Finance, Society for Education on Contraception and Sexuality (SECS, the primary family planning NGO), the Institute of Mother and Child (IOMC, an independent evaluation agency), the Directorate for Family and Social Assistance, the Commission of Obstetrics-Gynecology (Ob-Gyn) of the College of Physicians, and district health authorities (DHAs) with USAID, UNFPA, and POLICY staff assisting. Team meetings to assess reproductive health finance data became venues for social mobilization and awareness on FP/RH issues, including public sector funding of contraceptives.

In August 2000, the Prime Minister and the ministers of Finance and Health signed Funding for National Health Programs, which highlighted maternal and child health (MCH) protection, through the provision of a line item for contraceptives. The legislative order mandated for: central procurement and distribution of free contraceptives to the disadvantaged; establishment of revolving funds for local purchase and the sale of contraceptives to non targeted sectors of the population, with proceeds to build up local revolving funds; and distribution of public sector contraceptives by family doctors in rural areas without family planning clinics. Because of the August 2000 policies, the Romanian government made contraceptive funding a priority for the first time by specifying a line item for commodities in the state budget.

External Agents

Intermediate Actors

Nongovernmental groups that worked for CS policy changes were primarily members of the Coalition, composed of mostly Bucharest-based NGOs, such as SECS and Youth for Youth, and women's groups, such as the National League of Women (NLW). There were also provider associations with interest in contraceptive-related issues: the Ob-Gyn Society, the Association of Family Doctors, and the Family Planning Association.

International Actors

While Romania had tremendous international support from USAID and UNFPA, the POLICY Project-provided technical assistance proved important in influencing the contraceptive security policy reform process in Romania: policy research, capacity building, and multi-sectoral advocacy and policy dialogue. Policy research and stakeholder mobilization served as the primary starting points to further social mobilization and policy dialogue.

Institutional Factors/Infrastructure

Objective: Procure and deliver contraceptives

Strategy: Install logistics information and management systems prior to implementing CS strategy

Soon after approval of the August 2000 policies, problems with the logistics information and distribution systems were revealed as local governments and clinics attempted to put the policies into practice. National and local institutions that were designated to assess contraceptive needs and undertake procurement had not received appropriate training and resources. The efficiency of procurement and distribution was also questioned as supplies sent to local clinics did not match local demand. In short, procurement and distribution decisions were made without any real-time information about the real and future demand for contraceptives. The Romanian government had short changed the importance of building physical infrastructure prior to implementing CS strategies. The inability to process the demand and delivery requirements undermined the uninterrupted availability of contraceptives to those who wanted them.

THAILAND

CPR WB 1980s	CPR WB 2000	CPR UNFPA (last year available)	CPR UNFPA* (last year available)	Unmet Need DHS 1987
65	72	72	70	12%

* Reflects MWRA who use *modern* methods

Note: UNFPA did not report the data year in which their estimates are based.

Summary

Thailand received U.S. population assistance until 1990, when the government assumed full responsibility for FP and CSR. A country of 54 million, Thailand's CPR has increased from 14.8 percent in the early 1970s to 70.6 percent in 1987 to 72 percent in 2000. To date, Thailand has imported more U.S. goods than it received in population assistance.¹³ The case of Thailand illustrates how proactive support from the national government manifested in creative incentive schemes and coordinated efforts with a strong NGO can lead to successful adoption and implementation of CSR. Unmet need was 12 percent in 1996, unchanged from 1987 levels.

Supply Side Factors

Internal Agents

Executive Branch and Ministry of Health

Launched officially in 1971, Thailand's National Family Planning Program (NFPP) has been successful. Several factors account for the success. First, in contrast to the Philippines, whose population program has not been as successful, Thailand

¹³ Nepomuceno T. 1991. The "anatomy" of Thailand's successful family planning program. ICMH Newsletter. 1991.

has not experienced religious opposition to family planning, since Buddhists favor limiting children.¹⁴ The phase-out took place in the context of high levels of demand for FP commodities and the relatively advanced status of women which strengthened general public receptivity to FP. Success is also due to the program's demographic-economic approach, which stresses the economic implications of population growth.¹⁵ The availability and accessibility of family planning services has greatly contributed to the success of the program. All government hospitals have a family planning clinic, and midwives, nurses, and doctors all receive family planning training. External factors involved in Thailand's success include the extraordinarily large amount of external donor support, which has allowed development of a solid program infrastructure; the existence of good demographic data; and the country's strong transportation system, contributing to the mobility of women and to the support of program activities.

Another reason for the success of Thai's CSR program is that, from the outset, the FP program was promoted by a proactive government who established close working relationships with NGOs which were given clearly defined roles. For instance, in order to avoid duplication of programs and competition among field workers, the Ministry of Health coordinates all programs.

From the beginning, the leadership of the National Family Planning Program (NFPP) took the lead public role within MOH which resulted in an increasing share of resources from the national budget. It also increased foreign donor support and worked actively to involve the private sector. The NFPP also promoted CSR through a series of operational innovations, including the use of paramedical staff to provide OCs (including injectables) and the training of village volunteers and rural school teachers to sponsor IEC activities related to RH and FP.¹⁶

The government also established a very close relationship with the Population and Community Development Association (PDA), a private non-profit organization and the largest nongovernmental agency in Thailand. The leadership of PDA fueled the family planning effort in its early stages, raising it from a progressive program to an inspired celebration of contraceptive information. The PDA established a high profile public education campaign, staging such events as a condom balloon-blowing contest. PDA workers could be found handing out condoms at movie theaters and traffic jams. Even the traffic police were given boxes of condoms to distribute on New Year's Eve in a program known affectionately as "cops and rubbers." They also linked loans to contraceptive use. PDA used a variety of other family planning tools as well:

14 More than 90 percent of Thailand's population is Buddhist. Buddhist scripture preaches that "many children make you poor." by Edorah Frazer. Thailand: A Family Planning Success Story

15 by Edorah Frazer. Thailand: A Family Planning Success Story

16 by Edorah Frazer. Thailand: A Family Planning Success Story

birth-control carts sporting pills, IUDs, spermicidal foam, and condoms were distributed at bus stations and public events.

MOH supported PDA's lead and expanded the range of new contraceptive technologies available to the public. Thailand was among the first countries to allow the use of injectables, and remains one of its largest users. Thai physicians have also developed simplified methods of female sterilization, and now operating room nurses are trained to perform the procedures. Non-scalpel vasectomies are available at festivals and other public events, and in a characteristically celebratory manner, PDA offers free vasectomies on the King's birthday. Sterilization has now become the most widely used form of contraception in the country. While creative publicity techniques drew public attention to family planning issues, many attribute the Thai people's commitment to participate to the fusion of economic development with family planning education. PDA offers loans that are linked to people's use of contraception.

Financial Sustainability

Unless clients can demonstrate that they are unable to pay, all FP service providers require clients to pay a standard fee. Initiated at the creativity of the PDA, the Thai Population Program has evolved from a purely family planning contraceptive service to a community development program designed to improve the productivity of individuals which has helped it fund its own financial sustainability. Specifically, the government has implemented the Thailand Business Initiative in Rural Development, which involves the participation of civic-minded business groups in assisting community development, and ties FP practice to loans. Members of the loan fund received shares and dividends on the basis of the contraceptive method used; more effective methods had higher values. As the level of contraceptive prevalence within a village increased, so did the total amount of the loan fund. PDA also offers loans that are linked to people's use of contraception. PDA moved from contraceptive distribution to the issue of water, introducing a revolving loan scheme to build, with German funding, and later to the agriculture-oriented income generation. PDA established an incentive system that links FP participation to loan acceptance. Under a similar but separate government program, monetary loan funds were also set up in several villages.

TUNISIA

CPR WB 1970s	CPR WB 1980s	CPR WB 2000	CPR UNFPA (last year available)	CPR UNFPA* (last year available)	Unmet Need DHS 1998	Unmet Need UNFPA (last year available)
34	45.5	66	60	51	20%	39%

* Reflects MWRA who use *modern* methods

Note: UNFPA did not report the data year in which their estimates are based.

Summary

In 1994, USAID phased out its FP and contraceptives assistance to Tunisia, a country of 10 million. In 1983, the country's CPR was 41 percent, climbing to 50 percent in 1988 and 60 percent in 1995. The most remarkable change, is that, in 1956, an average of 7.2 children were born for every woman in Tunisia; by 1994, the rate had fallen to 2.9 children.¹⁷ The government spends about \$10 million each year to educate citizens about family planning and dispense birth control devices to the remotest corners of a country.¹⁸ The case of Tunisia once again reflects the critical need to of having the committed executive leader (or branch) promoting CSR and committing substantial financial and human resources to the effort. Unmet need was 20 percent in 1998.¹⁹

Supply Side Factors

Internal Agents

Executive Branch

When Bourguiba became the country's first president, he was determined to create a society based on a modern interpretation of Islam. Under his direction, Tunisia became the first Arab and African country to adopt a specific population policy in the mid-1950s. The Tunisian Family Planning Association was established in 1968. Much of Tunisia's FP program was aided by societal factors and legal supports. First, women enjoy equal access to education and employment and are guaranteed the right to equal pay as men. The awareness created through maternal and child health care programs has also increased or leveraged support for CSR programs. Second, in 1966, Tunisia also legalized abortion, and it still stands alone among Islamic countries in legalizing the procedure. The government also outlawed polygamy and raised the marriage age to 17 for women and 20 for men, from 16 and 18 respectively. Government subsidies to families were limited to the first four children.²⁰

In the 1970, the President and his population policy came under attack by conservative groups and the Muslim clergy. But, he overcame the challenge and was eventually able to persuade the country's religious leaders to loosen their

17 Tunisia: "A Country That Works" Tunisia's Family Planning Success Underlies Its Economic Progress by Richard H. Curtiss November/December 1996, page 72

18 Naik, G. August 8, 2003. Tunisia Wins Population Battle, And Others See a Policy Model. Wall Street Journal.

19 UNICEF. 1995. The unmet need for family planning. <http://www.unicef.org/pon95/fami0007.html>

20 Naik, G. August 8, 2003. Tunisia Wins Population Battle, And Others See a Policy Model. Wall Street Journal.

interpretation of the Koran to fit the FP and RH cause. Friday sermons in mosques are often devoted to reproductive health and related subjects.

Ministry of Health

Given the climate of awareness and the legal underpinnings for family planning, current government efforts are particularly effective. The MOH's Office of National Family Planning and Population runs mobile clinics and uses health care promoters to visit individual homes in rural areas to discuss FP and RH issues. There also are maternal care centers in hospitals that provide abortions, which are legal under certain circumstances if performed by qualified doctors, but not if performed by unqualified practitioners.²¹

In addition, the Tunisian government has set up a High Council for the Family and Population to advise its Office of National Family Planning and Population. The government also has established regional councils for the family and population in each governorate, chaired by the governor. The regional councils are consulted on the action plans of the Office of National Family Planning and Population before they are adopted.

External Agents

Implementation Actors

Throughout the four Schools of Medicine, FP is now managed by local gynecologists and midwives. There are efforts to expand contraceptive education to the entire medical profession. The Office of National Family Planning and Population has two research centers: 1) the Population Department, where demographers and statisticians evaluate the activities of the Family Planning Program, and establish a data bank on demographic parameters, and 2) the Center of Research on Human Reproduction, which evaluates the psychosocial and medical acceptability of contraceptive methods. It also contributes to the training of medical and paramedical personnel. It is currently completing studies on, the post-abortion insertion of IUD, and the acceptability of vaginal rings, and is studying the incidence of sexually transmitted diseases on sterility.

Demand Side Factors

Information

Objective: Disseminate information on FP services and increase ease of access to FP products and services

Strategy: Dispatch teams to rural areas; use health care promoters

Condoms are distributed free in all clinics and sold for a nominal price in shops. Birth-control pills and the morning-after pill are available free to almost anyone who needs them. Mobile clinics offer free pap smears and breast exams. To address unmet need in remote areas, the government has relied partly on mobile teams -- a nurse, a social worker, a midwife and a driver -- that dispense family-planning and reproductive-health services. Health care promoters visit homes

²¹ Curtiss, Richard. "Tunisia's Family Planning Success Underlies its Economic Progress."

individually to discuss FP and RH issues with women.²² Two years ago, Tunisia's government began educating men, as well.

TURKEY

CPR WB 1980s	CPR WB 1998	CPR UNFPA (last year available)	CPR UNFPA* (Last year available)	Unmet Need DHS 1992	Unmet Need UNFPA (last year available)
62.2	64	64	38	12%	10.1%

* Reflects MWRA who use *modern* methods

Note: UNFPA did not report the data year in which their estimates are based.

Summary

In 1994, USAID and the government of Turkey, a predominantly Muslim country of 70 million that had long been dependent on donated contraceptives, announced an agreement whereby contraceptive commodity donations would cease over the period 1995-2000. By 2000, all donor supplies had been phased out. The government first purchased contraceptives using its own revenues in 1997. As of 1999, the government has spent US\$1.07 mil and committed another US\$ 700K to finance 50 percent of MOH's stocks. Turkey's CPR (for all methods) has grown slowly from 61.5 percent in 1983 to 64 percent in 1998. The current CPR for modern methods is 38 percent. In 2002, the budgeted amount of contraceptive funding was US\$4.8 million, of which \$2.5 million was intended for contraceptive procurement. This permitted about 80 percent of the public sector FP program's need for contraceptive commodities, which represents a 10 percent increase over program's need in 1997. In 1997, spending for contraceptives was about \$500K, increasing to US\$ 2 million in 2000.²³ Unmet need was 12 percent in 1994.²⁴

Prior to 1994, USAID was the sole provider of contraceptive commodities to the Turkish government, which covered 55 percent of the population. The remaining 45 percent purchased contraceptives from the private sector. As part of a phase-out program beginning in 1994, USAID focused on enabling long-term sustainability in family planning and reproductive health. Because free access to health care was viewed as a right, the MOH recognized that significant resources would need to be dedicated to changing norms and behavior. Development of the CSR policy involved various inter-related processes. These included (a) awareness raising, (b) development of technical skills and information base, (c) internal and external policy advocacy.

²² Curtiss, Richard.

²³ The POLICY Project. 2002. Pathways to Contraceptive Security. The POLICY Project. Washington, DC: The Futures Group International.

²⁴ UNICEF. 1995. The unmet need for family planning. <http://www.unicef.org/pon95/fami0007.html>

Internal Agents

Ministry of Health

The general directorate of the maternal and child health/family planning office (GD MCH/FP), which plays the lead role in planning the response to USAID phase-out, was responsible for FP policy and CS and for forecasting contraceptive needs. The GD MCH/FP is responsible for mobilizing and using resources for the procurement of contraceptives. The GD MCH/FP took the lead role in creating broad awareness from the ground up about CS.

