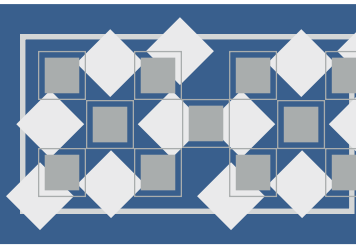
The POLICY Project

Karen Hardee

Janet Smith

Implementing Reproductive Health Services in an Era of Health Sector Reform



March 2000

Contents

Preface

The goal of the POLICY Project is to create supportive policy environments for family planning and reproductive health programs through the promotion of a participatory policy process and population policies that respond to client needs. The project has four components—policy dialogue and formulation, participation, planning and finance, and research—and is concerned with crosscutting issues such as reproductive health, HIV/AIDS, gender, and intersectoral linkages.

The POLICY Project is implemented by The Futures Group International, Inc., in collaboration with Research Triangle Institute and The Centre for Development and Population Activities. The U.S. Agency for International Development (USAID) funds the project under Contract No. CCP–C–00–95–00023–04.

POLICY Occasional Papers are intended to promote policy dialogue on family planning and reproductive health issues and to present timely analysis of issues that will inform policy decision making. The papers are disseminated to a variety of policy audiences worldwide, including public and private sector decision makers, technical advisors, researchers, and representatives of donor organizations.

An up-to-date listing of POLICY publications is available on the project's home page. Copies of POLICY publications are available at no charge. For more information about the project and its publications, please contact:

Director, POLICY Project
The Futures Group International
1050 17th Street, NW, Suite 1000
Washington, DC 20036
Telephone: (202) 775–9680
Fax: (202) 775–9694
E-mail: policyinfo@tfgi.com
Internet: www.policyproject.com
www.tfgi.com

Acknowledgments

Between December 1997 and January 1999, the POLICY Project held four meetings to identify the costs associated with implementing the International Conference on Population and Development (ICPD) reproductive health agenda. These "Costing Cairo" meetings sought to identify the costs of various reproductive health interventions, gaps in funding, potential new sources of funding, and ways of making existing resources go further. More than 150 specialists in reproductive health discussed the results of their research on issues in the economics and finance of reproductive health. Those who offered formal papers or prepared background materials, and many of those who commented during the meetings, are acknowledged below.

The authors especially wish to acknowledge the contributions of John Akin, Steven Akin, Adrienne Allison, Omer Alper, Lori Ashford, Elvira Beracochea, Paurvi Bhatt, Garland Brinkley, Rodolfo Bulatao, Martha Campbell, Jennifer Catino, Carol Collado, Shanti Conly, Clif Cortez, Peter Cowley, Paul DeLay, Tania Dmytraczenko, Robert Emrey, Joanne Epp, Marja Exterkate, Rebecca Firestone, Shephard Forman, Romita Ghosh, Amanda Glassman, Philip Gowers, Russell Green, Margaret Greene, John Haaga, Paul Hutchinson, Q.M. Islam, Jodi Jacobson, Barbara Janowitz, Robert Johnson, Edna Jonas, James Killingsworth, Marge Koblinsky, Dan Kress, Charlotte Leighton, Ann Levin, Ruth Levine, Craig Lissner, Elizabeth Maguire, Sylvia Marceau, Mark McEuen, Anthony Measham, Marc Mitchell, Elaine Murphy, Priya Nanda, M. Nizamuddin, Manuel Olave, Mead Over, Malcolm Potts, Allan Rosenfield, Pam Schwingl, Steven Sinding, Ernst Spaan, J. Joseph Speidel, Mary Ellen Stanton, Patricia Stephenson, Anne Tinker, Cindy Visness, Michael Vlassoff, Julia Walsh, and Nancy Yinger. The authors benefited from their written and spoken words, but none of these specialists is responsible in any way for opinions and views presented in this report.

The authors would also like to thank Tom Merrick of the World Bank for inspiring their thinking on the topic of reproductive health and health sector reform and for reviewing the paper. The Planning and Finance Group of the POLICY Project gave freely of their time in reviewing earlier versions of this report. At the time this paper was written, team members included Ruth Berg, Varuni Dayaratna, Nicole Judice, Ratha Loganathan, William McGreevey, Elizabeth Mumford, Jeffrey Sine, and William Winfrey. Harry Cross, Director, and Jeff Jordan, Deputy Director, POLICY Project, have provided ongoing support and encouragement for this work, and timely and useful commentary to move it forward. The authors would also like to thank the following people for their helpful comments on this paper: Hady Amr, Nancy McGirr, and Ellen Wilson of the POLICY Project, James Kocher of Research Triangle Institute, and Stan Bernstein of the United Nations Population Fund (UNFPA). Finally, Barbara Crane and Elizabeth Schoenecker of USAID were consistently helpful in the execution and review of this work. The views expressed in this paper, however, do not necessarily reflect those of USAID.

Executive Summary

The countries that agreed to the ICPD *Programme of Action* face a tremendous challenge in its implementation. Additional funds will help; however, in the face of scarce resources, countries also need to find ways to make existing resources go further. As countries strive to implement the reproductive health initiatives to which they agreed at Cairo, many are also undertaking health sector reform, a set of sweeping initiatives that affects all components of health, including decentralizing the management and provision of care, concentrating resources on cost-effective interventions (often through minimum or essential services packages), improving the performance of providers, expanding the role of the private sector, shifting the function of central ministries of health and improving their regulatory capacity, broadening financing, and shifting donor financing to support sector-wide health programs rather than vertical programs, such as family planning.

Reproductive health initiatives and health sector reform share the goals of equity and quality. The question of interest to those working in reproductive health is whether the reform measures aimed at increasing efficiency will be sufficient to ensure universal access to high-quality reproductive health services by 2015, as outlined in the ICPD *Programme of Action*. This paper reviews evidence that addresses the question of the complementarity of reproductive health initiatives and health sector reform.

Decentralization

While decentralization is sound in theory, it is not easy to implement in practice and may take as long as 10 to 20 years. Thus, the effect of decentralization on health care, including reproductive health care, is unclear. While some experiences with decentralization have been favorable, central governments have often transferred responsibility to local administrative levels without planning properly for implementation and without allocating adequate resources. In fact, existing human and technical resources are often underdeveloped at the local level. Decentralization may not promote equity, at least not in the short term. Local areas may have variable access to resources; thus, residents of poorer areas may receive less care than residents of wealthier areas. The need is clear for further analysis of health and equity outcomes related to decentralized management and provision of reproductive health.

Integration

The ICPD promoted integration of services to ensure greater responsiveness to meeting clients' reproductive health needs. In the context of health sector reform, integration is more

broadly defined; to reformers, integration of reproductive health as envisioned at the ICPD is just another vertical program.

Integration is best suited for services targeted to a similar clientele, for example, family planning linked with postpartum services. A few examples of successful integration of reproductive health services can be found, most notably in programs of nongovernmental organizations (NGOs). Since ICPD, family planning and STD/HIV/AIDS are the two main reproductive health components that have undergone integration, particularly in Africa. However, many family planning clinics are not equipped to offer services for the detection and treatment of sexually transmitted diseases (STDs), and staff members are not properly trained.

Essential Services Packages

Under health sector reform, more and more countries are implementing minimum or essential care packages of cost-effective interventions designed to reduce the burden of disease among the population. Essential services packages developed to date have generally included reproductive health components.

Making Better Use of Existing Program Capacity

More efficient, high-quality care could attract additional clients for reproductive health services and thus save money. Without improvements in quality, however, utilization of reproductive health services may suffer, particularly if cost-recovery schemes are introduced. Further evaluation is required to determine whether improvements in quality (as distinct from the availability of drugs) will lead to increased demand for services, which, in turn, can translate into increased revenue.

Evaluation of operational policies, including those affecting the provision of reproductive health services, often uncovers procedures that involve unnecessary and burdensome steps. Streamlining operational policies could make services more efficient. In addition, medical and other service barriers often inflate the cost of services. Many countries are updating their service delivery guidelines to reflect the recent international consensus on more streamlined but medically safe protocols for contraceptive and reproductive care.

