

Contraceptive Security

Ready Lessons II

9



Reaching the Underserved



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Contraceptive Security

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Ensure that the poor and underserved can access contraceptives and family planning services.

What Can a Contraceptive Security Champion Do?

- **Assess the contraceptive security situation disaggregated by income, demographics (e.g., age, marital status, ethnic groups), location, and other factors that affect access to identify underserved populations.**
- **Assess country-specific barriers to access with tools including poverty mapping, beneficiary assessments, and willingness to pay studies.**
- **Implement strategies to address the barriers and increase access to contraceptives and family planning services by the poor and underserved, such as expanding availability of FP products and services, targeting resources, providing subsidies, and increasing community participation.**

Key Concept — Multiple Factors Limit Access to Contraceptives, Creating Populations that are Underserved

Despite increasing attention to the health needs of underserved populations, inequities in access to health services — including family planning — remain a serious concern. Analysis of health survey data indicates that significant inequities in modern contraceptive use among women of different economic means exist in most countries where the contraceptive prevalence rate for women in union is at or below 50%. Ensuring access to, and choice of, contraceptives for underserved groups is a significant challenge for

contraceptive security champions as there are many impediments that lead to lack of access. Indeed, inability of the poor and underserved to access contraceptives is often due to lack of access to health services generally, as well as a lack of information about available health services and commodities.

Reduced access to contraceptives is not limited to the poor — many factors can limit access to contraceptives and family planning (FP) services. These include:

- **Geographic and physical availability** of products and services, including clients' ability to travel to service delivery points and the existence of products and providers at the service delivery points.
- **Affordability of products and services**, which is determined by the price of the commodity, the costs of travel, the clients' ability to pay, their eligibility for subsidized services, their participation in health insurance programs that cover family planning, and lost income resulting from time spent in travel and receiving services.
- **Appropriateness** of the manner in which services and products are delivered, such as the days and hours of operation, need for appointments, waiting times, client-provider relationships, privacy, and facility environment.
- **Acceptability**, which is determined by client attitudes about the available providers and methods, as well as provider biases regarding appropriate users of a specific method.
- **Quality**, including both the quality of the products and the quality of services in ensuring that products are used appropriately and side effects are satisfactorily discussed and managed. Quality access to a product requires access to trained and motivated providers, well-prepared service delivery sites, and the necessary information to make informed choices.

Each of these factors can be addressed through supply- and demand-side interventions. For example, poor geographic access can be addressed by building health facilities in remote areas or establishing extension or community-based distribution services to expand availability (a supply-side intervention), or by helping people reach facilities or services that already exist (a demand-side intervention).

Widespread success in addressing the needs of the underserved is elusive, but some countries have experience with promising strategies that can be adapted and utilized for improving contraceptive security for the underserved.

Assessing Contraceptive Security to Understand Barriers to Access

Selecting strategies that improve access to contraceptive services and products for underserved populations requires understanding which groups are underserved, where they are located, and what barriers to contraceptive access they face.

Data are needed to measure and analyze access. The contraceptive prevalence rate (CPR) is an important indicator of FP access. Other relevant indicators include the method-mix, fertility rates, rates of teenage pregnancy, unmet need, and out-of-pocket expenditure. To help identify underserved groups, each of these indicators should be analyzed by age, socio-economic group, urban versus rural residence, and geography (region/district/municipality). Demographic and Health Surveys, Standard of Living and Asset Surveys, and National Health Accounts can provide some of this data. Secondary analyses of these data sources, as discussed below, can provide a more refined picture of access for different populations. (See *Ready Lesson II #6: Mobilizing Financial Resources* for a discussion of National Health Accounts and Reproductive Health Sub-Accounts.) Data on public sector targeting (% of public sector contraceptives going to the poorest two quintiles) for many countries is available in the Contraceptive Security Index (see Further Reading).

There are several types of analyses that help to answer questions about access and the underserved, such as:

- **Poverty maps** create a visual representation of areas where the poor reside and where products and services are often scarce. The information can come from a variety of sources and can be presented at various levels (global, national, and local). Indicators of income poverty (such as GDP per capita or daily subsistence levels) or of well being (such as life expectancy, child mortality, or literacy) are most frequently used in poverty maps, and are derived from national census data or household surveys.
- **Beneficiary assessment** systematically investigates the perceptions of a sample of beneficiaries and other stakeholders to ensure that their concerns are heard and incorporated into project and policy formulation. This type of systematic listening can “give voice” to poor and other hard-to-reach beneficiaries, highlighting constraints to beneficiary participation, and provide useful feedback on interventions.
- **Whole market assessment/Market segmentation analysis** can identify the key drivers behind the use of specific services/products by different segments of the population, elucidating existing utilization trends, current needs, and gaps in the service delivery system (see *Ready Lesson I #3: Taking a Whole Market Approach* and *Ready Lesson II #7: Fostering Public-Private Collaboration for Improved Access*).