Internal social mobilization and awareness is defined by efforts by GD MCH/FP staff to promote their financing and program support needs to compensate for donor phase out. Targets of internal mobilization and awareness would be other MOH CDs, the MOH Ministers office and the MOF. Early phase out period was marked by hesitation to engage in internal advocacy. In 1997, bold internal advocacy action was taken. Increase in line item 300 funding (consumable supplies) was used to procure contraceptive supplies. This action served as launching pad for subsequent internal advocacy efforts.

The staff of the Minister's Office of the MOH takes a lead role in budget allocations. The MOF provides technical resources related to contraceptive procurement. Interagency dialogue and linkages between the MOH and MOF have increased the success of securing adequate funding for procurement of FP commodities.

The primary challenge facing the GD MCH/FP was to secure adequate financial resources. Other strategic challenges were: a) inculcate a sense of national responsibility; b) change cultural norms (sense of entitlement c) maintain a smaller supply of MOH contraceptives to signal private sector opportunity to serve the most indigent d) overcome resistance to allocate new budget monies. Principal technical needs were: a) institutionalize analytical skills b) mobilization of FP market structure and public sector program client (market segmentation) c) develop capacity to use skills/data to be tool for mobilization and awareness and d) develop advocacy capacity among NGOs, intergovernmental units, civil society.

There are three principal social insurance schemes are also stakeholders. Their beneficiaries make up 60% of MOH family planning clients. The Social Security Agency (SSK) is the largest of these schemes, its beneficiaries constituting 37 % of MOH's clients. Historically, MOH provided free FP services to anyone who wanted them. State planning organization (SPO) is the principal support group, serving planning and coordinating functions in state government. SPO has participated in discussions on CSR, it is the central body in priority setting. Commercial sector representatives have participated since 1995.

The government of Turkey sponsored a workshop to promote awareness of self reliance. Difficult to maintain priority since warehouses were bursting with stocks.

Building support within MOH was difficult because of turnover. It took several years. Targeting began in 1997. Willingness to consider alternative sources of funding has increased. Awareness about the cost of serving social insurance beneficiaries led to consideration of options to secure financial contributions from social insurance organizations. MOH client donations, collected through the Health and Social Aid Foundation (HSAF) are another source of financing.

External Agents

International Actors

As part of a phase-out program beginning in 1995, USAID focused on enabling long-term sustainability in FP and RH. USAID funding was used to finance demand creation activities with mass media advertising. OPTIONS II and POLICY projects supported USAID's efforts to help MOH adopt and implement a CSR plan. In 1996, the POLICY project conducted a secondary analysis that segmented potential contraceptive users according to their risk levels and procurement patterns. The POLICY project also helped the government of Turkey develop its CSR strategy. The POLICY project convinced the MOH that it could not provide free contraceptives.

Intermediate Actors

Social mobilization and awareness efforts by NGOs helped promote and sustain Turkey's CSR policy. IN 1997, the Advocacy Network for Women (KIDOG), an umbrella network of NGOS, took an active role in self reliance issues by developing a high profile mobilization campaign designed to bring greater visibility to the issue. With respect to raising awareness about the need for cost recovery schemes, KIDOG developed an advocacy campaign to address the potential problems that the MOH would face if it continued to dispense free contraceptive commodities to all. KIDOG identified opportunities to influence the policy process at the national level by targeting the president, Prime Minister and other key cabinet members with messages on Turkey's commitment to support the quality of life for women. The objective of the campaign was two fold. First the campaign applied pressure on policy makers to place CSR at the top of their agenda. Second, the campaign raised public awareness related to contraceptives self reliance need in Turkey and its effect on women's health. Soon the campaign both convinced policymakers to purchase contraceptive commodities and increased public awareness of the issue. Despite the campaign's initial success, it faced two significant obstacles: frequent turnover of political collations in Turkey and need for continuous social mobilization and awareness. KIDOG worked through its civil society network to make personal visits to key stakeholders.

Demand Side Factors

Preferences and Expectations

Objective: To increase CPR and reduce unmet need while shifting wealthier clients to private sector

Strategy: Encourage shift to private sector by implementing user fees for FP products and services

MOH has developed FP program that operates through a widespread network of facilities across the entire country. Today, the MOH dispenses about 70% of all intra-uterine devices and about 30% of OCs in the country. MOH's FP service provision has traditionally been based on free and universal access. As restricting access to public sector services was seen as unconstitutional, policymakers were unwilling to directly shift better off clients to the private sector. Instead, they set in place a donation policy where clients seeking contraceptives from MOH outlets were asked to make a voluntary donation based on self-declared willingness to pay. To ensure adequate supply of contraceptives for the indigent, Turkey targeted its provision based on market segmentation.

At the outset of the CSR strategy, the Health and Social Aid Foundation (HSAF), an NGO that operates parallel to most MOH facilities, piloted a cost recovery program in a selected number of Turkey's public health care facilities whereby clients were asked to contribute a share of the commodity cost. Individuals could self report and claim that they could not afford or were unwilling to pay. Those who expressed an unwillingness to pay even a partial donation were provided contraceptives for free. The results of the brief study indicated that there was little shift in demand from asking for donations. Overall, 60 percent of clients made a donation; 51 percent paid the full amount requested (full payment) and nine percent paid less than the full amount (partial payment). The other 40 percent were exempt based on their declared unwillingness or inability to pay. The proportion of clients making either a full or partial payment was nearly the same among OC and condom clients (57 and 59 percent respectively) but higher among IUD clients (73 percent).

Clients of MCH/FP center and health center tended to make full donations of contraceptive supplies, while a lower proportion were exempted. MCH/FP centers, located primarily in urban centers, are larger than health centers and fewer in number. One of the reasons why MCH/FP centers attract wealthier crowd is because they are perceived to provide better quality services and clients are willing to pay for services. MCH clients paid the full donation even as the donation price increased. Following the findings of the feasibility study, Turkey adopted the policy nationwide and has charged HSAF with collecting and managing donation revenues from clients seeking contraceptives from public sector facilities and outlets. The revenues received are then used to subsidize contraceptive supplies to the poor. Today, the donation policy is operational in 18 of Turkey's most populous provinces, covering 35 million of the total population, which accumulates revenues that represent about 15 percent of the total

resources needed to procure contraceptives.²⁵ In 2002, it is estimated that this will increase to 25 percent.

Financial Sustainability

In response to the contraceptive phase out, the government of Turkey (GOT) defined two principal features of a national CSR strategy. The first feature consisted of annual allocations from the public sector budget. The government successfully mobilized about 60% of the resources needed to purchase contraceptives for the public sector program. At the outset of the CSR policy, MOH committed to securing funds to procure contraceptives. The MOH agreed to support cost recovery programs and has further developed a targeting and cost-recovery strategy to place its financing policy on sustainable footings (Tatar and Sine 2000).

The donation policy (discussed above) was implemented at primary health care units (PHC) facilities. The HSAF manages the collected monies, centralized at HSAF headquarters for the procurement of contraceptives, which are then channeled back to the MOH to augment supplies purchased with MOH funds. Primary health care (PHC) facilities issue HSAF receipts to clients who made donations, and a copy of each receipt was later provided to the Province Health directorate. Donation policy for contraceptive supplies differed from HSAF donation policy for other health services. HSAF allowed local PCH facilities to retain some of the donation revenues as an incentive for adopting the FP donation policy. The revenue sharing plan for contraceptive donations is as follows: PCH facilities retain 20 percent of the revenue they generate from contraceptive donations, 10 percent is retained by HSAF branch, and 70% is sent to HSAF headquarters for commodity procurements.

The government of Turkey has also supported by CSR by encouraging participation from the private sector. With support of the POLICY Project, the MOH conducted a public private partnership workshop in May 1997. Between 1997 and 2001, the government completed large contraceptive tenders but not without difficulty in the areas of currency management and planning. Because MOH was only able to complete three out of ten planned tenders, some of the procurement process had to be assumed by regional MOH offices. Unfortunately, small, decentralized tenders were neither cost effective for the government nor profitable for manufacturers, leading to frustration on both sides.

From 1988 to 2002, USAID supported initiatives designed to increase the provision of contraceptives through the private sector. These initiatives included social market programs through the Social Marketing for Change (SOMARC) project and public-private workshops on CSR through the POLICY project.

²⁵ The POLICY Project. 2002. Pathways to Contraceptive Security. The POLICY Project. Washington, DC: The Futures Group International.

The objective of the SOMARC project was to increase provision of FP methods through the private sector. In 1988, SOMARC conducted an initial assessment and recommended social marketing intervention. The project proposed to leverage Turkey's well-developed private sector infrastructure through partnerships with pharmaceutical manufacturers. The corporate-heavy board of the Turkish Family Health and Planning Foundation (TFHPF), established by Turkey's most successful businessman, was able to enlist private sector support for SOMARC led activities. In addition, the Foundation's lobbying skills allowed the project to advertise branded condoms for the first time. When the first attempt to produce condoms (with Durex) did not function, SOMARC joined with Eczacibasi. USAID funding was used to finance demand creation activities with mass media advertising.

Socially marketed pills were purchased by two bottom quintiles. While OC sales did not increase dramatically, FP service providers encouraged clients to switch to low dose pills which made investment and production more attractive to pharmaceutical companies. Pill manufacturers continue to face legal obstacles (such as price controls and advertising restrictions) that discourage private sector investment in this class of products. Injectable contraceptives were launched for first time in private sector in 1997, just before the end of the SOMARC program. This method received less support than condoms or OCs. Low margins and low sales volumes kept private sector investment to a minimum after the SOMARC phase out.

Despite the presence of the commercial market, the private and public sectors have not found sufficient common ground to cooperate on issues of CS; as late as 2001, there was still confusion in the public sector about role of private sector. MOH wanted more participation by private sector in tenders, demand creation activities and training support for new products. MOH staff said that they acknowledged the value of social marketing campaigns but felt that they have had no impact beyond urban areas and that more needed to be done to serve high risk groups. Although the government emphasized the need for private sector participation, private sector representatives felt that the public sector was not supported in practice. Though the MOH, thru POLICY, attempted to engage the private sector in CS policy dialogue, market constraints (price controls) still discourage significant commitment by private companies. Pill manufacturers did not bid on government tenders because of meager margins. Conflicting agendas and high turnover in MOH personnel discouraged private sector representatives. In short, a weakness in CSR seems to be absence of continued collaboration with private sector. The shortcomings can be explained largely by the government's focus on management and procurement capacity at MOH.

VI. Challenges and Opportunities

Of course, many countries are currently in the process of implementing CSR so it is too soon to draw definitive conclusions. That said, there are a fair number of countries that have increased their CPR even after phase out, so it is important to consider some of the factors which are associated (perhaps not causal) with successful implementation. Synthesizing the individual country case studies, this section summarizes those factors and some of the challenges and opportunities associated with the design and implementation of CSR strategies and reforms.

Supply Side Factors

5.1 Internal Agents

Executive Branch and Ministry of Health

Comparative review of country experiences demonstrates the importance of national support – executive branch, specifically – in the promotion and implementation of CSR. Clearly, the one factor that is common across all ‘successful’ cases of CSR is the strong and sustained commitment from the national government for FP and CSR [Colombia, Peru, Thailand, Tunisia, Turkey]. Without political will, the barriers to adopting and implementing successful CSR strategies are much more insurmountable. And even when the executive branch of the government pledges commitment, but does not follow through, CSR programs are more likely to fail. As noted by Lush et al., strong and financially secure coalitions of policy elites were important in sharing the political risk associated with CSR policies and were subsequently crucial to successful adoption and implementation of CSR.²⁶ Heavy-handed, top-down policies may lead to more successful outcomes.

For instance, Pakistan’s FP program, launched in 1965, has suffered long years of neglect and frequent policy changes that accompanied political upheaval. The results have been disastrous. Because the national government has failed to support FP by committing necessary financial and human resources, free supplies at the public facilities has been erratic. In 1984, Pakistan’s CPR was only 11 percent. Over the last two decades, it has crawled upwards to 24 percent in 1996 and 27.6 percent in 2000.²⁷ The lack of leadership from the executive branch has subsequently discouraged involvement from NGOs and international donors. Armenia faces the initiation of donor phase out of contraceptive. To date, the government has not taken any steps to deal with the phase out of donated contraceptive supplies. In contrast, the Bolivian government has supported since the 1980s. Strong support from the executive branch has resulted in Peru’s commitment to finance 100 percent of its contraceptive needs. The government of Bangladesh has supported FP for more than 30 years. And the CPR has gone from 7 percent to 58 percent. The success of Egypt’s FP program was due in

26 Lush, L.;Cleland, J.;Lee, K.;Walt, G. (2000) Population Policy and Research Review Vol: 19

27 Guttmacher Report on Public Policy. 2001. Islam, Women and Family Planning: A Primer. Vol 4(6) December. World Bank CD Rom

large measure to the political support from top leadership, including the president, as well as donor support.

Another factor to consider is the relationship between the Office of the President and the Ministry of Health. If significant layers of the administrative ranks of the Ministry of Health are largely political appointments, then it is more likely that MOH projects and policies will remain subject to the political will of the President and the Minister of Health. If top administrative layers of the Ministry of Health (and other relevant agencies) are bureaucrats, then continuation of FP/CSR policies may be easier to sustain.

5.2 External Agents

Implementation Actors

National Coalitions and Steering Committees

In particular, one institutional feature that seems linked to more successful FP and CSR initiatives is the establishment or formation of a national steering committee that encompasses stakeholders from different levels and representatives from several different agencies. Bangladesh, Ghana, Kenya, Mali, Cambodia, Myanmar, Nepal, Nigeria, Laos, Yemen and Zambia are among the countries that have established or reinvigorated existing national working groups for RH supplies. Peru and Turkey, both successful cases of CSR, have established national committees specifically for CSR. National committees can effectively coordinate actions aimed at achieving program priorities, such as securing funding or building logistics capacity.

NGOs

In addition, many developing countries have more easily coordinated and managed the phase out when supported by one large scale NGO (usually the International Planned Parenthood Foundation -- IPPF). The benefits of the presence of a large-scale organization include: wide distribution and brand name recognition; ability to coordinate efforts and responsibilities among different and smaller stakeholders; supply and distribution channels and referral networks with both public and private suppliers. Unfortunately, many of the NGOs are also dependent on donated FP commodities. As such, they, too, will have to devise (cost recovery and targeting) strategies to address the impact of the contraceptive phase-out.

Many IPPF/WHR affiliates have launched commercial programs to sell medical supplies and contraceptives, usually at below-market rates. IPPF/WHR helps affiliates identify market opportunities and develop business models, and provides technical assistance in financial management.

IPPF affiliates are adapting to this changing environment by developing new alliances and partnerships with government agencies and the private sector. For instance, BEMFAM, the IPPF affiliate in Brazil, has participated in the decentralization of the health care system in Brazil by directly contracting with

municipalities to provide technical support to their sexual and reproductive health service provision activities. These contracts now account for 43 percent of BEMFAM's income.