Role of Public and Private Providers

Health sector reform promotes separation of the financing of services from the provision of services. In theory, governments should delegate service provision to organizations closer to communities, including local governments and the private sector, if one exists. Family planning programs have had some success in encouraging wider participation of the private and commercial sectors in service provision. Ministries of health should focus on sector management by developing legal and regulatory frameworks that direct the actions of both local governments and private providers and promote preventive care. Many countries regulate the behavior of private health providers and the distribution of drugs; enforcement of regulations, however, is another matter.

If governments remain in the business of service delivery, including reproductive health care, they should ensure a "level playing field" by providing similar subsidies and incentives to the private sector and NGOs as they provide for public sector services.

Broadening Health Care Financing

Results of initiatives in cost recovery, particularly the use of user fees, have been mixed, even for family planning. Some studies show that small increases in user fees do not affect health care utilization rates, particularly if quality of care (and drug availability) is improved. Other studies, however, have shown that user fees have adversely affected women and children, forcing them to forgo needed health care. Some countries are seeking to promote equity in health care through prepayment schemes and risk-sharing mechanisms.

Sector-Wide Assistance Programs

Donors and international financial institutions are testing various sector-wide assistance programs (SWAPs) to support health sector reform, in order to move from a narrow project focus to a sectoral focus and to help establish joint instead of donor-driven priorities. As with other aspects of health sector reform, SWAPs are not easy to implement and tend to function best in politically and economically stable environments, conditions absent in many developing countries.

Discussion

Health sector reform is complex and to be successful, requires time, political commitment, an initial investment of resources, and a favorable policy environment. Without proper planning and implementation, reform is unlikely to be successful and may even waste resources.

Within the context of health sector reform, several challenges exist in the design and implementation of reproductive health programs, including setting priorities, costing integrated services, determining new approaches for financing and providing services, and redefining the roles of central maternal and child health (MCH) and family planning divisions. With few current examples of successful reform positively affecting reproductive health programs, it is too soon to say whether health sector reform will promote efficient, effective, and equitable reproductive health care delivery, or whether reforms will result in the neglect of reproductive health in the face of other pressing health care issues. It is imperative that reform processes, including the reform of reproductive health services, be monitored, documented, and evaluated.

Equity and access issues often get lost in the details of implementing programs to increase efficiency. Those involved in reproductive health programs, including client advocates at the local, national, and international levels, need to be "at the table" when decisions on reforms are made. In addition to promoting more efficient programs and services for reproductive health, those involved in decision making must ensure that equity and access to high-quality services are primary goals of reform programs if the ICPD *Programme of Action* is to be achieved.

Abbreviations

AIDS	Acquired immune deficiency syndrome
ARI	Acute respiratory infections
CDD	Control of Diarrheal Diseases
COPE	Client-oriented and provider efficient
CYP	Couple-year of protection
DALY	Disability-adjusted life-year
DOT	Directly observed treatment
EPI	Expanded Program of Immunization
HIV	Human immuno-deficiency virus
ICPD	International Conference on Population and Development
IDA	International Development Association
IUD	Intrauterine device
IV	Intravenous
MCH	Maternal and child health
MOH	Ministry of Health
NGOs	Nongovernmental organizations
ORT	Oral rehydration therapy
RTIs	Reproductive tract infections
STDs	Sexually transmitted diseases
SWAPs	Sector-wide assistance programs
TB	Tuberculosis
TT	Tetanus toxoid
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
WDR93	1993 World Development Report

Implementing Reproductive Health Services in an Era of Health Sector Reform

Introduction

It is well established that available resources are insufficient for country-level implementation of the ICPD *Programme of Action* (McGreevey, 1999; Potts et al., 1999). Governments, donors, and individuals will no doubt contribute additional funds for reproductive health programs, but will the increase be sufficient to implement the Cairo agenda? McGreevey (1999) estimates that reproductive health resource requirements are 50 to 300 percent greater than the financial resources available in many low- and medium-income countries.

In light of the funding gap, it is vital that countries stretch available resources by improving the efficiency and effectiveness of reproductive health programs and by targeting resources to those most in need. In many countries, field workers often work far less than the prescribed number of hours. Facilities sit idle for lack of clients and staff. Clients reject public facilities because no drugs are available. Lower-level hospitals are sometimes virtually empty while major university and tertiary care hospitals and emergency rooms are crowded.

At the same time they are attempting to implement the ICPD *Programme of Action*, many countries are also undertaking sweeping health sector reforms, which are theoretically designed to improve the efficiency and quality of overall health services while ensuring equity in health care (Berman, 1995). In its ICPD+5 deliberations,[1] the United Nations recognized that countries must implement reproductive health in the context of health sector reform.

> *Governments, in collaboration with civil society, including non-governmental organizations, donors and the United Nations system, should: (a) Give high priority to reproductive and sexual health in the broader context of health sector reform, including strengthening basic health systems, from which people living in poverty in particular can benefit; (Paragraph 52)*
>
> Source: United Nations, 1999.

How are reproductive health initiatives and health sector reform related? Both share the goals of equity and quality. The question of interest to those working in the area of reproductive health is whether the measures to increase efficiency under the rubric of health sector reform will be sufficient to ensure universal access to high-quality reproductive health services by 2015, as outlined in the ICPD *Programme of Action*. This paper reviews evidence addressing the question of the

[1] *In 1999, the United Nations hosted a series of "ICPD+5" meetings to review progress toward implementation of the 1994 ICPD* Programme of Action.

complementarity of reproductive health initiatives and health sector reform. Discussion focuses on seven aspects of health sector reform and how they relate to attaining the goals of reproductive health. They are decentralization, integration, use of essential services packages, making better use of existing service capacity and improving service practices, the role of the public and private sectors, broadening health financing options, and sector-wide assistance programs (SWAPs).[2]

A Roadmap of Health Sector Reform

Health sector reform is not new. For the past decade, acknowledging scarce resources, international organizations spearheaded by the World Bank have advocated that countries undertake health sector reforms to increase the financial soundness of their health sectors and to improve the quality and equity of health care by increasing the efficiency of the health care system. In most parts of the world, health systems have been among the weakest government sectors. Ministries of health have often established fragmented, vertical programs administered centrally—such as family planning, MCH, immunization, HIV/AIDS—specifically designed to circumvent weak ministries of health. These and other programs have generally been under-financed and the services administered by the public sector inefficient. Therefore, the purpose of health sector reform is to address poorly functioning health systems by making improvements to each aspect of the system. Health sector reform also includes the integration of strong vertical programs, such as family planning, into the rest of the health system. Box 1 shows the components of health sector reform designed to strengthen the operation and financing of services.

Box 1. Components of Health Sector Reform

Health sector reform, intended to make long-term and permanent improvements by promoting equity and access to high-quality services, generally includes a number of components:

- *Decentralizing management and provision of health care services;*
- *Improving the performance of public sector health care providers;*
- *Improving the functioning of ministries of health (including their regulatory capacity);*
- *Concentrating sector resources on cost-effective interventions (often through essential services packages);*
- *Broadening health financing options, particularly through the introduction of managed care;*
- *Working with the private sector;*
- *Separating financing from provision of services;*
- *Shifting donor financing to results-oriented, policy-based sectoral programs (SWAPs); and*
- *Educating the public to make better health care choices.*

Source: Cassels, 1995; Merrick, 1999; Knowles, 1999.

[2] *This paper mainly cites literature that relates directly or indirectly to reproductive health. We have not attempted to include all of the growing body of literature on health sector reform.*

Decentralization

The ICPD and health sector reform share a number of goals. Chief among them is the desire to bring to the community decisions about both care and the provision of care. The *Programme of Action* recommended that governments promote community participation in reproductive health services by decentralizing[3] the management of public health programs and encouraging growth in the number of NGOs and private providers. A 1998 field inquiry in 114 countries conducted by the UNFPA (1999) found that 74 percent of the countries had taken at least some steps toward decentralization. Since ICPD, 27 percent had taken significant steps to decentralize health services and 16 percent some steps while 31 percent had decentralized their health systems before ICPD.