- **Willingness to pay (WTP)** studies can help determine price points and needs for targeted subsidies among different segments of the population. WTP can be assessed by a survey asking how much individuals from different sub-groups would be willing to pay for a health service or product. This allows the individual to consider the different factors that are important to them in the provision of contraceptive products, such as income, perceived value of the product, or convenience of different outlets. WTP studies are useful for setting prices that will be acceptable to a target population.

These assessments help identify the specific access barriers that the poor and other marginalized groups face in obtaining family planning products and services. The information generated is critical to develop appropriate strategies to achieve contraceptive security that includes the underserved.

Government of Guatemala leverages poverty data and creative partnerships with non-governmental organizations to reach the “hard-to-reach”

With more than 25 diverse indigenous populations dispersed throughout highly mountainous and difficult-to-access terrain, there are a number of formidable geographic, cultural, and language barriers to contraceptive use in **Guatemala**. For over a decade, the Guatemalan Ministry of Health, using Inter-American Development Bank support and government funds, has attempted to increase access for these populations by contracting local non-governmental organizations (NGOs) to provide a basic health services package through the “Extension of Health Services” program. The primary objective of this strategy is to reduce unmet need among rural and indigenous populations. NGOs are paid a per capita fee, in accordance with their coverage, which includes the costs of distributing contraceptives to community centers. The NGOs use a basic health team composed of ambulatory physicians, nurses, institutional facilitators, community facilitators, and traditional birth attendants. In 2003, FP services and contraceptives (condoms, pills, and injectables) officially became part of the Extension of Health Services program. In 2006, this program delivered contraceptives and FP services through partnerships with approximately 86 NGOs.

Poverty mapping was utilized at the start of the program to identify the poorest communities and those with the worst health indicators, especially for malnutrition. These areas were targeted by the Extension of Health Services program. Between 2002 and 2006, geographical coverage increased from 3 to 4.5 million people living in geographically and culturally isolated populations. Beneficiary assessments were carried out in 2001 and 2005 to assess improvements in health services for the underserved; these revealed both strengths and areas for improvement of the program. In the most recent beneficiary assessment completed in 2005, a sampling of 4,200 families reported high satisfaction with their health services provided to them by NGOs, and 60% of those surveyed were visited by NGO community health workers. These assessments are focused on maternal and child health, so they provide little data on the success of the program for family planning.

The Extension of Health Services program has great potential to sustainably reduce inequities in access to health care, and thus move toward universal health coverage in Guatemala. Between 2005 and 2006, couple years of protection in the coverage area increased by about 14%. This success can be strengthened further if NGOs focus more on family planning services, for example by including FP indicators in performance monitoring.

Strategies to Increase Access of the Poor and Underserved to FP Products and Services

The strategies presented below have been used to increase access to products and services for poor clients and other underserved populations. While these strategies have all demonstrated promising results for reaching underserved populations, they will need to be adapted and piloted for the specific country context to improve provision of reproductive health commodities in that country. Government strategies for increasing access to FP for the underserved should be included in national policy documents and monitored, for example by including equity goals, pro-poor strategies and equity-based indicators in the national reproductive health or contraceptive security strategic plans.

Promoting Universal Coverage of Basic Health Care is a strategy popular with governments worldwide. By aiming to make basic health services available and affordable to everyone, including the poor and hard to reach, governments promote equity. Programs may emphasize “essential services,” which often include key maternal and child health interventions, such as family planning, antenatal care, and child immunizations. While these programs promote equity, the challenges of achieving universal coverage with quality services mean that, in reality, groups in the population often remain underserved.

Targeting is the act of directing resources, or subsidies, to specific population groups in order to achieve certain policy objectives related to enhancing equity in the health sector (see *Ready Lesson II #7: Fostering Public-Private Collaboration for Improved Access*). Targeting identifies who is poor or in need and, therefore, eligible for certain benefits. Programs can target specific areas where underserved populations live or work or areas where products and services are scarce. Targeting is successful when most of the targeted resources reach the intended population. Targeting programs necessarily entail administrative costs to identify the intended recipients (for example, the cost of social workers who identify the poor through interviews). When these costs are high, they increase overall program costs and may reduce the amount of subsidy available.

Supply-side subsidies aim to increase utilization of specific health service providers by the poor and other underserved populations. For example, governments often provide subsidized products or services to areas with high concentrations of poor and underserved people through the public sector or NGOs, utilizing community-based or clinic-based family planning programs. The most commonly used supply-side subsidy is social marketing, where subsidized products are sold through public and private sector service delivery points. Social marketing is effective for making subsidized products widely available to all clients, and therefore does not efficiently direct subsidies to specific populations. Providers of socially-marketed commodities and services have little incentive to seek out poor or hard to reach clients, and limitations in distribution channels typically lead to greater availability in urban populations than in rural ones (see *Ready Lesson I #3: Taking a Whole Market Approach* for a discussion on targeting supply-side subsidies and effects on the commercial sector).

Demand-side subsidies include cash transfers, vouchers, and other mechanisms that reduce the cost of obtaining health care for specific clients. Because demand-side subsidies usually allow clients to choose among participating providers, they stimulate provider competition and link payment to performance. Greater choice empowers clients. However, experience is still limited and programs are complex to set up, present challenges for targeting clients, and have high administrative costs.