In Bolivia, the IPPF/WHO's Endowment Fund for Sustainability provided loan financing and technical assistance to CIES (Centro de Investigación, Educación y Servicios) in Bolivia for the development of a network of "Social Pharmacies." Intending to add pharmaceutical services at its clinics, CIES conducted a market study on which segments of the population to target, how to promote its strategies, which medications to provide, and what quantity to purchase for maximum profit and efficiency. As seen from several of the case studies, NGOs can provide a critical role in the design and implementation of CSR strategies.

Medical Professionals

Some countries have incorporated medical professionals and associations into the design and implementation of CSR strategies. As in the case of Colombia, this seems to be an effective way of building stakeholders and encouraging commercial sector participation.

Social Mobilization and Awareness Groups

Networks also expanded to include more groups, and thus helped build wider ownership for issues related to contraceptive security and consensus toward difficult and challenging policy actions such as giving the most vulnerable segments of society priority access to contraceptive subsidies. Not surprisingly, a review of the literature underscores the critical role that advocacy groups on the implementation and sustainability of CS policies. Countries with strong advocacy organizations appear to have been more successful managing the design and implementation of CSR strategies. Advocacy groups raise awareness and mobilize support for the continued public provision of affordable FP commodities. For instance, in Brazil, successful advocacy campaigns led the government to eliminate tariffs and other retail taxes that were making condoms too expensive.²⁸ In Peru, FP has been protected from well-organized opposition (from the Catholic Church and conservative groups) through public advocacy, continuous monitoring, mobilization of the press and active participation of NGOs, RH watchdog groups, health forums, and networks of women's development and social organizations. Some of these groups, like Red Mujer developed and employed advocacy tools (budget line items, policies and laws) for policymakers to consider and disseminated information on the benefits of FP. The result has been a steady increase in Peru's CPR and the government's commitment to finance 100% of contraceptive needs in 2004. Similarly, Morocco's population policy was led by non-governmental organizations (NGOs). In Brazil, the ability of the advocacy community to interact with the Ministry of Health and congress, as well as move into policy related positions, has worked in favor of achieving reproductive health goals.

²⁸ OUTLOOK. 2003. Ensuring Contraceptive Supply Security.

In Bolivia, a coalition of Bolivian family planning organizations developed an advocacy strategy that focused on the family health benefits of FP. The goal was to make the topic of family planning less taboo and to encourage public discussion through public media campaigns. The Bolivian campaign organizers obtained endorsements from President Sanchez de Lozada, Vice President Victor Hugo de Cardenas, and their wives, who stressed how family planning benefits mothers and their children.

In Turkey, seventeen women's organizations developed an advocacy strategy based on networks of supporters and collaboration among organizations. By adopting a common goal and theme, the organizations had far more influence on policy-makers than if each had made a case separately. As a coalition, they were able to obtain new government funding for contraceptive supplies, which helped compensate for the USAID phase-out.

As part of an advocacy campaign to increase men's approval of modern contraception, the Jordan National Population Commission focused on male religious leaders, physicians, social workers, and other community opinion leaders. The campaign sought to increase religious leaders' approval of contraception because their approval would strongly influence Jordanian men. To win their support, the commission sponsored community meetings, providing information about family planning and assuring the religious leaders that contraceptive use is safe and effective and in concordance with Islam. The meetings succeeded in motivating the leaders to discuss family health issues with their wives and to use health services. Participants agreed to return to their communities as advocates for family planning—creating a ripple effect that could reach as many as 50,000 people.

More specifically, information based advocacy to key policymakers has helped alleviate legal and regulatory barriers. In Pakistan, regulations on advertising branded contraceptives restricted social marketing of pills and injectables. As a result of advocacy and dialogue with key stakeholders, in 1999, the Ministry of Population Welfare and Ministry of Information approved method- and brand-specific television advertisements and permitted other marketers of contraceptives to advertise. In Egypt, following the disseminations of findings from a study on the legal and regulatory barriers to private sector provision of injectables, the MOH liberalized laws that restricted the provision of injectables to licensed ob-gyns, leading to expanded access of Depo-Provera to consumers.

Certainly advocacy is not unknown in the Philippines. In 1995, when religious groups publicly attacked FP as "anti-child, anti-family, and anti-life," the Family Planning Organization of the Philippines (FPOP) developed an advocacy strategy to refute their criticism. The strategy focused on providing persuasive information about the benefits of FP, demonstrating that in fact, family planning is "pro-child, pro-family and pro-life." In public messages the FPOP also stressed

the key role that family planning programs play in increasing reproductive choices for couples and improving their reproductive health. In addition, the FPOP persuaded President Ramos to declare his support for FP.

Community Based Distribution (CBD)

Several countries [Bangladesh, Colombia, El Salvador and Iran] are or have used community based distribution systems. Most NGOs have supported CBD programs with donated FP commodities. As such, some public health experts caution that NGOs may have a difficult time sustaining CBD programs once donated contraceptives are phased out. However, recent empirical evidence suggests that the benefits of CBD are quite significant. For instance, studies in Bangladesh and Iran indicate that CBD systems have been critical to disseminating awareness and information about FP particularly in rural areas and are associated with higher CPR.²⁹ As such, countries that are considering CBD or re-evaluating CBD in the era of contraceptive phase-outs may want to consider targeting CBD either at the early stages of reform when CPR rates are low or in certain geographic areas (usually rural). Alternatively, if policymakers do consider CBD to have significant benefits, one option is to have the government provide the FP commodities.

Intermediate Actors

Media

An important ally in advocacy efforts is the media. The media has been an important intermediate actor in several developing countries. For instance, While Bangladesh was successful in raising awareness about FP, it has been less successful raising awareness about contraceptive security. One of the reasons is that the media was not involved in the implementation of the strategy. Media representatives received very little training about the issue of CS and how to report it. Nepal, on the other hand, relies heavily on the media to gain access to remote areas. In Tunisia, the media has played a significant role in raising awareness by constantly airing FP goals.³⁰ Moreover, the most effective FP addresses specific groups. For example, in Bangladesh, a recent communication campaign was designed to address rural men after research found that men strongly influence women's reproductive choices and that many men resist FP. In Tunisia, the national FP program addresses young people who are about to marry or who have just married to inform them about the benefits of birth spacing. In Zimbabwe a multi-media campaign that focused on educating men about contraceptive use made a substantial difference.

But, the media participation is not automatic. Policymakers must extend concrete efforts to get media representatives onto the FP campaign and committed to raising public awareness. Some strategies to increase participation of the media include encourage participation of journalists in events that address CS, support journalism programs to include skills building for coverage of RH and FP, provide

²⁹ Jahanfar 2005
³⁰ Curtiss, Richard.

data and information about CSR to the media, convene forums and create networks that link the media and NGOs with FP and supply chain managers, and service providers.

5.3 Commercial Sector Participants

Private Sector Development and Participation

Roughly one-third of all FP users in the developing world already obtain contraceptives from private sector. In countries such as Cameroon, Colombia, the Dominican Republic, Ghana and Jordan, over 60 percent of users obtain their contraceptives from private source rather than public source. In Paraguay and Bolivia, the rate is above 50 percent. For most of the Latin America, it is more than 35 percent.³¹ Commercial shares in Asian countries vary widely but rarely exceed 30 percent and are usually lower. It can be relatively large in the Middle East and North Africa, but very small in sub-Saharan Africa. The fact that most developing countries have private sector presence suggests that two of the basic conditions needed for increased commercial sector provision of OCs exist: a) consumers who can afford to pay but who are currently using public sector products, and b) moderately priced commercial products legally registered in the marketplace.

Supporting continued private sector growth and participation has been the expansion of social marketing programs. The size and duration of social marketing programs are related to higher commercial outlet share³² and higher demand for contraceptives.³³ While these programs may increase the private share, their contribution in terms of direct sales is relatively small. However, social marketing has other important effects. The advertising and promotion involved may outlast the specific campaign in the public mind, as in Philippines. Social marketing may affect price of other brands (as in Indonesia). Social marketing has successfully involved the private sector in contraceptive distribution. The Social Marketing Company in Bangladesh and Wyeth-Ayers International signed an agreement in 2002 for marketing Nordette oral contraceptives over the next two years. The Futures Group, International and Pharmacia India signed a corporate agreement in March 2003 to expand and develop the market for an injectable contraceptive in three cities. Admittedly, there is little analysis on the efforts to transform subsidized programs into fully commercial ventures and of the impact of social marketing programs on the expansion of commercial markets. Qualitative analyses suggest that the movement from subsidized social marketing to fully sustainable programs is a slow and not always successful process

While governments have attempted to establish CSR by commercializing and/or establishing partnerships with private/commercial market representatives, there

31 OUTLOOK. 2003. Ensuring Contraceptive Supply Security.

32 Bulatao 2002.

33 Regional Contraceptive Security Report: LAC, October 2004.

are still several factors that hinder increased commercial sector participation. Some factors that determine market participation – such as size – fall outside the control of the government. Other factors– such as restrictions on licensing of pharmacies, price controls, rules and regulations around advertising – are directly under the control of the government and its FP programs. Policy decisions, in short, can play important role in increasing the private commercial share in the future. Knowing whether and under what circumstances the private sector could help close the contraceptive security gap is crucial. How governments regulate and how programs price and promote their products have consequences for the commercial sector that they should take into account.

There are four factors that might influence private sector participation:

- sufficient market size and critical (urban) densities
- competitive markets and market structure
- a friendly business environment void of excessive regulations and
- available distribution and promotion channels at a reasonable cost³⁴

In addition, additional macro-economic factors that matter include total population, macroeconomic health of country (stable inflation and exchange rates), and the size and depth of trained medical personnel.

Market size

Studies find that a higher commercial sector share appears to be related to higher numbers and densities of retail outlets. A better network of roads – to deliver product or facilitate consumer access to outlets – may also increase private share.³⁵ For instance, in Indonesia, the commercial market share of Cos remains small (12 percent). The failure of the commercial market sector to develop has to do with the tiny and inefficient distribution system which in a country as geographically dispersed as Indonesia, presents a significant disincentive.³⁶ One implication of this finding is that governments/NGOs may want to target limited free commodities to the poor in rural, sparsely populated areas where it is less likely that commercial sector representatives will ever participate (vis a vis retail outlets, pharmacies, etc).

Market competition: Prices

The price of public contraceptives is arguably the most important component. Smaller differences between public and private sector prices are associated with greater private sector share (Bulatao 2002, Foreit 2002). As public prices increase, higher proportions of OC users obtain their supplies from commercial providers, regardless of prices charged in commercial outlets. The overall results underscore the fact that public sector prices are a major determinant of use of commercial outlets for OCs, independent of commercial sector activities including

34 Bulatao 2002. What influences private supply of contraceptives?

35 Bulatao 2002.

36 Bulatao 2002.

social marketing. Specifically, a new policy of introducing small user fees in public systems (which currently provide untargeted free commodities) could have significantly and positively impact commercial sector participation (Foreit 2002).

As demonstrated by the case of Peru, the private sector was squeezed out by aggressive competition by the public sector which has been distributing free commodities, thereby making it impossible for the private sector to compete. That said, even after losing market share to the public sector, the pharmaceutical companies did devise new business strategies, including plans to sell directly to the national program.³⁷

The commercial market share is higher in Pakistan than in Peru. In 1994, 74 percent of pill users relied on private commercial sources. Pakistan's government has been an absent partner in FP and CS. Ironically, with little activity from the public sector and frequent stock-outs of supplies in public facilities, Pakistan's commercial sector has had the opportunity to increase their market share.³⁸ Similar trends are present in Paraguay which boasts a 60 percent commercial market provision of FP (43 percent through pharmacies) due to years of inconsistent supplies of FP products in the public health facilities and a hostile political environment to FP which thwarted even the participation of NGOs. In contrast, in Indonesia, pharmacies play a small role. In 1997, they provided 12 percent of private sector OC pills. Only for condoms do pharmacies provide most coverage (84 percent). Private doctors and clinics provide the remainder of private-sector contraceptives, including substantial informal sales of government procured product.

Of course, pricing policy (including controls) are influenced by the larger policy environments. In Egypt, prices are controlled by the government, and yet there are no subsidized pills in the commercial marketplace. In this case, private commercial providers of contraceptives have benefited from a stable environment. Price controls may have been beneficial to both users and suppliers, keeping methods affordable to consumers, guaranteeing commercial partners acceptable returns, and limiting competition from government outlets. The price of public sector provided contraceptives is equivalent to those of the private sector and NGO sector. While social marketing was introduced in 1979, it declined in the 1990s. Research indicates that Egypt's price control policy has been the single most important determinant in keeping the commercial sector engaged.³⁹

Enabling business environment

Unfavorable policies toward the private sector can undermine the impact of social marketing partnerships. This is especially true for pharmaceutical products. Price

37 Bulatao 2002.

38 Bulatao 2002.

39 Bulatao 2002.

controls, advertising restrictions and indiscriminate distribution of free contraceptives through the public sector all contributed to discouraging private sector investment. Though the POLICY project introduced the idea of targeting subsidies to the poorest, more efforts may have been needed to improve the context in which contraceptive manufacturers operate. Partnerships with the private sector can help increase CS, this role can be maximized through better coordination with policy activities.

The private commercial share of contraceptive provision in the Philippines is small. In 1998, only 22 percent of users relied on commercial outlets for pills. Pharmacies provide most of commercial sector condoms. Importation of contraceptives is permitted, though the paperwork may be onerous. Advertising for ethical products is legally prohibited. Commercial prices are high. Given relatively high commercial prices, social marketing probably has greater potential.

Engaging the Private Sector

To increase the likelihood of successful adoption of CSR strategies and reforms, the public sector – both the Ministry of Health and LGUs – should actively engage with the private sector and involve them in the decision-making and formulation of policy. Governments can involve private sector in a variety of ways that include joint strategic planning sessions, ongoing public-private stakeholder consultations, government business roundtables, and seminar/forums. In India, for instance, several multi-sectoral meetings and planning sessions resulted in the development of district action plans for two states that outlined a role for the private sector and specified several innovative schemes for public/private partnerships.⁴⁰ In the Ukraine, representatives of the government, NGOs, and the commercial sector formed a policy development group to develop a national reproductive health program for 2001-2004.

For policy makers in the early stages of design, studies have shown that the commercial sector can be leveraged during the earliest stages of program development to foster contraceptive prevalence and develop sustainability. However, mechanisms for involving large commercial companies may differ from those used to involve NGOs and smaller commercial providers. Larger corporations emphasize return on investment and efficiency above all, and may be less open to participate in meetings and forums. In such cases, public-private encounters could take the form of short focused meetings or could simply be included in regular meetings.

Some of the specific steps governments can take to engage the private sector are to:

- analyze the impact of public policies on the commercial sector and include representatives of private businesses in health care planning and decision making

⁴⁰ For instance, public sector doctors are now allowed to perform sterilizations in private hospitals.