While decentralization is sound in theory, central governments have in practice often transferred responsibility to local administrative levels without proper planning for implementation and the allocation of adequate resources (Sadasivam, 1999). McGirr et al. (1994), in a review of decentralization in five countries in Asia and Africa, caution that decentralization fails in the absence of skilled professionals, adequate financial resources, and appropriate infrastructure. Case studies conducted in Bangladesh, Indonesia, Mexico, South Africa, and Tanzania found human and technical resources underdeveloped at local levels, which are generally not capable of providing reproductive health services (Forman and Ghosh, 1999).

> *Decentralization is not a carefully designed sequence of reforms aimed at improving the efficiency of public sector service delivery; it appears to be a reluctant and disorderly series of concessions by central governments attempting to maintain political stability.*
>
> Source: Dillinger, 1994.

A study of locally elected leaders in Senegal, a country that has recently undergone decentralization, found on the whole that leaders lacked clear understanding of decentralization or their roles in it (Diop et al., 1998). Only about one in five local Senegalese leaders received any training; of those who underwent training, most said it was informal. Local leaders also said the health sector, particularly family planning, was important, although few had participated in the development of the district health plan; in fact, 85 percent had never heard of it. Moreover, local officials are not informed

[3] *Decentralization can take four forms: deconcentration, devolution, delegation, and privatization. Deconcentration occurs when an agency delegates greater responsibility to its peripheral units. Devolution occurs when responsibilities are given to local government structures. Delegation involves transferring functions to other agencies. Finally, privatization occurs when functions are transferred to the private sector.*

Effective decentralization cannot rest simply on the transfer of authority, functions and resources from national to local authorities but must be accompanied by a range of measures, including adequate training, designed to support the newly empowered localities.

Source: Forman and Ghosh, 1999.

of the health needs of the population, and civil society groups have not stepped in to provide needed information. Finally, funding is a major constraint to decentralization in Senegal, and local areas do not always enjoy flexibility in allocating the resources they receive.

Implementation of decentralization and other reforms may take as long as 10 to 20 years. Aitken (1999) agrees, noting that the success or failure of decentralization depends in large part on how quickly the process is implemented. Botswana and Sri Lanka have been relatively successful with decentralization over a long period (Mills, 1990). Botswana started its decentralization process in 1965 under the provisions of the Local Government Act. In 1973, the government started transferring responsibility for primary health care to district councils, and, by 1987, regional teams that support the local services were operating. Sri Lanka began decentralizing its health program in 1952. Initially, the process included delegation of financial and administrative responsibility. It was not until 1984, however, that responsibility for several health services, including family planning, MCH care, and immunization, was delegated to the districts.

Based on a review of the decentralization process in 10 countries in Africa, Asia, and Latin America, Kolehmainen-Aitken and Newbrander (1997) list the complexities of decentralization (see Box 2). Agyepong's (1999) study of decentralization in Ghana outlines several ways in which health service delivery and utilization at the district level could be improved (see Box 3). In a review of decentralization of national AIDS control programs, Hollister (1998:10) warns that programs should not be "seduced by the superficial attraction of decentralization." However, given that decentralization is often part of a larger reform process, managers of AIDS programs may have no other options. Hollister lists six steps necessary for effective

Box 2. The Complexities of Decentralization of Health and Family Planning Programs

1. *Decentralization is a political issue that commonly arises from political pressure outside the health sector.*
2. *Guiding principles for decentralization policy are often lacking.*
3. *Some functions should not be decentralized.*
4. *National leaders and donor organizations often do not appreciate the complexity of decentralization.*
5. *Legal and/or regulatory implications frequently go overlooked.*
6. *Maintaining a consistent policy direction is a challenge.*
7. *Changing the role of the central level is difficult.*
8. *Clear standards and norms are essential for equity and quality.*
9. *Resources are often not commensurate with decentralized responsibilities.*
10. *Broad participation is needed for local progress.*
11. *Management training needs are greatly increased.*
12. *Creative local solutions should be disseminated, but generally are not.*
13. *Monitoring and evaluation yield results, but appropriate analysis of results is rarely carried out.*

Source: Kolehmainen-Aitken and Newbrander, 1997.

Box 3. Experience with Decentralization in Ghana

Reform and decentralization require time, flexibility, innovative programming, and training of all staff. Health service delivery and utilization at the district level in Ghana could be improved by

- *Raising awareness among providers that increasing resources will prove successful only if it leads to improvements in coverage, utilization, and quality;*
- *Developing performance indicators that assess and reward the local-level use of resources for improving coverage, utilization, and quality;*
- *Increasing the flexibility of central government regulations for resource allocation and use;*
- *Integrating service delivery at the district level with more decentralized planning to make services more responsive to local needs;*
- *Changing basic and in-service training strategies; and*
- *Exploring how the public and private sectors can, given available resources, effectively collaborate to achieve maximum coverage and quality of care.*

Source: Agyepong, 1999.

decentralization, from building political support and understanding of decentralization policies and objectives to developing organizational structures and procedures and creating an effective grant management system. Other steps include providing support for the organizations brought into the HIV/AIDS service delivery and prevention effort, strengthening managerial and administrative systems within the national AIDS control program, and creating links among organizational levels and implementing agencies.

Equity is another goal shared by the ICPD and proponents of health sector reform. Equity implies that all members of society should have access to a basic level of health services. Gilson (1998) contends that reform initiatives focus heavily on efficiency at the expense of equity. Adeyi et al. (1998:1900) counter that "without efficiency, equity is an illusory objective." In any event, decentralization may not promote equity, at least not in the short term. Local areas may have variable access to resources; thus, residents of poorer areas may receive less care than residents of wealthier areas (Knippenberg et al., 1997).

Gender can be as important an equity issue as income, but little data on health sector reform and decentralization are sex-disaggregated; therefore, it is difficult to say if women are at a disadvantage in terms of access to and utilization of services, although indications suggest that they are. Given that local officials are generally men, decentralization can lead to local priorities that fail to reflect the needs of women and, by extension, children. In addition, staff reductions intended to make services more efficient often affect female providers disproportionately. One solution is to encourage full participation of individuals and community groups, including women's health organizations, in promoting the reproductive health needs of women.

In summary, the effects of decentralization on the provision of health care, including reproductive health, are not clear. Aitken (1999:124) contends, "Where resources are scarce, new health problems and challenges, such as reproductive health, are particularly threatened under a decentralized system." As a study group at WHO (1996:61) noted, "empirical evidence suggests that greater caution should be used in estimating gains. In Mexico, regional disparities have heightened; in Latin America, there have been increases in the influence of dominant groups; and in Papua New Guinea, centralist tendencies have moved to the district level." Further analysis of health and equity outcomes related to decentralized management and provision of care is needed.

Integration of Reproductive Health Elements

The ICPD *Programme of Action* calls for family planning to be integrated with other reproductive health services[4] to ensure greater responsiveness to client needs and to enhance the efficiency and effectiveness of service delivery (Hardee and Yount, 1995). Integration in the context of health sector reform is more broadly defined; to reformers, reproductive health as envisioned at the ICPD is just another vertical program (Merrick, 1999). It implies the availablility of a set of cost-effective services, which might include some reproductive health services, offered in an integrated manner through essential services packages (discussed below). Nonetheless, the offer of essential services packages requires reorientation of services; thus, the experience with integration in the reproductive health field is instructive.

Programs face many challenges to effective integration. Countries must take into account the differences among administrative, service, and role integration if they are to undertake efficient integration of a wide array of health interventions. Administrative integration of policy and program components may occur at the national, provincial, district, local, or other administrative level. Service integration requires modification of worker roles; allocation of time and referral requirements; careful planning for medical support, supplies, and logistics; updated service delivery guidelines and record-keeping systems; and supervision. Role integration occurs at the service delivery level and can involve linking several provider functions.