Community-based health insurance schemes that cover contraceptives and family planning services can improve access and commodity security for its members by enabling prepayment and risk sharing, thereby reducing payments at the point of service. If governments or donors subsidize premiums for the poor or disadvantaged (e.g., in Rwanda, the government and donors pay the premiums for indigent populations to enroll in Mutuelles), the benefit to underserved populations is even greater. Community-based health insurance has had success in improving ability of the poor to access health services and supplies in communities across the globe, but FP services and contraceptives are not included in some plans (see *Ready Lesson II #6: Mobilizing Financial Resources*).

Public-private partnerships (PPPs) with NGOs that already work with poor or hard to reach populations can be leveraged to increase access for the underserved, by supporting the NGOs to provide specific FP products or services. Partnerships can also collaborate with existing private providers to motivate them to offer services to poor or vulnerable clients. PPPs are discussed in greater detail in *Ready Lesson II #7: Fostering Public-Private Collaboration for Improved Access*.

Increasing the availability and quality of health services and products can eliminate the barriers created by lack of knowledge, distance to services, or poor perceptions of services or family planning methods. The needs of rural clients can only be met when products and health services reach their communities. Expanding the method mix available to underserved groups, especially to include affordable methods such as IUD and the Standard Days Method, improves choice and acceptability for clients (see *Ready Lesson II #8: Expanding Contraceptive Choice by Supporting Underutilized Methods*). Home-based and community-based provision of services and commodities can increase availability and access to services for those populations. Community-based distribution (CBD) has been utilized successfully in many contexts to increase the availability of products for underserved populations in rural and urban areas, often through partnerships between the public sector and NGOs (see Malawi example on page 9).

Motivating health providers or clients can expand the supply or utilization, respectively, of family planning services. Governments can offer performance-based rewards that encourage health providers in either the public or private sector to improve the efficiency and quality of health services they deliver, or to improve access to services for select populations including poor or rural clients. The success of the program in reaching the target populations can be determined by documenting income or geographical indicators for clients. Governments can also compensate clients for expenses incurred when seeking services; for example, vouchers were given to poor women in China and Indonesia that they could redeem for delivery and maternal and child health services. Vouchers are a type of demand-side subsidy, as dis-

cussed previously. Since rewards can be powerful motivators, it is paramount to ensure that use of family planning is strictly voluntary. To comply with the Tiahrt Amendment requirements, providers and referral agents in USAID-supported family planning programs cannot be subject to targets for number of births, family planning acceptors, or acceptors of a particular family planning method. Program personnel cannot be provided any reward or incentive for reaching these targets. Clients must not receive any reward or incentive in exchange for becoming a family planning acceptor, and can not be denied benefits if they choose not to accept family planning.

Increasing community participation, through community-based programs that use participatory approaches, can improve the health of the poor by involving beneficiaries in program design, implementation, and evaluation. Participatory programs can help empower communities, create a sense of ownership, and foster accountability to poor clients. Community outreach and community-based services, such as adding family planning information to micro-finance programs and income generating activities, are also useful strategies for reaching isolated groups or those who would not otherwise seek health care.

Frequently, several of the strategies described in this Ready Lesson should be used in combination to significantly improve access of family planning products and services for underserved populations. This was the approach taken to increase contraceptive access amongst the poor and rural people in Malawi, as described on the next page.

Community-based distribution and outreach contribute to Malawi's increase in contraceptive prevalence across the economic spectrum

Malawi increased CPR from 7.4% to 26.1% between 1992 and 2000, with a greater proportional increase in rural areas (from 6% to 24%) than in urban areas (from 17% to 38%). Despite a predominantly rural population and high poverty rates, the increase in CPR was experienced across all economic levels. Malawi employed multiple strategies to increase the availability of quality health services and products for poorer clients.

Improving CPR required strong political leadership and sustained interventions. The strong leadership brought increased commitment to consistent product supply, greater service availability, better information and education, and an improved policy environment for family planning. The Government of Malawi developed a new logistics management information system, which resulted in improved logistics management and increased availability of supplies. In addition, widespread community-based distribution (CBD) was implemented by Banja la Mtsogolo (BLM), an NGO with a network of 29 facilities. This CBD program not only made services more convenient for actual and potential clients, it also made them affordable to poorer clients through a subsidy fund. CBD workers' interpersonal communication messages regarding services were complemented by an informational campaign utilizing multiple media channels.

Through this multifaceted approach, Malawi made dramatic improvements in contraceptive security for its population as a whole, and especially for the poor and rural clients who are traditionally underserved.

Further Reading

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World Bank web page on poverty and health, providing country report data on inequities, suggestions for programming to reach the poor, quantitative means of analyzing inequity, and distance learning courses. <http://www.worldbank.org/povertyandhealth>

The USAID Commodities Security and Logistics Division works to advance contraceptive security by providing global technical leadership and support to country programs in research and analysis, strategic planning, program design and implementation, and monitoring and evaluation.

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