- create favorable business policy environment (incentives, regulations, price controls, competitive markets)
- stress benefits to private sector
- recognize and define the target populations for respective sectors,
- communicate the private sector's role, niche opportunities and target populations
- jointly define the roles, responsibilities and goals/objectives of both private and public sectors in achieving contraceptive security
- assess the size and depth of the market
- devise incentives to attract private sector participation
- broad public education activities aimed at increasing demand for RH products and services
- undertake public private partnerships aimed at sharing the risks of expanding commercial markets for reproductive health products
- think creatively about public private partnerships
 - in the Dominican Republic, Schering agreed to cut the price of its oral contraceptive brand in half in exchange for advertising paid for by the USAID funded social marketing organization
 - In Brazil, Pharmacia sought to market its injectable contraceptive Depo Provera to wealthy customers at a high price. In exchange for marketing support for the USAID, the company agreed to cut its price in half and promote the product to less well off customers

Private sector development has to be done in conjunction with other initiatives including the mobilization of governments, the efficient use of public resources, and coordination or allocation and use (distribution) of resources from host of different sources.⁴¹

The impact of private sector participation

Across the developing world, commercial outlet share is modestly correlated with OC prevalence and with total users. However, this relationship is driven entirely by South America. In other words, outside of South America, commercial outlets do not systematically tap into the larger OC markets. Data shows no strong pattern of growth in the commercial sector market share as contraceptive prevalence rate increase. Thus, growth of commercial sector share is not an inevitable consequence of increased adoption of FP.

5.4 Financial Sustainability

Budget Line Item

The overarching concern of most countries is how to fund the purchase of contraceptive commodities in the face of a phase out. Most countries face a looming public sector funding gap, exacerbated by declining tax revenues and competing priorities for essential drugs and vaccines (the demand and costs of

41 DELIVER/POLICY ISSUES Creating Conditions for Greater Private sector Participation in FP/RH: Benefits for Contraceptive Security

which are rising). Many countries have attempted to secure financial sustainability for the purchase of FP commodities by including a line item in the national public budget for the purchase of contraceptives [Bangladesh, Bolivia, Mexico, Paraguay and Peru]. Creating a line item for the purchase of contraceptives protects resources from being co-opted or directed away from FP towards some other expense or need.

On the other hand, policymakers in some countries may want to avoid the budget line item if it makes the program more visible and subsequently more visible to attacks by opponents. In this case, policymakers may want to lump specific items for the procurement of FP commodities under general health public expenditure or the procurement of all pharmaceutical products.

Another related option is to survey the budget to examine how other budgetary items (e.g. vaccination programs, DOTS programs, welfare programs, education programs) are 'protected' and pursue similar policy protection for FP and the procurement of contraceptives.

Social Security Institutes (SSI) are well poised to play a bigger role in the financing of CSR.⁴² Currently, clients access contraceptives through other channels (commercial markets, public facilities). However, as contraceptives decline, MOH should consider ways to shift responsibility of serving eligible clients back to SS health providers. As more and more people move into the formal sector, SSI is expected to grow. El Salvador's SSI makes FP services a priority. The USAID continues to provide contraceptives to Guatemala's SSI, even though the direct supply of contraceptives to the MOH is being phased out.

Cost Recovery Mechanisms

Programs that depend mostly on international donor funds, typically those that are operated by nongovernmental organizations (NGOs), have few options for increasing revenue. Charging a fee to family planning clients is one strategy for recovering costs. Other approaches include charging clients for related health services, such as laboratory tests, or selling program services, such as training or education, and using a portion of that money to subsidize family planning programs. Fees can help ensure a steady source of revenue, thus enabling a program to become sustainable as international donor support diminishes. Revenues generated by fees may also lead to improvements in quality of care, decreased dependence on donor agencies, and increased financial sustainability for individual family planning programs.⁴³ Fees can be used to broaden access to services. Within the public sector, fees can guide clients to low-cost service delivery points (pharmacies instead of clinics, health centers instead of

42 SSIs may also play indirect roles in CSR strategy implementation. For instance, policymakers in Tunisia claim that the SSI has helped build support for CSR because it eliminates the concern of parents that they need many children to support them when they retire.

43 Barnett, B. Do client fees help or hurt? *Network* 18(2):6–11 (1998).

hospitals). Revenues can give program managers greater flexibility in planning clinic activities and more control over clinic policies and services. Fees charged to middle-income clients can subsidize services for the poor and can improve efficiency of services by encouraging competition between the public and private sector.

Public resources can be focused more effectively on low-income clients if people who are able to pay shift to the commercial sector. This requires convincing consumers that private-sector services are affordable and have advantages over public services. Free public services, lack of information and training, and legal restrictions have slowed down the expansion of the commercial sector into family planning, but some donor agencies and government health ministries are helping train private-sector providers in family planning, including pharmacists, midwives, and private physicians.⁴⁴

Even if countries implement a voluntary donation policy [Turkey] which may not recover the full cost of the contraceptives, collected fees can be reinvested in the service facility and can provide revenue for offering health services. Evaluative studies indicate that clients tend to demand more responsive services when they pay for them direct, especially if local communities are involved in the design and application of user fees. Based on the experience of Turkey, policymakers suggested that in order to increase effective CSR, health promoters – ALL health providers – including midwives, etc. should be designated to discuss donation policy with clients. Discretion about payments should be left to each facility and not established at the national level. Facilities should be required to log donation categories and method dispensed.

Creative strategies have also been used to help subsidize the costs of services and improve program sustainability. In Bangladesh, the Concerned Women for Family Planning (CWFP) established a maternal-child health and family planning clinic, which required income in order to match donor support. CWFP began charging fees for clinic services on a sliding scale, based on clients' ability to pay, although no client was denied services. CWFP also opened a restaurant and catering service, a laundry and a beauty parlor. These activities served the dual purpose of providing jobs for local women and generating income for the organization. This is similar to the project in Thailand whereby FP participants were eligible for economic development loans.

The Fundación Mexicana para la Planificación Familiar (MEXFAM) in Mexico has increased fees for family planning and has begun selling training materials as part of IPPF's Transition Project. PROFAMILIA in Colombia recovers 50 percent of its total costs through the sale of medical and surgical services and a social marketing program. Income is used to help subsidize family planning programs.

44 Finger, W.R. Commercial sector can improve access. *Network* 18(2) (1998).

Preliminary evidence suggests that charging user fees in public sector has not reversed gains made in FP programs and is associated with higher use of commercial products sold through commercial outlets. To encourage non-poor consumers to choose commercial sector sources, governments could consider increasing the price of contraceptives at public sector outlets. Fortunately, most research has found that prices increases do not reverse gains made in FP and CSR programs. In Indonesia, prices for OCs at the public sector outlets quadrupled over the past 10 years, with no decrease in consumption (Foreit 2002). Lewis (1994) notes that when prices for contraceptives increased in Colombia, Jamaica, Sri Lanka and Thailand, there was no decrease in contraceptive prevalence in those countries.

Moreover, results show that there is a positive correlation between the percentage of public sector clients who pay for their pills and the commercial sector share of the pill market. In other words, the collection of user fees in the public sector is associated with a larger commercial sector for pills. This correlation is particularly strong for low-income countries, which may be the result of social marketing programs. Consequently, in low-income countries, the charging even a small user fee in the public sector appears to make social marketing programs more competitive.

5.5 Institutional Factors/Infrastructure

CSR requires a minimum set of institutional capacities which are as important as the financial resources required to purchase FP commodities. Effective CSR strategies require the physical infrastructure provided by a logistics management system which covers planning, procuring, transporting, storing, and distributing not only contraceptives themselves but also any clinical supplies required to provide high-quality services, such as rubber gloves for IUD insertion, and informational materials for service providers and clients.⁴⁵ Related information systems are required to produce reliable and useful data, policy decision-making criteria, performance benchmarks, priority setting, logistics, evidence based interventions, program implementation and monitoring. Without good logistics, stock-outs or inadequate supplies often result. Institutional capacities in the form of trained health personnel, standards of practice and clinic renovations and equipment, as well as MIS, also require maintenance and expansion and ongoing training. An efficient LMIS can help health program managers improve their systems by reducing commodity costs, enhancing program management, informing policymakers by providing decision making data, providing better customer services, and allowing greater control of control of contraceptive flows and accountability of donated contraceptives.

Challenges

Developing country organizations face a number of obstacles in designing and implementing multi-tier LMIS, including a dearth of technical skills (especially at

⁴⁵ OUTLOOK. 2003. Ensuring Contraceptive Supply Security.

the regional and local levels), lack of resources, inadequate infrastructure for technical and communication services and literacy rates. The public organizations in which these systems are established can also hinder successful implementation since there is underdeveloped organization capacity for management which finds it difficult to manage the increasingly complex relationships between multiple partners at multiple layers and decentralization. Consequently, delivery to health facilities and supervision are continuing problems. The absence of global coordinating mechanisms contributes to overlapping or conflicting donor efforts as well as to supply emergencies. Bolivia, El Salvador, Guatemala, Nicaragua, Paraguay and Peru have logistics systems in place to plan procurement, coordinate donors, and allocate scarce resources to match local needs. Despite improvements, forecasting capacities remain weak, resulting in wasted stocks [Bolivia, Peru]. The current logistics systems do not pay attention to seasonal demand or related factors. For instance, Paraguay always bases current demand on historic demand, never taking into account possible increases; the result is frequent stock-outs.

To illustrate the difficulties: in Nigeria, the Department of Community Development and Population Activities (DCDPA) manages most of the supply chain capacity, while the NPHCA (National Primary Health Care Development Agency) manages the zonal warehouses. The division of responsibility across two different agencies creates an inefficient communication flow that has hampered the flow of products from central level to the states. Transactions between center and zonal warehouses are ad hoc rather than systematic. Moreover, the allocation of commodities from the central warehouse to zonal warehouses is not based on consumption data, as it should be to prevent shortages and oversupply. At zonal level, contraceptives were rationed when issued to state stores, due to insufficient supply.

This difficulty in coordinating among the different entities is exacerbated by the fact that countries maintain programs and operations that are vertically integrated. As FP programs grow, they must coordinate logistics at regional or national levels. The process of integration vis a vis logistics systems and different levels of governments requires strong incentives. More often than not, units are vertically organized with little communication and interaction between the various policymakers. At present, in Egypt, there are 29 uncoordinated government and public entities along with NGOs, numerous private vertical programs such as FP. Weak capacity in strategic planning, investment management, cost accounting and budgeting, and weak management systems (Khalifa 2001). The trend in the region to integrate logistics systems extends not only to warehousing and transportation but also to integration of information and inventory management systems.

Additionally, one of the issues is whether to integrate all medicines or just those limited to FP. In some instances, it makes sense to process and integrate the vertical distribution system for family planning commodities with commercial ones

for essential drugs, vaccines and medical supplies [Tanzania]. Bolivia, Ghana, Nicaragua and Peru have adapted management systems for all medicines and supplies. In other cases [Guatemala], it may not make sense.

Another challenge in maintaining effective logistics and information management systems is lack of trained personnel. But, logistics system can work. In Nigeria, the logistics system has trained personnel, guidelines and manuals for operations, practice and responsibilities at all levels. The success was due, in part, to high level MOH sustained commitment to improving the system. Other countries, have addressed the challenges of building an effective logistics and management information system. As demonstrated by the case of Peru, the government found it easier to outsource the management and supervision of the logistics system. Training and supervision have been a worthwhile investment. The result has been adequate logistics expertise at the intermediate and service delivery point levels. These staff managers are now able to manage the system without PRISM. Now that MOH has begun to purchase its own contraceptives, USAID will need to allocate additional resources to logistics, to protect its investment.⁴⁶

Opportunities

Several NGOS, donors and private foundations started the Supply Initiative. It is a web-based tool that supports common procurement and shipment data platform for major contraceptive donors. It also provides a strategic framework to assess strengths and weaknesses of country's effort to expand access to FP commodities and services.

Above all, the logistics management and information systems (LMIS) should be established with a goal of gathering indicators to measure performance so as to assess effectiveness of CSR strategies. Specifically, the LMIS should include indicators of efficiency and effectiveness, system cycle-time and its relationship to cost structure of running the system together impact the capacity of the current system to meet its objectives. Adjustments and constant monitoring are necessary and must be built in [Tanzania]. Countries that did not do this include Ghana.

Another problem that many developing countries face is that the process for design and implementation of LMIS entails a top down approach but fails to address the needs or support the activities of those using the program. Successful cases of CSR adoption involve instances where users participated in the design so as to support their specific needs. For instance, in 2002, the MOH of Nigeria convened a meeting of RH stakeholders to discuss the logistics system and the issue of CS. The discussions led to the establishment of a Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) committee, a JSI/DELIVER-sponsored tool designed to help countries develop

46 Godinez 2000.

and implement strategies to secure essential supplies for FP and RH programs, comprised of 19 stakeholders and 25 in-country experts in a range of fields. In 2003, the group led a four-day CS strategic planning workshop, convened by the MOH. A broad range of stakeholders reviewed a draft CS strategy prepared by the core group. The MOH formally approved the strategy and the parliamentarian representing the national legislative committee on population promised legislative support. Nigeria was first country to adopt a strategic plan using a comprehensive, long-term, holistic approach which helps prevent stock-outs. This led to the development FAMPLAN, a model that enables one to project country's requirements for condoms and contraceptives.⁴⁷ Training people and developing LMIS through a participatory process establishes buy in of the LMIS as well as the CSR program.

In the end, the best cases of successful CSR are ones which established LMIS systems that tailored the design to the local context, inculcated ownership in the system at all levels and across all stakeholders (through training and transfer of logistics skills), held regular meeting with key policy makers and program officers, presented data at meetings, and sponsored logistics seminars and workshops. Significant external support – funding and technical expertise – are critical components to ensure the initial success of the system. That said, after the implementation, the benefits may not ensure/guarantee institutionalization. Other support, including local funding and technical expertise is required. It may also be important to set of an impartial mediator – i.e. someone who is not involved with management or design of logistics system [Tanzania].

Demand Side Factors

5.6 Preferences, Information and Expectations

Preferences

Beyond simply providing contraceptives and meeting unmet need, policymakers must consider the method mix of contraceptives since the method used has financial implications. Generally, contraceptive costs have increased since the mid 1990s due to higher demand for injectables of which the government is the primary supplier. The related drop in IUD use in Peru and Nicaragua and voluntary sterilization in Honduras and Bolivia are cause for concern since the shift away from permanent methods to temporary methods translates into higher costs for the public burser. Creating long term demand for new or permanent methods requires sustained marketing efforts focusing on both supply and demand.