Past attempts to integrate services without effectively integrating administrative structures have met with mixed success (Pratt et al., 1989; Simmons et al., 1990; Mitchell, 1994; Pendzich, 1998), especially given that, historically, various agencies within ministries have often competed more than cooperated. While some experts worry that integrated services will cause one service to suffer at the expense of another, others suggest that integrated services require fewer (but more effective) worker/client contacts, reduce duplication, promote the sharing of facilities, and use workers to perform multiple tasks.

[4] *There are many ways to operationalize the ICPD definition of reproductive health services. The following reproductive health concerns and related information and services are generally included in definitions of reproductive health: prevention of unintended pregnancy through provision of family planning services; provision of safe pregnancy services to reduce maternal morbidity and mortality, including services to reduce perinatal and neonatal mortality; provision of postabortion care services and safe abortion (where permitted by law); prevention and treatment of reproductive tract infections (RTIs), sexually transmitted diseases (STDs), and HIV/AIDS; provision of reproductive health services to adolescents; improvement of maternal and infant nutrition, including promotion of breastfeeding; screening and management of specific gynecological problems such as reproductive tract cancers (including breast cancer) and infertility; and addressing social problems such as prevention and management of harmful practices, including female genital cutting and gender-based violence.*

Integration is most successful when the target clientele for the integrated services is the same, for example, family planning linked with postpartum services or postabortion care services in hospitals. Walley (1997) offers some principles for successful and efficient integration based on experience with an integrated MCH program in Ethiopia (see Box 4).

In many countries, family planning and MCH services have been integrated for years. Since ICPD, family planning/MCH and STD/HIV/AIDS have been the main reproductive health components that have undergone integration, particularly in Africa. Integration of these components is considered a potentially cost-effective way of reaching sexually active women and their partners with information and services that can help treat and prevent infections (Askew et al., 1998).

Integrating family planning and MCH elements is new; therefore, experience is limited. In the Philippines, a situation analysis of 22 health centers found the centers poorly prepared to offer RTI case management. The situation improved after participation in a program that provided training, upgraded laboratory facilities, strengthened record-keeping procedures, and promoted supervision. Providers identified far more RTI cases after the intervention (Costello, 1997). In India, an operations research project in rural health clinics that tested the feasibility of integrating the case management of women symptomatic for RTIs identified the potential for implementing the service. Furthermore, women would be willing to partake of the service as part of a reproductive health program. However, administrative issues, such as staff turnover and the length of time it took to procure laboratory reagents and drugs, inhibited program implementation (Khan et al., 1997).

Based on situation analysis findings from several countries in Africa, Askew et al. (1998) conclude that there is insufficient information on which to base the promotion of clinic-based, integrated family planning and STD services. They found that many family planning clinics were not equipped to offer STD services and that the staff was not sufficiently trained. Dehne and Snow (1998) also cite the lack of conclusive evidence of the benefits of integrating family planning and STD services. In light of these findings, USAID (1999) has identified challenges

Box 4. Some Principles for Successful Integration of Services

- ***Win over staff*** *by demonstrating that integrated services are beneficial to clients and more interesting to providers.*
- ***Simplify the workload.*** *Providers need to be convinced that although each visit may take longer, they require fewer contacts with each client as services are integrated.*
- ***Reorganize case records*** *so that all services are listed on one card, if possible.*
- ***Rearrange client flow*** *to avoid missed opportunities for delivering services.*
- ***Assess outreach services*** *and be realistic about how many services can be provided through outreach workers.*
- ***Integrate supervision*** *so that all supervisors are competent to supervise the integrated services.*
- ***Promote coordination*** *through the establishment of a District Health Management Team. Central staff s role changes from operational management to supporting the district team.*
- ***Promote community participation and intersectoral communication.***
- ***Train health staff*** *in all components of the integrated package of services.*
- ***Manage donors*** *so that they think in an integrated manner rather than in terms of vertical programs.*

Source: Walley, 1997.

related to integrated family planning/MCH and STD/HIV/AIDS programs, including overemphasis on the clinical management of STDs; significant problems in implementing clinical management protocols; ineffectiveness of the syndromic algorithm for vaginal discharge; and inadequate support for primary prevention of sexual transmission of HIV and other STDs, especially for condom promotion and behavior-change intervention. The Population Council has used operations research findings in a number of countries in Africa, such as Botswana, Kenya, Uganda, and Zimbabwe, to help strengthen the ability of programs to offer integrated family planning and STD/HIV services. Interventions to promote integration have included the design and use of checklists, additional training, revised service delivery guidelines, improved supervision, and legislative amendments regarding prescribing practices for STD drugs (Population Council, 1999).

Little is known about the costs of integration, although one study by Mitchell et al. (1999) in Zimbabwe and Mexico suggests that integrated services provide opportunities for cost savings. The largest share of program costs is staff costs, but combining services can reduce those costs. The cost per visit decreases when services are combined simply because the same cost factors are frequently involved. For example, several reproductive health interventions require taking a history, counseling, and performing a physical examination. In Zimbabwe, combining an IUD check, Pap smear, and RTI screening in a single visit could save $2.20 (the combined visit cost of $3.67 compared with $5.87 for three visits).[5] While clients may not always want or need all three services, the findings illustrate the potential cost savings of combining services at each visit.

In addition, using less costly but equally well-trained staff to provide services can reduce costs. Nurses, for example, can perform many of the services provided by doctors. In Brazil, a study for PROMEDICA, the private health maintenance organization, calculated that every dollar invested in family planning services for postpartum women saved the company $2.80 in pregnancy-related services (PROMEDICA and Population Council, 1995).

In Guatemala, a study by the Ministry of Health and the Population Council's INOPAL Project showed that the cost of providing more than one service per client visit is considerably less than providing the services during different visits. For example, the cost of providing family planning and postnatal services separately was $32.80 compared with $19 when services were combined. Similarly, the cost of separately providing well-child services and vaccinations was $21.50 compared with $14 for integrated services (Brambila et al., 1997). A study by the Population Council in Mombassa, Kenya, found that offering STD services to a symptomatic client who requested oral contraceptives during the same visit cost $8.60 compared with $12.40 for delivering the services during two separate visits. The difference was largely due to savings in staff costs and overhead (Twahir et al., 1996). A study in Colombia, in which family planning employees of PROFAMILIA also conducted AIDS outreach and prevention activities, showed that the new activities did not cause contraceptive sales to decline (Vernon et al., 1990).

Countries would benefit from additional documentation of successful integration of reproductive health components. PROFAMILIA in Colombia, ReproSalud in Bolivia, and Gold Star clinics in Egypt are already noteworthy examples. An eight-

[5] *Unless otherwise noted, all costs in this paper are stated in U.S. dollars.*

country case study of implementation of the ICPD *Programme of Action* found that countries are seeking models of successful integration (Hardee et al., 1998). Askew et al. (1998) call for additional operations research on the effectiveness and cost-effectiveness of integrating STD education, diagnosis, and treatment into clinic procedures. They also suggest a study of the impact of integrated family planning and STD services on sexual behavior and the incidence of infection in female clients and the general population in clinic catchment areas.

Health sector reform processes will continue to stress integration of all health components, including reproductive health, through essential services packages. Experience with integration in the area of reproductive health will continue to provide lessons for wider integration of health services under health sector reform.

Essential Services Packages

Some countries have coupled health sector reform with the development of essential services packages as described in the *1993 World Development Report* (WDR93) (see Appendix for a list of illustrative services in an essential services package). Essential services packages funded by governments are designed to provide an integrated package of basic services to as many people as possible. While reproductive health is not always part of a country's essential services package, countries such as Bangladesh, India, Mexico, Senegal, South Africa, Uganda, and Zambia include it. For example, Bangladesh's essential services package includes maternal health (antenatal, delivery, and postnatal care, menstrual regulation, and postabortion complication care); adolescent health; family planning; management and prevention/control of RTIs/STDs and HIV/AIDS; and child health.[6] Some countries such as Bangladesh have sought to provide all services at one location; other countries such as India have made different services available at different levels of the delivery system, which is the more common approach (Farrell et al., 1998; Visaria et al., 1999).

Typically, several considerations shape the design and content of essential services packages, including the health needs of the population, the services required to meet those needs, the capacity to deliver the services at various levels of the health care system, the availability of resources, and the demand for services.[7] The WDR93 used the notion of reducing the burden of disease in developing the concept of the essential services package.

Although it has its limitations, the DALY (disability-adjusted life-year) methodology used in the WDR93 can be a useful tool to help policymakers and other stakeholders make decisions about resource allocations for health services (Murray and Acharya, 1997). Anand and Hanson (1997) argue that the methodology is flawed, particularly regarding the age-weighting and discounting used by the DALY framework to value life-years lived by people of different ages and generations. By favoring certain groups (those of middle age) and the able-bodied, the DALY methodology leads to decreased resources for the poor and the disabled, thus perpetuating inequality. Some experts also question whether the DALY methodology adequately captures the true

[6] *Child health components include the Expanded Program of Immunization (EPI), treatment for acute respiratory infections (ARI), control of diarrheal disease (CDD), and prevention of malnutrition.*

[7] *McGinn et al. (1996) also list six factors to consider in determining priority interventions in reproductive health: the importance of the reproductive health problems and identifying potential interventions; efficacy of the potential intervention; program requirements; costs; capacity of the health system; and cultural, policy, and legal factors.*

burden of disease and disability associated with sex and reproduction (AbouZahr, 1998). Paalman et al. (1998), in a review of the WRD93, argue that the report's reliance on intervention-based cost-effectiveness analysis as the primary tool for priority setting is questionable. They contend that minimum health packages cannot be prescribed in isolation; they must reflect the socioeconomic and political context of each country. Furthermore, the authors question whether health improvement can occur in the absence of social and economic development. They conclude, however, "the methodology…represents an important contribution to the debate of providing 'evidence-based policy' in the health sector" (p. 25). All critics acknowledge the lack of reliable data on which to base any type of priority setting.

Not all countries can immediately offer a complete package of essential services. The appropriate stakeholders in a country must set priorities to decide what services to provide and how to phase them in. Recently in Nepal, for example, a meeting of stakeholders suggested three levels of priorities among a number of reproductive health interventions listed in the country's reproductive health policy. The highest priorities were ongoing programs that the stakeholders wanted to strengthen, such as family planning, some basic safe motherhood interventions, and STD counseling. Second-level priorities such as care of newborns and basic emergency obstetric care were also important, but the infrastructure was not sufficiently strong to support them, and more information was required on effective interventions. In addition, stakeholders identified adolescent counseling and training of providers to serve adolescents as second-level priorities. Third-level interventions included those that stakeholders did not think would have a major impact in the near future: early detection and management of cervical, breast, and uterine cancer at the tertiary level; treatment for uterine prolapse; recanalization to reverse sterilization; and partner notification for STD/HIV/AIDS (POLICY, 1998b).

Evidence from Uganda on essential services packages suggests a range of methodological difficulties associated with establishing their cost (see Box 5). According to Akin Econometrics (1998), few estimates of coverage levels exist for the essential health package interventions carried out today. Furthermore, it is

Box 5. Health Resource Planning in Uganda

Based on an analysis of efforts to cost an essential services package for Uganda, Akin Econometrics concluded that lessons learned from implementing essential services packages, including funding gap analysis, have limited utility in developing countries such as Uganda. Limitations include the following:

- *Most health spending in Uganda occurs in the private sector. Little is known about the spending and how to motivate it toward services in the essential package.*
- *For the most part, it is impossible to determine current levels of health expenditures applied to the delivery of essential packages.*
- *The fact that political motivations drive the inclusion of some components of an essential services package diminishes the theoretical basis of an essential package; there is less control over the use of cost-ineffective interventions.*
- *Much of the essential-package costing work as it applies to Uganda allows for unrealistic and non-data-based assumptions of efficiency.*
- *WDR and Ministry of Health (MOH) estimates of the cost of the essential package are based on no increases in infrastructure, an unrealistic assumption.*
- *Neither the WDR nor MOH essential package cost estimates include essential-package start-up costs such as clinical training, equipment, quality-of-care training, and so forth.*
- *These start-up costs in themselves are impossible to estimate given the lack of data available on quality of care or coverage for services in the essential package.*

Source: Akin Econometrics, 1998.

difficult to discern the quality of the interventions. Finally, making adjustments to costs in consideration of the inefficiencies in the Ugandan health care system is based on educated assumptions with little scientific basis.

At a 1998 meeting on the implications of health sector reform for reproductive health rights, several participants noted the shortcomings of reform in Zambia. Munro (1999:39), however, points to some aspects of the reforms, including decentralization and use of an essential services package, that have benefited reproductive health (see Box 6).

Box 6. The Effect of Health Sector Reform on Reproductive Health in Zambia

[There are] three potential advantages of sector reform for gender and reproductive health concerns in Zambia and the opportunities that have been created for change. For example, decentralization and democratization of decision making have created an opening for the incorporation of reproductive health and gender concerns into planning and service delivery. The focus on an essential services package of care at the primary level has increased the likelihood that women and girls will have access to care because services are closer to home. Passage of the Nurse-Midwife Act, which expands the scope of private practice and nursing home care by midwives and eliminates the requirements that nurses only provide care under a physician s supervision, will create the potential for greater access to care and a significant increase in women s participation in women s care.

In some districts, the quality and quantity of both reproductive and general health care have improved notably since the reforms took effect in 1991, as districts have become more confident and proficient in developing their own plans to provide essential services. Greater efforts were made throughout 1997 and 1998 to bring community concerns into the planning process, and some districts have made reproductive health care a priority.

These successes have been accompanied by a variety of problems. The most important of these for service delivery and district-level implementation of reforms have stemmed from the process of integrating vertical programs, the de-linkage of workers from the health care system, and drug shortages.

Source: Munro, 1999:39.

As with many other aspects of health sector reform, experience with essential services packages is too recent to assess the packages' success in delivering high-quality, equitable services. Saltman and von Otter (1995, in Koivusalo and Ollila, 1997:161–162) call the use of essential services packages a "routinized form of health care rationing, reconfigured as an administrative device." Koivusalo and Ollila (1997:162) caution that countries should guard against political decisions masquerading as technical and administrative issues. Experience with the Bamako Initiative, however, suggests that reform, including use of minimum services packages, can work. Launched by a group of African health ministers in 1987, the Bamako Initiative seeks to promote sustainable health services at the decentralized level by combining cost-effective, minimal care packages with health center and district revitalization, rationalization of resource use and management, and community outreach, co-management, and cost sharing (Knippenberg et al., 1997).[8] Most African countries have adopted either the Bamako Initiative or other similar health reforms. In Congo, Togo, and Zaire,[9] Bamako Initiative centers have operated despite political instability. As long as drugs and supplies are available, services were provided. Bamako Initiative clinics provide a limited range of integrated primary

[8] *Strategies to improve effectiveness of health care under the Bamako Initiative include implementation of an essential health care package at the health center level, including cost-effective preventive, curative, and health promotion activities; availability of essential drugs and other supplies; improved geographic access to care by specifying catchment areas and target populations for each health center and organizing regular outreach activities to villages more than five kilometers away; integration of various health interventions to reduce missed opportunities; improved continuity of care through better follow-up of target populations; improved quality of care through use of standardized diagnosis and treatment flow charts and implementation of routine supervision procedures; and ensuring the accountability of health staff and communities for ongoing adaptation of strategies in order to improve coverage through the local monitoring and microplanning processes (Levy-Bruhl et al., 1997).*

[9] *Currently the Democratic Republic of Congo.*

health care services for about $1 to $2 per person per year. Adding reproductive health services would probably not add considerably to current per capita costs (Soucat et al., 1997a).