Another concern for program managers is how to subsidize services for clients who cannot afford to pay. Market segmentation and targeting are crucial to

47 Ministry of Health, Nigeria. 2003. Projections for Contraceptives, including Condoms for HIV/AIDS in Nigeria. USAID.

2004. Contraceptive Security: Ready Lessons.

developing viable cost recovery programs.⁴⁸ Targeting is underdeveloped in most of Latin America as well as Bangladesh. However, a quasi form of targeting is used by the Paraguay MOH. Contraceptives are provided for free to clients, but a small fee is charged for FP consultations. Those who are poor are exempted. Targeting can help programs move toward contraceptive security by addressing: unmet need, inequitable distribution of FP commodities and services, product availability and sustainability of FP commodities and services. Targeting can also help remove barriers and improve access for underserved groups.

Generally, there are three types of targeting: characteristic, individual and mixed. In Indonesia, an example of characteristic targeting is that all residents in the designated "poorest" villages are issued health cards entitling them to free maternal health and family planning services at the nearest health facility. As an example of mixed targeting, in Romania, all students and all rural residents are eligible to receive free contraceptives on presentation of proper identification. As for individual targeting, in Romania, the poor who are neither students nor rural residents are eligible to receive free contraceptives after completing a means-tested certification process. In Turkey, public sector family planning clients are asked if they are willing to make a donation to cover the cost of the FP commodities. Those who self declare that they are unable receive free contraceptives. In both South Korea and Costa Rica, governments distributed vouchers to the poor on the basis of means-testing. The vouchers entitled the holder to FP services at her choice of source. The government reimbursed providers for vouchers submitted.

In Peru, the Instituto Peruano de Paternidad Responsable (INPPARES) implemented a sliding scale to waive or reduce fees for low-income clients. In Kenya, the Marie Stopes/Population Health Services Program developed a checklist to help program managers determine whether clients should be exempt from paying: poor mothers who were unemployed or working for very low wages were exempt, as were clients who owned less than an acre of land. One strategy for ensuring that poor people continue to have access to family planning is "cross-subsidization." Charges for other health services, such as lab tests, are used to subsidize family planning services.

Information

One factor that emerges from the review of country experiences is the significant role that health promoters and mobile units have played and can continue to play in maintaining demand (CPR) and/or addressing unmet need. Most of the Latin American countries, even the densely populated ones [El Salvador] rely heavily on health *promotores*. In Mexico, MEXFAM trains and equips a network of volunteer health promoters that bring family planning and basic health care to

48 Schuler, S.R. et al. Reconciling cost recovery with health equity concerns in a context of gender inequality and poverty: findings from a new family health initiative in Bangladesh. *International Family Planning Perspectives* 28(4):196-204 (2002).

rural areas of the country. Bolivia, Thailand, Tunisia and Turkey have mobile units to reach the most isolated rural populations. Associations in Bolivia and Guatemala utilize mobile units to provide basic health and family planning services.⁴⁹

Sustaining demand requires that (potential) consumers have access to information. From the clients' point of view, not only the technical quality of services is important but so are other aspects, including privacy and confidentiality, competent counseling, friendly personnel, and the opportunity to make an informed choice about contraception. In a study of a family planning clinic in Santiago, Chile, women defined high-quality care as being treated well. Among the elements of quality that clients identified were hygienic conditions, prompt service, useful and accurate information, adequate time for consultations and counseling, opportunities for learning and personal growth, friendly and interested staff, and being treated as an equal.

Women are more likely to use family planning if they respect and have a positive relationship with service providers. Research shows that health care providers' attitudes and treatment of clients often determine which health services women use and even determine whether women seek services at all. For example, in Nepal service providers' poor treatment was one reason that women made little use of clinical family planning services. A study found that, when lower-status women visited clinics, they received less courtesy and less information than educated, middle-class clients. Women who were treated poorly discussed their bad experiences with friends and neighbors, and thus family planning services developed a bad reputation.

A recent study in Iran found that community distribution of FP was effective because it increased the level of knowledge regarding contraceptive methods and enhanced correct choice of contraception by couples (Jahanfar 2005). In short, CBD provides for better knowledge, proper choice, and correct and continuous usage of contraception. Admittedly, not all countries implement CBD, but the findings suggest that information and quality of service play an important role in maintaining and possibly increasing CPR.

Expectations

Preliminary research indicates that wealthier contraceptive users would be willing to pay once donated contraceptives are phased out. This is not surprising given that studies in Egypt, India, Indonesia, Jordan, Morocco, the Philippines and Turkey have shown that large numbers of women with the ability to pay for FP products and services are using the highly subsidized services of the public.

49 Arends-Kuenning, M. Reconsidering the doorstep-delivery system in the Bangladesh family planning program. *Studies in Family Planning* 33(1):87-102 (March 2002).

Results also suggest that field workers will be most effective if they target their visits to women who are uneducated or live in poor areas.

sector (Foreit 2002). A recent analysis of ten donor dependent countries reveals that 45 percent of pills and 56 percent of condoms supplied by the public sector and social marketing initiative went to those who can afford to pay.

Prior to 1990, Indonesia's National FP Coordinating Board distributed contraceptives for free. Subsequently, the program began to encourage payment, first to promote a shift to privately procured methods and second, to use nominal payments as a means of improving the image of public commodities. Public outlet prices are now probably within the range of commercial prices. And levels of CPR have not fallen. A recent study in Ghana found that more than 80 percent of those interviewed indicated that they would be willing to pay at least 50 percent more for their FP commodities (Winfrey 2003).

Although women who can afford to pay are a minority of the total OC market, moving them to commercial providers would reduce the burden on the private sector and motivate the growth of commercial markets. And out-of-pocket spending on other health care suggests that where sufficient motivation exists, consumers can access the commercial sector for supply methods. For instance, a recent reproductive and child health (RCH) accounts indicates that household out of pocket expenditure accounts for 80 percent of total RCH expenditure in India. In Morocco, half of women see private health workers for RH and child delivery. In Peru, the Philippines and Tunisia, 25 percent of women seeking care use private sources for prenatal services.

In Indonesia, women who pay for private maternal and child healthcare (MCH) accounted for 9 percent of OC users. If all these women were to purchase their supplies privately, the private sector share of the OC market would increase by 25 percent and the government burden would decline by 6 percent. In the Philippines, women who pay for private MCH accounted for 13 percent of all OC users. If these women were to pay for their supplies privately, the private sector share of the OC market would increase by 22 percent and the government burden would decline by 7 percent (Foreit 2002).

Some social marketing studies suggest that couples are willing to pay about 1 percent of their income for contraception. In establishing a fee system, Management Sciences for Health (MSH), a U.S.-based organization that provides technical assistance to developing country health programs, recommends that contraceptive prices mirror those of other household items. To determine the impact of price increases on client use of contraceptives, Ecuador's Centro Médico de Orientación y Planificación Familiar (CEMOPLAF) conducted a study that compared what clients said they would do with what actually happened when prices were increased. The study found that while there was a slight decline in the number of clinic visits but no significant change in the client economic mix. In other parts of the world, Turkey implemented a donation policy in which clients are asked to make donations for contraceptives. There

was no significant change in demand patterns and 60% of clients offered some level of payment.⁵⁰

5.7 Socio-Political, Legal and Regulatory Environment

Decentralization, integration, private sector involvement and other processes related both to health sector reform and reproductive health have not been well coordinated, and such fragmentation has resulted in overlapping policies and lagging programs. Policy and program development have also been hindered by inadequate human and financial resources, uneven allocation of responsibility between different levels of the health system and service components, a lack of communication between program staff, and limited political and organizational commitment to improving health service and quality and equity.

Decentralization

Many countries, including Bolivia, the Dominican Republic, Ecuador, Peru, and Zambia have taken measures to decentralize services and financing to the local and/or regional levels of government. Some countries, like Honduras, Nicaragua and Paraguay, are only decentralizing health care authority, services and financing.

Opportunities

The advantages of decentralization are that it puts authority in the hands of the managers, often at the district level who tend to be better acquainted with local conditions than persons at higher levels. Decentralization can mean greater flexibility in how resources are allocated and used. It can also promote capacity building by ensuring that training and other investments are adapted to local needs. Decentralization of health care services can make delivery of FP commodities and services more efficient. For instance, Chile's strong central government decentralized health budgets to the regional level. The decentralization of decision-making has actually strengthened its FP logistics program.

Challenges

Decentralization actually increases the challenges faced by governments [Indonesia]. As in the case of Zambia, resource allocation to districts has been consistently insufficient, resulting in partial or incomplete implementation of budgets and work plans. Dialogue and coordination between regional, national and local actors involved in health care reform and RH have been limited. In many cases in Latin America and the Caribbean, the delivery of health care services has become a separate political and technical process.

One of the greatest challenges posted by decentralization is that it requires greater technical and management capacity at all levels of the health system and strong, efficient structures to link local and district level systems to the national

⁵⁰ Challenges: Financial Sustainability (Turkey)

level. Recent studies show poor outcomes in terms of successful transfer of decision-making capacity and improved equity. The central MOH procures contraceptives (to take advantage of economies of scale) but the regions are in charge of their procurement budgets, product selection and forecasting. Since these responsibilities were devolved to the regions, there has been a 75% decline in the procurement of OCs by the central authority. Supporters of FP are concerned that the autonomous regional health administrations, usually headed by doctors may be giving less attention to contraceptives in favor of other commodities and programs. Without a strong national policy or agenda to guide the implementation of critical services at local level, results tend to fall short of expectations (and may result in stock-outs, waste). Then primary challenges include a lack of technical, administrative and financial management expertise and limited awareness of reproductive health problems as public health priorities at the local level.

Arguably, one way of overcoming some of the challenges is to engage in and maintain a continuous dialogue at the national, regional and local levels. Successful CSR outcomes depend on stakeholders at all levels of government developing and buying into a shared vision.

Health care reform

Many countries have attempted to link FP reform and CSR strategies with general health care reform (HCR). On the one hand, new development assistance programs (such as SWAs and PRSPs) provide opportunities to bring CS into the foreground of national priorities. The need for ownership and broad stakeholder participation required to implement health care reform spills over onto CSR. The pooling of funds for sector programs can offer security as a country can secure commitment of more than one donor/partner to support availability of contraceptives.

However, new financing mechanisms also bring new challenges. Movement away from direct program support towards a macro-level, sector focus may mean that RH and FP programs and their achievements are orphaned either out of neglect or the transfer of funds into other programs [Ghana, Bangladesh]. Program agendas with a broad focus may fall short on developing explicit performance goals [Ghana]. An emphasis on poverty means governments must focus on programs that reduce poverty (so as to achieve goals) to secure more external funding, which may not necessarily have any impact on contraceptive self-reliance or contraceptive prevalence. For instance, in Zambia, despite inclusion of RH in SWAp and PRSP, no specific budgetary allocation was made and no FP indicators were selected to monitor progress towards meeting the goals laid out in strategy. Possible solutions include linking planning and budgeting processes to broader national and international objectives and making

sure that donor assistance programs include specific performance indicators for FP and CSR.⁵¹

Regulatory Factors

A review of country experiences suggests that one policy change or instrument that can effectively promote FP is to include FP commodities on national lists of essential medicines. Surprisingly, many countries have yet to demonstrate their full commitment to FP. A recent review of essential medicines lists in 112 countries found that many national lists did not include basic contraceptives such as IUDs and condoms. There are, however, a few countries which are reorienting their CS programs around supplies. For example, a statement on security supply was written into Bangladesh's new population policy. In Mexico, federal health authorities recognized the importance of securing contraceptives for the national FP program. After negotiating with 32 individual states, national health authorities classified contraceptives supplies as a national security item, a step that established a budget line item to aid in procurement. While it is fine to incorporate contraceptives into essential drugs budgets, there are some potential constraints that may undermine CS. First, problems with inadequate budget funding and competing priorities, fixed budgets versus consumption based allocation of supplies, and inadequate information and product flow in decentralized systems may hinder CSR.

Regulations surrounding the procurement of contraceptives can impede successful adoption and implementation of CSR.⁵² A review of country experiences suggests the need to further explore the ways in which regulations impede contraceptive procurement.

Many countries have procurement regulations that facilitate purchases of most products. With the exception of a few countries [Peru which produces a Depo-provera equivalent locally], most developing countries do not produce contraceptives locally. Although ministries of health are able to offer international tenders, very few countries have purchased contraceptives on the international market place.⁵³ Instead, many countries purchase contraceptives from local distributors and laboratory representatives [El Salvador, Paraguay, SSIs of Peru

51 Ensuring Contraceptive Security within New Development Assistance Mechanisms.

52 Regional Contraceptive Security Report: LAC, October 2004. Generally, there are roughly six procurement options: a) centralized procurement through international organizations (UNFPA); centralized procurement through national tender and bid; decentralized financing and procurement; centralized procurement with decentralized funding; partnerships between manufacturers and NGOs; and regional pooled procurement or regional negotiation of prices.

53 The Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Paraguay and Peru have all begun to contribute to contraceptive and condom costs but none has purchased contraceptives on the international market place.

Turkey, however, has.

and El Salvador]. Other governments use UN agencies as their source of contraceptives [Peru, Guatemala].⁵⁴

One of the reasons countries have not gone to the international market place is because national procurement practices favor local manufacturers and distributors over international competitors. In Peru, bids from national companies are awarded higher points. High-level government approval is required before international procurement is permitted. Even purchases made through UNFPA and PAHO may be approved only after several requests for bids have failed to produce an acceptable offer. Moreover, direct contracting between the government and international manufacturers is not possible without local representatives and/or distributors acting as middle-men. This is because those manufacturers will only sell through their own regional and country representatives. The result, however, is a higher price associated with the middle-man. This makes it impossible for developing governments to obtain contraceptives at favorable prices.

Governments also face tiered pricing, which means that two countries may get different prices, based on the pharmaceutical industry's analysis of their respective economies and pharmaceutical markets. Moreover, there is limited competition at the low end of the market. Few manufacturers and distributors offer low cost OCs, IUDs or condoms in their product lines.

Procurement options available to governments have an important effect on costs. Peru has been able to cover its contraceptive needs in 2004 because the MOH is purchasing contraceptives at lowest available prices through UNFPA. However, in Honduras, where the government is paying higher prices, it was only able to cover 20 percent of total requirements.

In addition, many countries have price controls, cumbersome product registration, licensing and certification processes and restrictions on brand advertising and marketing of FP commodities. This discourages commercial sector participation. While seemingly minor, advertising has two main functions that can affect CSR: it provides information about the availability of a product and its characteristics and differentiates a product in order to increase brand loyalty; it reduces competition from substitutes (which can help shift contraceptive users away from public facilities and products), and increases market share and profits.

Some of the steps needed to eliminate regulatory and legal barriers include:

- Removal of import and local taxes, making contraceptives more affordable and accessible to low-income clients and private entities seeking to enter the contraceptive market

⁵⁴ Peru has purchased Depo-provera and condoms through the UNFPA reimbursable procurement program. Guatemala has been contributing increasing amounts each year to a revolving contraceptive fund managed by the UNFPA Guatemala office. Honduras' MOH included contraceptives in UNDP pharmaceutical procurements.