Improving Use of Existing Program Capacity

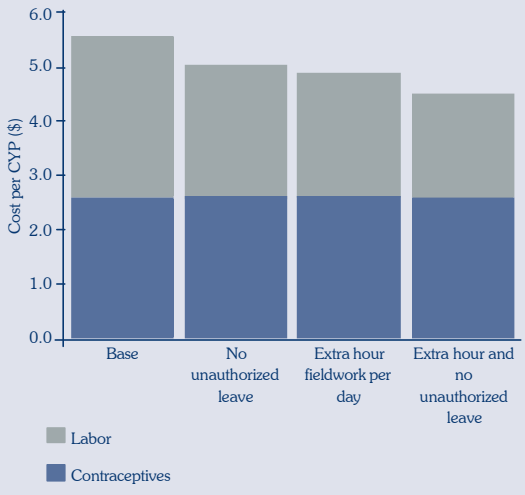
Health sector reform aims to make the functioning of the public sector, including its providers, more efficient. Several international and local family planning and reproductive health organizations are also working to improve the use of existing capacity by increasing labor productivity, upgrading quality of care, streamlining operational policies, and improving service practices.

Increasing Labor Productivity

Studies of family planning clinics around the world have highlighted several inefficiencies that increase the cost of service provision. To begin, a secondary analysis of five situation analysis studies in Africa found that most providers saw three or fewer family planning and MCH clients per day. A significant amount of staff time, therefore, may be available to increase the length of client visits, improve the quality of information provided during visits, and expand the range of available reproductive health services (Haberland et al., 1998). A study of family planning service delivery in Bangladesh showed how better management could improve efficiency (see Figure 1). Earlier observers (Simmons et al., 1991) had noted how little time field workers spent on the job. More recently, Janowitz et al. (1996) tracked the behavior of a small sample of family welfare assistants. The analysis showed that if unauthorized leave were eliminated or family welfare assistants were to work an extra hour per day, labor costs per couple-year of protection (CYP) would decline relative to current cost. If one extra hour of fieldwork were coupled with the elimination of unauthorized leave, labor costs would drop by one-quarter.

Similarly, a Family Health International study of the Ministry of Health system that provides 16 percent of all family planning services in Mexico found that more efficient use of staff time could increase the number of clients served and reduce costs. An increase in work hours from the current 6.5 to eight would provide 0.3 million additional CYP

Figure 1. Increasing the Productivity of Family Welfare Assistants



Source: Janowitz et al., 1996.

by 2010 while the cost per CYP averaged over all contraceptive methods would decline from about $26.40 in 1995 to $24 in 2010 (Hubacher et al., 1999).

A study of maternal health care services in Uganda revealed a range of costs for prenatal and delivery care at four health facilities. Costs ranged from $2.21 at the public health center to $6.43 at the mission health center for prenatal care, and from $2.71 at the public health center to $33.90 at the public hospital for a normal delivery (Levin et al., 1999). The study concluded, "public and private providers alike could make better use of their resources by changing their drug supply practices, staffing patterns, and utilization rates" (p. 8). To make more efficient use of staff, the study recommended relying on midwives rather than medical officers to handle routine care and reserving physicians for obstetrical complications. Furthermore, in facilities with few clients, reducing the number of midwives would increase the number of deliveries per midwife and thus reduce the cost per delivery, assuming that demand for services does not increase.

Improving Quality of Care

Quality of care has many dimensions, all of which are important (Bruce, 1990). From studies in Africa, Vandmoortele et al. (1997:s165) list three important factors for good-quality services: availability of drugs, cleanliness of the health facility, and attitude of the health staff. Studies show that improvements in the quality of service provision that simultaneously enhance efficiency can be undertaken at reasonable cost; without such improvements, use of services may suffer, particularly if cost-recovery schemes are introduced (Kols and Sherman, 1998). Improvements in quality, however, particularly with respect to drug availability, can offset fee increases and client loss if clients are more willing to pay higher rates (Litvack and Bodart, 1993; Wouters et al., 1993; Janowitz et al., 1999).

Many countries have adopted quality management as a means of improving services (Hardee and Gould, 1993; Kols and Sherman, 1998.) Quality management is a participatory approach based on the following five principles: obtaining top-level managerial commitment to improving quality, using a systems approach to assessing and improving work processes, maintaining a client-perspective on improvements, assuring staff involvement in identifying problems and suggesting and testing solutions, and, finally, using information to develop solutions. The USAID-funded Quality Assurance Project, which was designed to help improve health care programs worldwide, includes six activities to achieve the principles of quality management: capacity building and training, setting practice standards, quality design of program systems, quality monitoring, quality improvement, and documentation of activities (Nicholas, 1999).

Among the team-based approaches to improving quality, one of the most widely applied tools is COPE, which stands for client-oriented and provider efficient. Used in more than 35 countries, COPE is based on a set of simple self-assessment tools developed for workers and supervisors in family planning clinics. Staff members analyze client flow, conduct interviews with clients, and complete a questionnaire on every aspect of service delivery. An evaluation of COPE at 11 clinics in Africa found that teams had solved 59 percent of problems identified through the process (Lynam et al., 1993). Whether improvements in service quality, as distinct from the availability of drugs, will lead to increased demand and revenue, however, requires further evaluation.

Evaluations of family planning programs have often cited weak supervision systems as a detriment to efficient service delivery. "It is surprisingly common to find that no defined process exists for a basic function, such as inventory control. In many cases, the existing process is incomplete, or otherwise does not fulfill program needs. Currently, few supervisors are prepared to respond to such problems, but the common-sense principles known as Quality Design address this frequently overlooked deficiency" (Heiby, 1998:3). Several countries are implementing quality assurance and management systems to improve supervision, including Chile, Ecuador, Niger, Uganda, and Zambia (Burnham and Stinson, 1998; Marquez and Madubuike, 1998). In addition, programs are under development in several countries to provide supervisors with the tools to help providers solve problems. Once quality standards for service delivery are made explicit, supervisors and providers have a clear idea of performance standards (Stinson et al., 1998.) Quality management and improvement programs, including the supervision components, appear to be improving service delivery and quality of care. Evaluations that study the new programs' efficiency gains should be conducted.

Streamlining Operational Policies

One element of an effective service delivery system is a supportive operational policy environment that emphasizes efficient, streamlined procedures. Thus, as part of its new target-free or community-needs approach, India's Ministry of Health and Family Welfare has vowed to improve the efficiency and effectiveness of its health system. Currently, a labyrinth of operational policies inhibits health workers from carrying out their duties in Uttar Pradesh, the country's most populous state. A series of studies identified several operational policies that could be changed to make program operations more efficient (POLICY Project, 1998a). First, political expediency rather than objective criteria often drives decisions, particularly those regarding staff changes and transfers. Second, the ministry is too centralized such that programs are not based on local needs and requirements. Third, job functions are not clearly defined; as a result, workloads are not evenly distributed. Finally, supervision and monitoring are weak or nonexistent. Systematically addressing the issues associated with operational policy design and implementation could help lead to improved service delivery.

At the subcentre level, auxiliary nurse midwives fill in 13 registers and prepare four monthly reports. Once introduced, registers are never withdrawn. Excessive recording and reporting procedures burden staff and distract them from more important tasks. There has been no effort to review existing systems and integrate and simplify the systems to eliminate duplication of information.

Source: POLICY Project, 1998a.

Improving Service Practices

Changing the service practices of providers can increase the efficiency and quality of services and reduce costs.[10] Medical and other barriers to care that currently plague many programs inflate the costs of services (Shelton et al., 1992; Bertrand et al., 1995; Hardee et al., 1998). One-third of providers in Burkina Faso require a husband's consent before providing oral contraceptives to a woman. In Senegal, sterilization is available only after a woman has had six children (Miller et al., 1998). The requirement in many countries that a client must be

[10] *Service practices refer to the medical and interpersonal care given to clients. Service delivery guidelines, norms, or protocols generally govern service practices.*

menstruating before she can receive service represents another barrier to contraceptive use (Stanback et al., 1997). In some countries, women cannot even receive counseling unless they are menstruating; they are simply told to return at the appropriate time. Such a practice limits family planning service availability to 60 days a year. The menstruation requirement has further implications for women in need of other reproductive health services, especially if services are integrated.

Some studies have attempted to measure the costs of restrictive service practices. A study of the Mexican Ministry of Health found that CYP costs could be reduced by increasing the number of units of pills and condoms provided at each visit and by switching from a one-month to a three-month injectable (Hubacher et al., 1999). Requirements for unnecessary laboratory tests add to the cost of services. In parts of West Africa, for example, women are required to have a blood test to rule out liver and cardiovascular disease before they receive the combined oral contraceptive. One study found that the expensive blood test (between $55 and $216 in Senegal) identified very few at-risk women (Stanback et al., 1994). Requiring clients to return frequently for follow-up visits is also expensive and may be unnecessary. For example, Janowitz et al. (1994) found that reducing the number of follow-up visits for the IUD is medically safe.

Activities to improve service practices in other areas of reproductive health are also underway. Dayaratna et al. (2000) document the interventions that experts consider essential in reproductive health: family planning, maternal health, and STDs, including HIV/AIDS. In the area of maternal health, a 1997 conference (held a decade after introduction of the Safe Motherhood Initiative) highlighted best practices in safe motherhood (Starrs, 1998). One of the conference's main findings, based on years of research, is that the use of traditional birth attendants for delivery does not provide the desired obstetric outcomes. In fact, meeting participants noted the need for skilled attendants—a nurse or midwife—at delivery. Internet sites, including www.rho.org, maintain current information on safe motherhood as well as on other areas of reproductive health. With respect to STDs, the United Nations Programme on AIDS maintains an Internet site (www.unaids.org) that documents best practices in the area of STD/HIV/AIDS.

Countries could benefit from reviewing and updating their service delivery guidelines on all aspects of reproductive health. Indeed, many countries are already doing so; moreover, documents are available to guide countries through the review process (TGWG, 1994; WHO, 1996; MAQ Task Force, 1997). Revising service delivery guidelines is, however, only the first step; disseminating the guidelines and training staff on their application is vital to ensuring compliance.

Role of the Public and Private Sectors

Health sector reform urges governments to revise their role in the provision of services. The ICPD promoted expanded involvement of the private sector and NGOs in providing services. Historically, governments have provided many health care services, including family planning, through their network of health centers. In some countries, governments have focused services in rural areas while NGOs and the private sector have served urban areas. Often, governments have subsidized health care for the poor, effectively eliminating competition between the public and private sectors and even thwarting development of the private sector. While there may be cases where government services are more efficient than private ones, the reverse is generally true (Behrman and Knowles, 1998).

Health sector reform promotes the separation of service financing from service delivery. Central governments should focus on health care financing by organizing insurance and social security programs and delegating service provision to organizations that are closer to communities, including local governments and the private sector (if the latter exists). Ministries of health should develop legal and regulatory frameworks that govern both local government and private provider delivery of health care, promote preventive services, and offer incentives for efficient, effective, and equitable services. If governments do choose to remain in the business of service delivery, they should ensure a "level playing field" by providing subsidies and incentives to the private sector and NGOs similar to those provided in the public sector.

Noting that health sector reform often began in the context of resource-poor and weak public sectors, then the requirements imposed on the state due to the need for regulation of privatization are nearly impossible to meet. This problem may be compounded by ongoing decentralization as part of health sector reform.

Source: Kumaranayake, 1997.

In fact, government regulations and control can be used to promote private sector services while maintaining an adequate standard of care for clients. Yesudian (1994:79) contends that "unregulated expansion of the private sector will do more harm than good." Legal regulations and controls could extend to licensing, registration of facilities, ways to ensure minimum quality of care and prevent over-treatment and oversupply of care, mechanisms for the investigation of complaints, means of disciplining providers, and consistent implementation of regulations (Smith, 1999; Yesudian, 1994). Kumaranayake (1997) notes that

many countries regulate the behavior of private health providers and the distribution of drugs. The degree to which regulations are enforced, however, is another matter both in middle-income countries such as Thailand and low-income countries such as Malawi (Roemer, 1991; Ngalande-Bande and Walt, 1995). Still, it is important to establish a legal and regulatory framework for privatization early in the health sector reform process; delay only makes the regulations more difficult to enforce. Analysis can help identify the laws, regulations, and guidelines that should be changed (Kenney, 1993).

The challenge is to design exemption mechanisms to limit the negative effects of local cost recovery on the most vulnerable, especially their financial exclusion from using essential curative care, while maintaining the positive aspects of local cost recovery.

Source: Soucat et al., 1997c.

Little data exist with which to evaluate private provision of care in developing countries and on which to base a shift in service delivery to the private sector. However, the family planning and reproductive health field has long used national surveys (e.g., national fertility surveys, contraceptive prevalence surveys, and demographic and health surveys) to collect data on source of contraceptive method and MCH care. Some countries, such as Jamaica, have conducted mapping studies of all providers within their bounds (Bailey et al., 1994; HOPE Enterprises, 1998). Hanson and Berman (1998) conclude that further data need to be collected on all aspects of the private sector including its size, dual practice among government-employed physicians, utilization of different types of providers, and how specific features of the institutional and regulatory environment affect the size and growth of the private sector. The authors also call for additional information on the impact of private provision on social welfare outcomes, including equity in access and health status.

Broadening Health Care Financing

Many governments provide primary health care services to clients for free. With shrinking resources, however, the sustainability of free services is no longer a certainty. Therefore, one major aspect of health sector reform is to identify alternative methods of paying for services. User fees, insurance premiums, and community health funds can, among others, broaden financing.

Cost recovery through community financing has been a major component of the Bamako Initiative. In Benin and Guinea, a variety of mechanisms finance services in Bamako Initiative health centers. User fees generate revenue to cover local operating costs, including drugs, while the governments pay the salaries of health care staff and donor funds cover vaccine and investment costs. In a study of 400 Bamako Initiative clinics in Benin and Guinea, Soucat et al. (1997b) found that cost recovery was variable. In Benin, some centers recovered more than twice the costs targeted for community financing; in Guinea, one-quarter of the centers were not able to recover local recurrent costs. Deficits were due to small target populations, lack of access to care, and lack of trained midwives at centers. At present, Bamako Initiative health centers are subsidized equally; perhaps a more equitable distribution of subsidies favoring health centers in poorer areas would result in greater equity in health care utilization and outcomes.

Most family planning associations, particularly in Latin America, are seeking ways to make their clinics sustainable in light of reduced donor support. Careful analysis of both client demand for services and client willingness and ability to pay is crucial for success. In Ecuador, the Centro Medico de Orientacion Planificacion Familiar (CEMOPLAF) analyzed its client base and discovered that many of its clients were middle-class and thus could afford to pay for services (Barnett, 1998). Upon concluding that its fees were too low in most clinics, CEMOPLAF slowly increased charges. In addition, since 1992, CEMOPLAF has been offering specialized services, such as ultrasound, in some clinics in order to attract greater numbers of paying customers.

When the price of low-quality health care services increases, rational health seeking behavior will invariably result in a decline in utilization.

Source: Vandmoortele et al., 1997.