In 2001, as a result of mobilization by the National Population Commission, Jordan's Ministry of Finance, Ministry of Industry and Commerce and general director of customs exempted all modern contraceptives from duties and tariffs. The Council of Ministers also exempted all modern contraceptives from sales tax

- Lower and/or remove sales tax on contraceptives
Sales tax on RH health products and services as high as 20 percent in some countries, imposing costs on private suppliers that are passed on to the consumers. In many countries, imports designated for commercial markets are heavily taxed, while donated goods are usually imported free of charge, putting commercial firms at a further disadvantage in competing with subsidized programs.
- Remove restrictions on advertising of FP products and services through broadcast media
- Allow for the inclusion of reimbursement purchase of contraceptives and condoms in health insurance policies
- Streamline process of product registration, licensing and certification
- Relax price controls on commodities
- Standardize product registration procedures
- Relax controls on classification of contraceptives

VII. National and International Stakeholders involved in FP and CSR in the Philippines

NATIONAL

1. DKT (Social Marketing Company)

DKT International is a Washington, D.C.-based charitable organization that implements social marketing programs. DKT-Philippines, which began operations in 1991 with the introduction of Trust condoms, program in the Philippines has two major objectives. One is to increase the trial and continued use of contraceptives by making affordable, high-quality condoms and oral contraceptives conveniently available to low-income couples. The other is AIDS prevention, which includes educational campaigns, street theater and condom promotion in hotels.

In January 1997, DKT introduced Trust pills, a low-dose oral contraceptive manufactured in Germany, which has since become the leading condom brand in the market. Last year (2004), it launched a low-cost injectable. This project has become an important 'bridge' between the public and private sectors.

2. Pharmaceutical Companies

At the LEAD sponsored roundtable of pharmaceutical representatives in June 2004, company representatives revealed that they are not disposed to enter the Philippine market with a low-cost oral contraceptive. Research and discussions

with other stakeholders in the medical services/pharmaceutical industry uncovered the following biotechnology company.

Philippine Blue Cross Biotech Corporation, Subsidiary of Beijing Blue Cross Biotech Corporation <http://www.bluecrossbiotech.com>

Established in 1992, Beijing Blue Cross Biotech Co., Ltd. is a high-tech biotechnology and pharmaceutical Sino-Canada joint-venture with its own development, manufacturing, distribution and advisory service. The Corporation has a growing line of medical diagnostic tests, including a fertility test, infectious diseases test, tumor marker test, sexually transmitted diseases test and the "Blue Dream" brand one-step pregnancy test which has been a useful tool in China's FP efforts. Currently, Blue Cross Biotech Corporation is exploring production of a low-cost oral contraceptive pill and has spoken with members of the Harvard-LEAD team about possible distribution in the Philippines.

3. Philippine Health Insurance Company (Phil Health)

In many countries, social security agencies are playing an increasingly important role in CSR. In the Philippines, the regional director of Phil Health in Pangasinan expressed interest in exploring innovative financing and reimbursement policy options to promote CSR. Briefly, Phil Health assumed the responsibility of administering the former Medicare program for government and private sector employees, with its transfer from the Government Service Insurance System (1997) and Social Security System (1998). With this transfer came the turnover of the health insurance funds. The amount covers employee and employers' shares in the medical care program. Phil Health funds were also used to reimburse LGUs for the premium contributions of indigent members. Currently, Phil Health only reimburses permanent FP methods, including vasectomies and tubal ligations. Several stakeholders, including CEPA and LGUs and MSH have approached Phil Health senior management, especially in Pangasinan about extending reimbursement to other forms of birth control. Conversations indicated that

4. FPOP (IPPF Local Affiliate)

The Family Planning Organization of the Philippines, Inc. (FPOP) is the largest NGO family planning organization in the Philippines. Important FP service delivery models which have been implemented by the FPOP, such as the Magdamayan Project (a community-based family planning project), have been replicated by the government. The FPOP's role and programs are aimed at: ensuring universal access to quality family planning information, education and services; to increase adolescent involvement in addressing their sexual and reproductive health concerns; and to mobilize public support to safeguard the individual right to family planning. Their programs target and serve married couples of reproductive age, high-risk mothers and their children, men and women of reproductive age.

FPOP clinics provide, for example, voluntary surgical contraception (tubal ligation and vasectomy) and other reversible contraception methods and natural family planning. The clinics also provide medical back-up and laboratory services. FPOP also tries to motivate men to participate more actively in family planning and child-rearing and to accept major responsibility for the prevention of sexually transmitted diseases.

5. Technical Assistance Providers/NGOs

John Snow Inc. (JSI)

John Snow Inc. (JSI) and its non-profit affiliate, John Snow Research and Training Institute Inc., are Boston-based consulting firms dedicated to providing technical and management assistance to public health, family planning and environmental health programs throughout the world. Since its establishment in 1978, JSI has become a recognized leader in the implementation of innovative improvements in public health, environmental health and sanitation, health financing, health policy development, family planning and organizational development.

In the Philippines, JSI/RTI started with the Philippine NGO Strengthening Project in 1991, which was also funded by USAID. After three years, a second phase was launched in 1994 and extended up to 2000. It is now called as "Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Non-Governmental Organizations II Project" (TANGO II) in support of NGOs with midwife-owned clinics.

Well Baby Clinics (John Snow, International Inc./Research and Training Institute (JSI/RTI))

The Well-Family Midwife Clinic (WFMC) is a clinic, affiliated with a JSI/RTI partner NGO, which is owned, operated and managed by a licensed midwife, equipped with birthing facilities, private delivery and examination rooms, provides FP and maternal and child health care services, and various types of contraceptives and health products (including laboratory services). There are currently 190 Well-Family Midwife Clinics owned and managed by licensed midwives all over the country. Beginning in the last quarter of 2000, JSIRTI, in cooperation with its partner NGOs, started opening 50 new clinics.

DELIVER

The DELIVER project helps developing countries establish effective and efficient supply chains for public health and family planning programs. Our motto—No Product, No Program—is a reminder that health programs cannot operate successfully without a continuous, reliable flow of essential commodities. Well-functioning supply chains are critical to the realization of commodity security, which exists when every person is able to choose, obtain, and use essential health commodities whenever they are needed.

Begun in 2000, DELIVER is funded by the United States Agency for International Development (USAID) and is managed by John Snow, Inc. (JSI) with subcontractors The Manoff Group, Program for Appropriate Technology in Health (PATH), Social Sectors Development Strategies, Inc., and Synaxis, Inc. DELIVER is the expanded follow-on project to the USAID-funded Family Planning Logistics Management projects that, from 1986 to 2000, facilitated the improvement of family planning and health logistics systems in more than 30 countries. That experience has enabled DELIVER to continue developing new approaches to supply chain management that promote commodity security for contraceptives, HIV/AIDS commodities, drugs for treating sexually transmitted infections and tuberculosis, and other essential health products.

DELIVER improves health program supply chain performance by strengthening logistics management information systems; developing streamlined procurement, inventory control and distribution systems; training managers at all levels of those systems; helping governments and donors develop policies that support commodity security; and mobilizing necessary financing to procure and distribute essential health supplies.

The Futures Group

Futures Group specializes in the design and implementation of public health and social programs for developing countries. We work with government agencies, foundations, corporations, and nongovernmental organizations to address conditions that compromise the well-being of people around the world. Futures Group helps countries and communities build local capacity and forge public-private partnerships.

The POLICY Project

The POLICY Project works with civil society and government partners in developing countries to create enabling policy environments for high quality, sustainable HIV/AIDS, family planning, reproductive health, and safe motherhood programs and services. The project embraces a multisectoral, participatory approach to HIV/AIDS that seeks to build capacity and collaboration across key sectors to contribute to policymaking and program implementation. Our partners include government agencies; policymakers; networks of people living with HIV/AIDS; faith-based organizations; nongovernmental organizations; businesses; journalists; and affected communities.

POLICY offers technical assistance in four strategic focus areas: setting targets and effective resource allocation, improving operational policies: assisting countries to develop the operational policies to ensure the smooth implementation of services, reducing barriers to access, and strengthening leadership. POLICY is funded by the U.S. Agency for International Development and is implemented by Futures Group, in collaboration with the Centre for Development and Population Activities and Research Triangle Institute.

6. Civil Society

Catholic Church

The Catholic Church is an influential player in Philippine national policies and has close ties with the GMA administration and political parties. The Catholic Church opposes the use of modern methods of FP. The private sector, including pharmaceutical companies, has been very susceptible to pressure from the Catholic Church. The Church organized a campaign against Upjohn products after promotion of the injectable Depo-provera. Only after one year did Upjohn pharmaceutical sales recover to pre-boycott levels.

Business Groups

An increasing number of business groups and associations, including but not limited to the Makati Business Club, Employers Confederation of the Philippines, and the Trade Union Congress of the Philippines, have urged the Philippine Government to adopt a stronger population program. The groups have expressed concern about the negative effect of a high birth rate on the quality of life of workers and their families.

INTERNATIONAL

7. United Nations Population Fund (UNFPA)

UNFPA, the United Nations Population Fund, is the world's largest international source of funding for population and reproductive health programs. Since they began operations in 1969, the Fund has provided nearly \$6 billion in assistance to developing countries. UNFPA is the largest international public sector supplier of contraceptives, condoms and other reproductive health essentials. The Fund purchases nearly \$80 to \$100 million in goods and services each year for many partners in development.

UNFPA works with governments and non-governmental organizations in over 140 countries, at their request, and with the support of the international community. UNFPA provides annual contraceptive donations and is covering short term country needs for certain donors. UNFPA offers reimbursable procurement services that are open to government agencies. Organizations that use UNFPA's reimbursable procurement service participate in pooled procurement at the international level.

8. World Bank

The World Bank Group's mission is to fight poverty and improve the living standards of people in the developing world. It is a development Bank which provides loans, policy advice, technical assistance and knowledge sharing services to low and middle income countries to reduce poverty. The Bank promotes growth to create jobs and to empower poor people to take advantage of these opportunities. World Bank Credits can be used to purchase contraceptive commodities. (Bangladesh, Bolivia and Nicaragua used WB credits to purchase essential medicines.) The World Bank also supports health sector reform projects.

9. US AID

USAID is an independent federal government agency that receives overall foreign policy guidance from the Secretary of State. USAID supports long-term and equitable economic growth and advances U.S. foreign policy objectives by supporting: economic growth, agriculture and trade; global health; and, democracy, conflict prevention and humanitarian assistance. USAID has been the primary funding source of contraceptives for NGOs and social marketing programs, and has partnered with UNFPA to supply contraceptives to most ministries of health.

Other development agencies which have provided FP contraceptives

Canadian International Development Agency (CIDA)

Japanese International Cooperation Agency (JICA)

Netherlands AID

Norwegian Development Agency (NORAD)

U.K. Department for International Development (DFID)

This agency funds contraceptive and condom donations. In many cases, the donations are part of multi-year programs that are expected to result in the establishment of revolving funds to facilitate future government purchases.

10. CATALYST Consortium

The CATALYST Consortium is a global reproductive health activity initiated in September 2000 by the Office of Population and Reproductive Health, Bureau for Global Health, U.S. Agency for International Development (USAID). The Consortium is a partnership of five organizations: the Academy for Educational Development (AED), Centre for Development and Population Activities (CEDPA), Meridian Group International, Inc., Pathfinder International and PROFAMILIA/Colombia.

CATALYST works in sexual and reproductive health through synergistic partnerships and state-of-the-art technical leadership. Its overall strategic objective is to increase the use of sustainable, quality family planning and reproductive health (FP/RH) services and healthy practices through clinical and non-clinical programs. CATALYST provides technical leadership to improve clinical and non-clinical services in sexual and reproductive health, assists local groups to scale up successful program models and interventions, creates opportunities for South-to-South technical assistance and collaboration, creates linkages between health and nonhealth programs to provide an environment that supports women's decision-making about their reproductive health, e.g., links with literacy, political participation and economic empowerment, establishes technical collaboration among USAID Missions, U.S. foundations and other donors to help ensure the quality and sustainability of family planning and reproductive health programs, and expands FP/RH services through partnerships with private commercial sector and nongovernmental organizations, in order to address the unmet needs of men, youth and underserved populations

11. Pathfinder International

Pathfinder International supports FP and RH services throughout the developing world. By partnering with local governments and grassroots organizations, Pathfinder creates innovative programs that are responsive to the health needs of individual communities. In isolated rural areas, Pathfinder trains community members to provide their neighbors with contraceptive services and RH counseling in their own homes.

12. Summa Foundation

The Summa Foundation provides financing and technical assistance to the private and commercial health sector in developing countries. Our goal is to strengthen and expand the role of the private sector in the delivery of affordable health services and products. We consider proposals for a broad range of health projects but focus on maternal and child health, including reproductive health and family planning.

13. The Commercial Market Strategies

The Commercial Market Strategies (CMS) project is a five-year contract implemented under the Commercial and Private Sector Strategies (CAPS) Results Package of the United States Agency for International Development's

(USAID) Center for Population, Health, and Nutrition (G/PHN/POP). As the flagship project of CAPS, CMS aims to increase the use of family planning and related health products and services through the private and commercial sector. The CMS project's main program areas include: social marketing, private provider networks, health financing alternatives, partnerships with pharmaceuticals, corporate social responsibility, Summa Foundation loans, NGO sustainability, and policy analysis and intervention that enables the private commercial sector to better participate in meeting national health and family planning goals. To fulfill its mandate, CMS conducts technical assessments in selected countries to evaluate the conditions and markets for private sector FP and related health care. Based on these reviews, the assessments recommend program interventions for the selected country.

VIII. Recommendations for the Adoption and Implementation of CSR in the Philippines

The following recommendations are derived using two criteria:

- a) The recommended strategies were adopted in a significant number of successful cases and/or
- b) experts and policymakers have proposed the recommendations in their own comparative analysis of CSR strategies

1. Strengthen Targeting and Market Segmentation

Targeting and market segmentation are critical to achieving contraceptive security. As illustrated in Bangladesh, contraceptive users are more likely to discontinue using FP if a change in policy is seen as unfair or unclear (Bates 2002). Well-designed and executed market segmentation policies are more likely to minimize any fallout from the implementation of CSR and shifting of consumers from public facilities to the private sphere.

As stated earlier, targeting policies should take into account the barriers to private sector participation. For instance, as stated earlier, private sector agents require critical densities which suggests that commercial sector players will limit participation to urban or semi-urban areas. This suggests that governments may need to think about both economic and geographic disparities when devising allocation formulas and targeting strategies.

2. Emphasize Relationship between CSR and Economic Development and/or Broader Health reforms

Many of the successful CSR campaigns gained momentum after closely linking CSR as one aspect of national economic development and/or related to broader health care reform. Public acceptance and momentum seemed to increase in countries [Ghana, Kenya, Peru, Thailand] where the national government emphasized economic development goals and/or health care reforms. While the Philippines has discussed in FP in relation to economic development, those promoting CSR need to consistently emphasize the link to economic development. Media and advertising campaigns should boldly promote the link and frame all public discussions to the link between CSR and development.

3. Formulate a Top-down, National Committee to Promote and Sustain CSR

CSR strategy in the Philippines needs to be managed and promoted by a national CS action committee comprised of stakeholders from various executive branch cabinets and from different areas (i.e. commercial representatives, medical professionals, NGOs, advocacy groups, media representatives). Most countries, especially those with successful CSR programs [Colombia, Peru, Thailand] have established national 'steering' committees to promote CSR, create political will needed from a variety of different pockets of society, and build public awareness. The Philippines, however, has yet to form a national coalition or committee of powerful senior level authorities across a wide range of sectors

and interests to promote CSR across the nation. As with any other organization, members must craft the CS committee's mission, structure, standard operating procedures, norms of operation, and leaders/officers.⁵⁵ Policymakers should allocate resources to strengthen the CS committee and the technical capacity of its members so that it can play a more effective role in advocating and implanting CS strategies. Policymakers should take care to position the CS committee under individuals with sufficient authority and credibility to influence MOH and broker the necessary public and private partnerships.

4. Develop national stakeholders and support implementation actors

Effective CSR strategies have involved the development of and/or active promotion of a set of national implementation actors. In several countries, this strategy has involved the expansion of FP training the medical schools and trained a cadre of medical professionals in the area of FP [Colombia, Thailand]. CEPR/HSPH field research with general practitioners found that medical schools are not training doctors or general practitioners in FP. Thus, in order to expand private and public sources of FP provision and to promote CSR, it is highly recommended that stakeholders work with medical schools to reinstitute training of medical professionals in the area of FP.

Second, most of the countries, especially those with successful CSR experiences, have promoted and sustained CS with the assistance of a dominant non-public provider (usually an NGO) that provides FP commodities and services [Colombia, Peru, Thailand]. Surveying the Philippine landscape fails to uncover an equivalent player. While FPOP is active, it does not play the role that Colombia's PROFAMILIA or Kenya's Family Planning Association has played. As part of the CSR strategy, it is recommended that human and financial resources are dedicated to developing and promoting a non public source of FP commodities and services. The NGO can assist the government in advocating for greater commitment of human and financial resources from the national government. Also, a sizeable non public player can increase bargaining strength of the buyer for commodity prices.

5. Reform Regulatory Environment

Supporters of CSR need to assess regulatory and legal environment to those laws and regulations at the national, regional and local level that may hinder the implementation of CSR, especially with respect to procurement of FP commodities. Specifically, efforts should be made to include FP commodities on the national essential medicines list. Second, while current laws do allow national interests to offer international tenders and purchase contraceptives overseas, the administrative costs to doing so are high and should be revamped and

55 Regional Contraceptive Security Feasibility Study. 2004. JSI/DELIVER and Futures Group/POLICY

streamlined.⁵⁶ Third, advertising laws should be relaxed so as to allow brand and product advertising for FP commodities and services. Finally, while the Philippines exempts commercial imports of OCs from import duties, the process to obtain the exemption is cumbersome and time consuming and should be streamlined.

6. Expand FP Coverage of PhilHealth

Countries like El Salvador and Mexico are working with insurance providers and Social Security Institutes to expand the coverage of FP products and services. Efforts should be made to continue dialogue with PhilHealth to expand coverage. Dr. Ernesto Beltran, Director of PhilHealth in Pangasinan, has recognized the need to reevaluate PhilHealth's financing options in light of CSR. He suggested shifting currently allocated resources for permanent methods to temporary methods. Policy dialogue should continue with PhilHealth officials at all levels of government (national, regional and local).

7. Strengthen Social Mobilization Efforts

As demonstrated from country case studies, successful CSR strategies are a function, in part, of the strength and breadth of national social mobilization and education efforts and awareness campaigns to build all stakeholders' commitments to CS [Peru]. In some cases, this strategy has been driven by a top-down, national coordinating committee that has the influence to bring together a broad group of stakeholders. In any event, mobilization efforts can pressure national policymakers to maintain their commitment to CSR. Efforts should be made to identify and secure technical assistance to help develop advocacy tools and skills related to CS [as Peru RED Mujer did]. Advocacy efforts should identify and support 'policy champions' in the public and private sectors. Policymakers should develop a strategy for working with civil society and consumer watch groups at the regional and national levels and involve these groups in protecting sexual and reproductive health rights, lobbying to increase the FP budget and/or procurement of contraceptives, and monitoring services.⁵⁷ Advocacy at the LGU level is especially important in decentralized systems like the Philippines.

Certainly, the Philippines has developed some creative advocacy projects. For example, in April 2003, Advocates for Better life (ABLE) in Pangasinan was launched as a multi-sectoral network that advocates for access to and availability of FP products. ABLE has achieved success in strengthening the LGU's commitment to CSR through its two-track advocacy approach: internal advocates within LGUs gatekeeping roles in policy development coupled with civil society advocates among community based groups. But again, the success of local

⁵⁶ Bulatao, Rodolfo. 2002. What influences the Private provision of Contraceptives? Technical Paper Series number 2. Commercial Marketing Strategies (CMS): Washington, DC.

⁵⁷ Regional Contraceptive Security Feasibility Study. 2004. JSI/DELIVER and Futures Group/POLICY

efforts requires complementary national efforts that can maintain pressure on national policymakers to make CSR and FP a priority and commit necessary resources. Finally, greater efforts need to be made to involve and strengthen the support of business associations for CSR and FP. As the case of Thailand demonstrates, business groups are a powerful voice for the stressing the relationship between CSR and economic development.

8. Develop A Media Campaign

As country experiences demonstrate [Bangladesh, Peru, Tunisia], policymakers must actively incorporate media representatives onto the CSR campaign and enlist their help in raising public awareness. But, media participation is not automatic. Part of the advocacy component requires providing media representatives with training and other skills-building for advocacy and strategies for media reporting on the issue of CSR. Some strategies to increase participation of the media include encourage participation of journalists in events that address CS, support journalism programs to include skills building for coverage of RH and FP, provide data and information about CSR to the media, convene forums and create networks that link the media and NGOs with FP and supply chain managers, and service providers. Finally, policymakers should encourage participation by the media and advocacy groups in contraceptive security planning and implementation.

9. Improve quality of FP services and support health promoter programs

The goal of CSR is not only to maintain, CSR but to increase CSR by addressing the unmet need. There are two ways that CSR levels might be increased. The first is through greater attention to the quality of FP services offered at public (and private facilities). Studies indicate that one important determinant in maintaining CSR is the quality of services. Research shows that health care providers' attitudes and treatment of clients often determine which health services women use and even determine whether women seek services at all. For example, in Nepal service providers' poor treatment was one reason that women made little use of clinical family planning services. A study found that, when lower-status women visited clinics, they received less courtesy and less information than educated, middle-class clients. Women who were treated poorly discussed their bad experiences with friends and neighbors, and thus family planning services developed a bad reputation. Thus, in addition to simply procuring contraceptives and distributing them, local public and private FP service providers should allocate sufficient human, administrative and financial resources to assessing and improving the quality of FP services offered at public (and private) facilities.

The second way that LGUs might increase CSR levels is to work with public providers and NGOs to develop and strengthen health promoter programs. Across the developing world, strong health care promoters have had significant impacts on successful implementation of CSR strategies [Colombia, Mexico].

10. Explore financing options

Many of the countries that have are making progress on the CSR programs have established line item in the national budget for the procurement of FP commodities [Brazil, Colombia, Peru, Paraguay]. Given that LGUs are to assume primary responsibility for the procurement and distribution of FP commodities, it makes sense to establish a budget line item in both the regional and local public budgets. FP budget resources secured at the national and regional levels can be used to assist poorer LGUs or to assist public providers in areas that lack political support of local and/or regional executive. In addition, policymakers should conduct a cost benefit analysis of the various procurement options.⁵⁸

However, if protecting FP expenditures as a budget line item is impossible given the political environment, policymakers should explore other options. One is just to include FP procurement expenditures in the general public health budget. Alternatively, policymakers in LGUs should determine how other comparative budget items/programs (e.g. vaccination, DOTS, HIV/AIDS, welfare programs) are protected and lobby for the same kind of protection for FP commodity procurement.⁵⁹ Finally, governments may want to implement a revolving fund from initial sales which is then managed and maintained exclusively for the purchase of future commodity requirements.

11. Strengthen Participation from Private Sector and Include in Decision-Making

Commercial market share of contraceptive provision in the Philippines is small. In 1998, only 22 percent of users relied on commercial outlets for pills where prices are higher relative to other developing countries. Pharmacies provide most of commercial sector condoms. Policymakers must continue to create conditions that support private sector market development. Research indicates that the price of publicly distributed contraceptives is one of the most important issues. Smaller differences between public and private sector prices are associated with greater private sector share.⁶⁰ Currently, the commercial sector appears to exercise little initiative in expanding its share.⁶¹

The first step towards achieving greater private sector participation is to include the private sector in all aspects of the design and implementation of CSR strategies. Greater efforts should be made to balance the interests of both private and public stakeholders; some of these include making methods accessible and changing laws to allow for marketing and advertising of contraceptives. Policymakers should reinforce the role of the private sector commercial and NGO through strategic alliances, non-monetary incentives, technical assistance, and financial support. One option is to promote the establishment of a buyer's

58 Country Perspectives on the Future of Contraceptive Supplies

59 Regional Contraceptive Security Feasibility Study. 2004. JSI/DELIVER and Futures Group/POLICY

60 What influences private supply of contraceptives? Bulatao

61 What influences private supply of contraceptives? Bulatao

consortium for NGOs. Finally, governments should think creatively about private-public partnerships. For instance, one strategy might involve “rewards” programs with the private sector (e.g. pharmacies and/or manufacturers).

In the meantime, the underdeveloped private sector and relatively high commercial prices suggests that the country’s social marketing firm, DKT International, has a significant role to play as the country moves towards CSR. Strategies to support DKT and its products including promote recruitment of distributors (in areas that are currently underserved), use of health care promoters as sales force, expanded presence in networks of pharmacies, commercial and community outlets and community promoters. Again, DKT products would benefit from changes in policy that would allow advertising of socially marketed contraceptives.⁶² Additionally, another is to work with the commercial sector to establish social marketing ventures that depart from the traditional donor-funded model.⁶³

12. Strengthen Contraceptive Logistics and Management Information System (LMIS)

Efforts must be made to strengthen and integrate the Philippines’ logistics and management information system (LMIS). All CSR programs require supply chain strengthening to achieve CS. Policymakers should establish clear indicators or measures of success within the LMIS that can assess and identify potential crisis points before stock-outs and wastage result. As country experiences suggest, the Philippine’s LMIS system should involve several different layers of stakeholders for the monitoring and performance assessment tasks. Finally, an effective contraceptives LMIS system must train and develop capacity at all levels, particularly at the LGU level. Personnel must be trained to monitor as well as solicit and use data and information to inform policymaking decisions by local leaders.

13. Tailor the Approach

Finally, the best way to achieve CSR is to tailor policies to the specific policy and country constraints. Performance should be assessed on a range of indicators. For instance, as the case of Paraguay demonstrates, an increase of commercial market participation may not be seen as a “success” if unmet need levels remain stagnant or increase. Similarly, it is not the case that LGUs will not successfully achieve CSR if they fail to implement all of the recommended strategies. Some steps may be more critical to address at the early stages of reform than later.

62 Regional Contraceptive Security Report: LAC, October 2004.

63 Regional Contraceptive Security Report: LAC, October 2004.

IX. Bibliography

Adamchak, Susan Enea, William D. Bair, Souleymane Barry and Clifford Olson. 1995. Final Evaluation of the Ghana Family Planning and Health Project. (FPHP). Virginia: Population Technical Assistance Project for the US Agency for International Development.

Advance Africa. Status and Trends of Family Planning in Sub-Saharan Africa. 2003. Virginia: ADVANCE Africa.

Aloo-Obunga, Colette. 2003. Country Analysis of Family Planning and HIV/AIDS: Kenya. The POLICY Project. Virginia: The Futures Group, International.

Antarsh L. 1989. Old and new ways: family planning in Kenya. AVSC News. 27(1):2-3.

Arends-Kuenning, M. 2002. Reconsidering the doorstep-delivery system in the Bangladesh family planning program. *Studies in Family Planning* 33(1):87–102 March.

Armand, Françoise C. 2002. Contraceptive self-reliance in Turkey: Lessons learned from policy and social marketing programs involving the private sector.

Armand, Françoise and Cindi Cisek. 2002. Engaging the Private Sector in Turkey: Can Public/Private Partnerships Help Achieve Contraceptive Security. Washington, DC: Commercial Marketing Strategies.

Aronovich, Dana Gelfeld and Steve Kinzett. 2001. Kenya: Assessment of the Health Commodity Supply Chains and the Role of KEMSA. Arlington, VA: DELIVER/John Snow, Inc. for the U.S. Agency for International Development.

Barnett, B. 1998. Do client fees help or hurt? *Network* 18(2):6–11.

Bates, James and Sandhya Rao. 2000. Zambia: Implications of Health Sector Reform for Contraceptive Logistics. Arlington, VA: Family Planning Logistics Management/John Snow, Inc. for the U.S. Agency for International Development.

Bates, Lisa M. Md. Kahriul Islam, Ahmed Al-Kagir, Sidney Ruth Shuler. 2003. From Home to Clinic and from Family Planning to Family health: Client and Community Responses to Health Sector Reforms in Bangladesh. *International Family Planning Perspectives*, vol 29, no. 2. pp. 88-94.

Bennett, A, Frisen, C, Kamnuansilpa, P and J McWilliam. 1990. How Thailand's family planning program reached replacement level fertility: lessons learned. Vol. 93. November 9, 1990. Arlington, Virginia: Population Technical Assistance Project, Dual and Associates, Inc., International Science and Technology

Institute, Inc., for USAID/Thailand and Office of Population, Bureau for Science and Technology, Agency for International Development, Washington, D.C.

Bornbusch, A and Pandit, T. Contraceptive Security: What can you do? Global Health Technical Brief

Bossert, Thomas, Diana Bowser, and Johnnie Amenhyah. 2003. Guatemala: Decentralization and Integration in the Health Logistics System. Arlington, VA: DELIVER/John Snow, Inc. for the U.S. Agency for International Development.

Bowers, Gerard. 2002. Planning and Managing Contraceptive Phaseout. LTG Associates.

Bulatao, Rodolgo. 2002. What influences the Private provision of Contraceptives? Technical Paper Series number 2. Commercial Marketing Strategies (CMS): Washington, DC.

Brumburgh, Scott and Sangeeta Raja. 2001. Ghana: Process Mapping – First Steps to Reengineering the Healthy Supply Chains of the Public Sector Reform. Arlington, VA: DELIVER/John Snow, Inc. for the U.S. Agency for International Development.

Burns, Patrick. What Causes Birth Rates to Drop? Population Institute of Canada.

Centre for Health and Population Research. 2003. Use of Family Planning Services in the Transition to Community Clinics in Abhoynagar: 1998-2002.

Chandani, Yasmin and Gerry Breton. 2001. Contraceptive Security, Information Flow, and Local Adaptations: Family Planning Morocco. African Health Sciences vol 1(2) December.

Chandani, Yasmin, Kathryn Crowley, John Durgavich, Ramona Lunt, Paula Nersesian, Norbert Pehe, and Timothy Rosche. 2000. Ghana: Implications of Health Sector Reform for Family Planning Logistics. Arlington, VA: Family Planning Logistics Management/John Snow, Inc. for the U.S. Agency for International Development.

Chawla, Deepika, David Sarley, Susan Scribner, Ruth Berg, Asma Balal. 2003. Bangladesh: Contraceptive Market Segmentation Analysis. Arlington, VA: John Snow, Inc./DELIVER for the U.S. Agency for International Development.

Combary, Perle and Alex Muhawenimana. 1996. Assessment of Community-Based Distribution in the Republic of Ghana. PRIME. Intrah at the University of North Carolina at Chapel Hill.

Conteh, Lesong and Kara Hanson. 2003. Methods for studying private sector supply of public health products in developing countries: a conceptual framework and review. *Social Science and Medicine*. Vol 57. pps 1147-1161.

Country Perspectives on the Future of Contraceptive Supplies. 2001. Meeting the Challenge. Interim Working Group on Reproductive Health Commodity Security (IWG).

Curtiss, Richard. 1996. Tunisia's Family Planning Success Underlies its Economic Progress. Washington Report on Middle East Affairs. November/December.

Department of Health, the Philippines. Guidelines on the Management of Contraceptives Supplies for Family Planning under the contraceptive self reliance strategy.

DELIVER. Achieving Contraceptive Security in El Salvador. Critical Issues Series. Commercial Marketing Strategies (CMS): Washington, DC.

DELIVER. Segmenting Markets to Maximize Contraceptive Security. Critical Issues Series. Commercial Marketing Strategies (CMS): Washington, DC.

DELIVER. Developing a Strategy for Contraceptive Security in Bangladesh. Critical Issues Series. Commercial Marketing Strategies (CMS): Washington, DC.

Developing a Strategy for Contraceptive Security in Ghana. DELIVER. John Snow International: Washington, DC.

Echeverria, Sandra, Alfredo Fort, Milton Cordero, John Massey, Ann Lion-Coleman, Douglas Jarquin. 2001. An Assessment of Health Promoter Effectiveness in El Salvador. PRIME Project. Intrah, University of North Carolina at Chapel Hill.

Finger, W.R. 1998. Commercial sector can improve access. *Network* 18(2).

Fleischman Foreit, Karen. 2002. Broadening Commercial Sector Participation in Reproductive Health: The Role of Public Sector Prices on Markets for Oral Contraceptives. CMS Technical Series. Washington, DC: USAID/CMS.

Foreit, Karen Fleischman. 2002. Broadening Commercial Sector Participation in Reproductive Health: The Role of the Public Sector Prices on Markets for Oral Contraceptives. Technical Paper Series number 3. Commercial Marketing Strategies (CMS): Washington, DC.

Frazer, Edorah. 1992. Thailand: A Family Planning Success Story. In *Context*. Spring 1992, IC#31.

Futures Group and U.S. AID POLICY. 2000. A Guide to Planned Contraceptive Self-Reliance (CSR) in the Philippines.

Godinez, Carolina and David Papworth. 2000. Peru: Contraceptives Logistics System: Review of Accomplishments and Lessons Learned 1994-1999. Arlington, VA: Family Planning Logistics Management/John Snow, Inc. for the U.S. Agency for International Development.

Gomez de Leon, Jose and Daniel Hernandez. 1998. Poverty and Contraceptive Use in Rural Mexico. PROGRESA: Mexico.

Guttmacher Report on Public Policy. 2001. Islam, Women and Family Planning: A Primer. Vol 4(6) December.

Health Communication Partnership. 2003. Media Advocacy for Contraceptive Security: Key Findings and Recommendations from an Asia Regional Workshop. John Hopkins Bloomberg School of Public Health.

International Planned Parenthood Foundation. Western Hemisphere Region. http://www.ippfwhr.org/programs/program_sd_e.asp

Jahanfar, Shayesteh, Zahra Ghodsi, Faranghis Shahpoorian, Rohangiz Jamshidi. 2005. Community Based Distribution and Contraception Usage in Iran. Working Paper. Royal College of Medicine, Perak, Malaysia.

John Snow, International. *Global Contraceptive Security: Implications of Health Sector Reform for Contraceptive Logistics.*

John Snow, International. Global Trends Affecting Public Sector Supply Chain Management. Policy Papers. Global Contraceptive Security: Implications of Health Sector Reform for Contraceptive Logistics. Washington, DC.

John Snow, International and DELIVER. 2004. Regional Contraceptive Security Feasibility Study. Washington, DC: USAID, JSI/DELIVER and Futures Group/POLICY.

KenPop News. Vol 1(1). April-June 2004.

Khalifa, Mona, Sharma, Suneeta and Moreland, Scott. 2001. Issues and Strategies for Sustainability of Family Planning Services in Egypt. The POLICY Project. The Futures Group International: Washington, DC.

Kinzett, Steve and Jim Bates. 2000. Bangladesh: Contraceptive Logistics System: Review of Accomplishments and Lessons Learned. Arlington, VA: Family Planning Logistics Management (FPLM)/John Snow, Inc. for the U.S. Agency for International Development.

Kinzett, Steve and Ramona Lunt. 2000. Mali: Contraceptive Logistics System--Review of Accomplishments and Lessons Learned (1988-1998). Arlington, VA: Family Planning Logistics Management/John Snow, Inc. for the U.S. Agency for International Development.

Lush, Louisiana, John Cleland, Kelley Lee and Gill Walt. 2000. Politics and Fertility: A New Approach to Population Policy Analysis. *Population Research and Policy Review* 19: 1-28.

MacDonald, Shawn and Susan Mitchell. Private Provider Networks and Family Planning: REDPLAN Salud (Peru). 2002. CATALYST and CMS Project.

McGregor, Kieran and Yasmin Chandani. Experiences from the Field: Strategies for Skills Transfer in Supply Chain Management for Developing Countries. Arlington, VA: Family Planning Logistics Management/John Snow, Inc. for the U.S. Agency for International Development.

Ministry of Health, Nigeria. 2003. Projections for Contraceptives, including Condoms for HIV/AIDS in Nigeria. The POLICY Project. The Futures Group International: Washington, DC.

Naik, Gautam. 2003. "Tunisia Wins Population Battle, And Others See a Policy Model." *Wall Street Journal* August 8, 2003.

Nepomuceno T. 1991. The 'anatomy' of Thailand's successful family planning program. *ICMH Newsletter* Vol 18(189) Jan-Feb 1991.

Network. 1998. Do Client Fees Help or Hurt? Charging a fee for family planning services helps recover costs but may discourage use. Vol. 18, No. 2, Winter 1998.

Njeri Nduyu, Louisa. 2001. Gender and Family Planning Programs, what are the links? Maseno University: Maseno, Kenya.

Olave, Manuel. 2000. Financing Reproductive Health in Bolivia. The Development Group prepared for the POLICY project (The Futures Group International: Washington, D.C.).

OUTLOOK. 2003. Ensuring Contraceptive Supply Security. Vol 20(3) July. PATH: Seattle.

Perkin, Gordon. 2003 Cushner Lecture. ARHP.

POLICY Issues in Planning and Finance. 2003. Number 3. "Targeting: An Essential Element of National Contraceptive Security Planning." The Policy Project. The Futures Group International: Washington, DC.

POLICY Issues in Planning and Finance. 2004. "Creating Conditions for Greater Private Sector Participation in FP/RH: Benefits for Contraceptive Security." Number 4. The Policy Project. The Futures Group International: Washington, DC.

The POLICY Project. 1999. Case Study of Contraceptive Self-Reliance Efforts in Turkey: Prospects and Lessons Learned. The Policy Project. Washington, DC: The Futures Group International.

The POLICY Project. 2002. Pathways to Contraceptive Security. The POLICY Project. Washington, DC: The Futures Group International.

Quansah-Asare, Gloria. 2004. Meeting the Commodity Challenge: The Ghana National Contraceptive Security Strategy. Ghana Health Services.

Quesada, Nora. 2000. Mexico: Contraceptive Logistics System (DGSR), A Review of Accomplishments and Lessons Learned - NGOs. Arlington, VA: Family Planning Logistics Management/John Snow, Inc. for the U.S. Agency for International Development.

Quesada, Nora, Sandhya Rao, and Steve Kinzett. 2001. Mexico: Contraceptive Logistics System (DGSR) – Review of Accomplishments and Lessons Learned. Arlington, VA: Family Planning Logistics Management/John Snow, Inc. for the U.S. Agency for International Development.

Quijada, Caroline, Tania Dmytraczenko and Beaura Mensah. 2004. Ensuring Contraceptive Security within New Development Assistance Mechanisms. Bethesda, Maryland: Partners for Health Reformplus for ABT Associates.

Rao, Sandhya. 2000. Jordan Contraceptive Logistics System: Review of Accomplishments and Lessons Learned (1997-2000). Arlington, VA: Family Planning Logistics Management/John Snow, Inc. for the U.S. Agency for International Development.

Ridley, Robert G. 2001. Putting the Partnerships into public-private partnerships. *Bulletin of the World Health Organization*. Vol 79:8.

Roberts, M, Hsiao, W, Berman, P and M Reich. 2003. Getting Health Reform Right: A Guide to Improving Performance and Equity. Oxford University Press: London.

Rosen, James E. and Shant R. Conly. 1999. Getting Down to Business: Expanding the Private Commercial sector's Role in Meeting Reproductive Health Needs. Washington, DC: Population Action International.

Rosero-Bixby, Luis. 1998. Child Mortality and Fertility Transition: Aggregated and Multilevel Evidence from Costa Rica. In Commission on Behavioral and Social Sciences and Education's From Death to Birth: Mortality Decline and Reproductive Change.

Sanga, Catherine, Daniel Mmari, Ben Mkasa, Steve Wilbur, Kim Peacock. 2001. Tanzania: Integration of Contraceptive Products into the Medical Stores of Department's Distribution System. Arlington, VA: Family Planning Logistics Management/John Snow, Inc. for the U.S. Agency for International Development.

Seltzer, Judith and Fernando Gomez. 1998. PopTech Report 97-114-062. Washington, DC. Population Technical Assistance Project for the U.S. Agency for International Development.

Sharma, Suneeta and Issa Almasarweh. 2004. Family Planning Market Segmentation in Jordan: An Analysis of the Family Planning Market in Jordan to Develop an Effective and Evidence-Based Strategic Plan for Attaining Contraceptive Security. The POLICY Project. The Futures Group International: Washington, DC.

Sharma, Suneeta and Varuni Dayaratna. 2005. Creating conditions for greater private sector participation in achieving contraceptive security. *Health Policy*. Volume 71, pps. 347-357.

Sharma S, Gribble JN, Menotti EP. Creating options in family planning for the private sector in Latin America. *Rev Panam Salud Publica*. 2005;18(1):37-44.

Sine, Jeffrey. 2002. How Much is Enough? Estimating Requirements for Subsidized Contraceptives -- Results from a Ten-Country Analysis. Technical Paper Series number 4. Commercial Marketing Strategies (CMS): Washington, DC.

Sulzbach, S, Winfrey, W, Feeley, F, Scribner, S and Armand, F. 2002. Contraceptive Security in Armenia: Segmenting the Family Planning Market. Country Research Series number 7. Commercial Market Strategies (CMS): Washington, DC.

Sulzbach, S, Winfrey, W, Feeley, F, Scribner, S and Armand, F. 2002. Addressing the impending contraceptive crisis in Armenia. Commercial Market Strategies (CMS): Washington, DC.

Sundquist, Bruce. 2004. "Could Family Planning Cure Terrorism?" The Controversy over U.S. Support for International Family Planning Edition 5. August 2004.

Tarmann, Allison. 2001. Contraceptive Shortages Loom In Less Developed Countries. Population Reference Bureau.

Tatar, Fahreddin, Baser, Zerrin and Jeffrey Sine. 2001. Toward Contraceptive Self-Reliance in Turkey: Results from a Pilot Test of a Cost Sharing Mechanism. The POLICY Project. The Futures Group International: Washington, DC.

Tatar, Fahreddin, and Jeffrey Sine. 2001. Client Donations for Contraceptives: An Innovative Approach to Sustainable Financing in Turkey. The POLICY Project. The Futures Group International: Washington, DC.

Taylor, Patricia, Nora Quesada, Wendy Abramson, Varuni Dayaratna and Leslie Patykewich. 2004. Contraceptive Security in Latin America and the Caribbean: Results and Recommendations. Arlington, VA: John Snow, Inc/DELIVER, and Washington, DC: Futures Group/POLICY II for the U.S. Agency for International Development.

Teclerariam, Lea, Tim Williams and Rebecca Copeland. 2003. Nigeria: Baseline Assessment of the Contraceptive Logistics System. Arlington, VA: Family Planning Logistics Management/John Snow, Inc. for the U.S. Agency for International Development.

UNICEF. 1995. The unmet need for family planning. <http://www.unicef.org/pon95/fami0007.html>

United Nations Population Fund (UNFPA) and the Netherlands Interdisciplinary Demographic Institute (NIDI). 1999. Financial Resource Flows for Population Activities: A Case Study (Peru).

United States Agency for International Development (U.S. AID). 2004. Contraceptive Security: Ready Lessons.

Vian, Taryn. 2003. Uganda: Assessing the Costs of Distribution to Health Sub-Districts. Arlington, VA: Family Planning Logistics Management/John Snow, Inc. for the U.S. AID.

Winfrey, William. 2003. *Willingness to Pay Increased Prices for Reproductive Health Products*. Country Research Series Number 12. Washington, DC: USAID/Commercial Market Strategies Project

Winfrey, William, Laura Heaton, Tamara Fox, Susan Adamchak. 2000. Factors Influencing the Growth of the Commercial Sector in Family Planning Service Provision. Working Paper Series No. 6.

World Health Organization. 2000. Health sector reform and reproductive health in Latin America and the Caribbean: Strengthening the Links. *Bulletin of the World Health Organization* 78(5).

Zosa-Feranil, Imelda. 2004. *A Policy Approach to Contraceptive Security in Romania, 2000–2003*. The POLICY Project. The Futures Group International: Washington, DC.