Expanding the commercial sector for those able to pay could help governments target resources to those unable to pay. The commercial sector can include physicians, clinics, pharmacies, and hospitals that do not rely on donors or the government for

operating support (Finger, 1998). While the commercial sector for family planning is small in most of Africa, some countries in Latin America, North Africa, and the Near East claim well-developed and growing commercial sectors (Winfrey et al., 2000). For example, in most Latin American countries and in countries such as Egypt, Jordan, and Turkey, the commercial sector provides at least 40 percent of contraceptives.[11]

The effects of user fees on sustainability are mixed. Some studies show that health care utilization rates are not adversely affected by small increases in user fees, particularly if the quality of care improves (Alderman and Lavy, 1996; Akin et al., 1995; Shaw and Griffin, 1995; Hotchkiss et al., 1998). Furthermore, the revenue generated by fees can give providers an incentive to deliver better quality care, thereby leading to increased utilization and lower unit costs. Others contend that user fees can force, and have forced, poor women and children to forgo needed health care (Sadasivam, 1999; Ekwempu et al., 1990; Kutzin, 1995; Standing, 1997). In Niger, a study revealed that an annual tax and small fee-for-service program (social financing) rather than a pure fee-for-service system led to greater access to care for women, children, and the poor. The study also found that quality improvement and cost containment, particularly with respect to drugs, and the method of cost recovery (tax and small fee-for-service or pure fee-for-service) were important factors in achieving sustainability (Diop et al., 1995). In fact, free services are generally not free at all, and clients often have to pay for drugs and supplies, if not for a provider's time. In Sri Lanka, the government found that households could pay for most outpatient primary health care but not for catastrophic, in-patient care. Thus, the government provides funds for hospital care and people pay for their own primary health care (Rannan-Eliya and de Mel, 1997). Such an approach makes health care sustainable in Sri Lanka, but it may not work in other countries.

In a review of the results of a study of health-seeking behavior in Bamako Initiative health centers in Benin and Guinea, Soucat et al. (1997c) concludes that curative and preventive care utilization increased significantly, even among the poor. While use rates for preventive services increased for both richer and poorer households, curative care use rates increased more substantially for richer households. Guinea is now experimenting with ways of ensuring access to health care among the poor and most vulnerable groups, perhaps through prepayment and risk-sharing mechanisms. A study in Ghana of health care-seeking behaviors related to the cost-sharing policies introduced between 1985 and 1992 found that the policies have led to an increase in self-medication and other behaviors aimed at cost reduction (Asenso-Okyere et al., 1998). At the same time, people perceived an improvement in the drug supply as well as in the service delivery at public sector facilities. The Ghana study reached the same conclusions as other studies. While it is important to improve quality of care and the drug supply in order for people to be willing to pay (or pay more) for services, exemptions are essential for the truly needy, who will postpone health care in the face of user fees.

Russell (1996) cautions that willingness to pay and ability to pay are not synonymous. He contends that families and households sometimes pay for health services with resources that they would otherwise allocate to basic needs such as food or education. Governments need to be

[11] *Encouraging service provision by the commercial sector does not imply that government should necessarily provide all services for the poor. Governments could also subsidize the private sector (including NGOs) to provide services to the poor.*

sensitive to the willingness/ability distinction when designing cost-recovery schemes.

As of 1994, all but five sub-Saharan African countries had introduced some type of user fee in the public sector (Bennet and Ngalande-Banda, 1994). Janowitz et al. (1999), in a review of issues related to financing family planning services in sub-Saharan Africa, make several policy recommendations regarding charges for family planning services (which have often been free even when other services are not). They note that government and NGO programs should consider the introduction of limited fees for family planning services. Without such fees, they concluded, programs will be unable to expand services to meet rising demand, particularly for high-quality reproductive health services. They also found that means testing cannot reliably ensure that vulnerable groups will have access to the offered services in a fee-based system. At least in the short term, the authors suggest that programs charge low fees and target populations by geographic area or facility type. They recommend that service delivery outlets retain some revenue from fees to improve service quality. Finally, they propose that, given the problems inherent in means testing in much of sub-Saharan Africa, greater attention should be given to encouraging the growth of the commercial sector and reducing costs where possible in subsidized programs. McPake (1993:1403) also notes the need for introducing user fees, saying, "it is difficult to see an alternative [to cost recovery] for those countries whose health systems are most degraded, for which there is no prospect of improved public funding…."

Some countries are using social financing or social insurance to broaden finance. For example, social insurance schemes are under development to cover emergency obstetric care. Some communities that offer effective safe motherhood services also support self-financing transportation schemes. The Prevention of Maternal Mortality Network in West Africa helped mobilize the support of transportation workers in Kebbi State in Nigeria. The creation of an emergency fuel fund established the trust of the transportation workers (Shehu et al. in Maine, 1997:173–180). Behrman and Knowles (1998) discuss a successful community insurance scheme for emergency obstetric care in Indonesia. Russell (1996), noting that programs could include local savings schemes or rural health insurance schemes, provides examples of prepayment programs in parts of Guinea and Burundi.

A pilot project in Egypt demonstrates that the process involved in reforming of health care and shifting service provision to the private sector is indeed time-consuming. In an effort that began in 1994 and is not expected to be complete until 2007, the Egyptian government is working with donors to test a social insurance program for health care (currently in Alexandria). The program calls for introducing a minimum package of benefits available to all Egyptians, shifting service provision to the private sector, improving the government's regulatory capability, and shifting services financing from the government to a more diverse funding base. Family doctors provide a package of basic services funded through government, employee, and patient contributions. Primary health care services in the minimum package include family planning and MCH components; however, there are no current plans to dismantle the highly successful Gold Star family planning program, which is seen by managers of the new program as a vertical family planning program (Paterson, 1999; Berman et al., 1997; El Gebaly et al., 1998).

Sector-Wide Assistance Programs

Donors and international financial institutions are testing various sector-wide assistance programs (SWAPs) that might support health sector reform. SWAPs offer a means to move from a narrow project focus to a sectoral focus and to help set forth joint instead of donor-driven priorities. Experience with different forms of SWAPs is limited. According to Peters and Chao (1998), however, SWAPs are not a panacea but may provide a way to deal with the problems of weak health sectors in low-income countries.

In the past, most loans and grants provided for careful monitoring and evaluation of donor funds without consideration of the complementary efforts and resources of cooperating governments. As a result, donor money has come to replace funds that governments might otherwise have allocated to the health sector. If, for example, a donor funds a health project, a government can then buy an airplane with the money it saved by not funding the same project. In such a case, donor assistance may even replace money that households would have spent for goods and services. The outcome can be far less beneficial than donors intend (see the analysis in World Bank, 1998:72–74, Table 3.2). SWAPs try to avoid a government's reallocation of funds by seeking government/donor agreement on a multiyear program that includes resources from both parties; annual reviews offer an opportunity to determine whether all the parties are contributing to program objectives as originally outlined. A preliminary review of several programs in sub-Saharan Africa showed favorable results (Noman, 1997).

The SWAP is not a panacea to all that ails the health sector in low-income countries, but it is providing a way to deal with them in a more coherent manner.

Source: Peters and Chao, 1998.

The recently approved Health and Population International Development Association (IDA) credit to Bangladesh is an example of a new development that involves both a SWAP (see Box 7) and an essential services packages. If the project proves successful, it may guide future assistance in reproductive health in other countries. Nonetheless, it faces many potential obstacles to implementation (see Pendzich, 1998; Buse, 1999).

Walt et al. (1999:273) reviewed SWAPs in Bangladesh, Cambodia, Mozambique, and Zambia and concluded that "coordination and management of external resources is inherently unstable, involving a changing group of actors,

Box 7. Reproductive Health Reform in Bangladesh

Over more than two decades, donor assistance helped the government of Bangladesh strengthen its population programs. Modern contraceptive use has risen, and fertility has declined by nearly 50 percent since 1980. The Fourth Health and Population Project, a $605 million program that concluded in 1998, coordinated efforts of the government, United Nations agencies, a dozen bilateral donors, and two development banks in executing over 60 subprojects (WDR93: 170).

The Fifth Health and Population Project, agreed to in 1998, will support further reforms by focusing on just two components: strengthened service delivery and policy improvements. Improvements include integration of the population and health wings of the Ministry of Health; better use of staff resources in the field; a focus on an essential package to benefit vulnerable groups of women, children, and the poor; and annual reviews of donor and government funds allocated to health. Donors will focus on fewer individual projects and will instead monitor and support ministry actions that are consistent with shared goals. According to Pendzich (1998), experts in Bangladesh contend that the success of the new project rests on the integration of the health and population wings of the Ministry of Health, a political move that may prove extremely difficult.

many of whom enjoy considerable autonomy, but who need each other to materialize their often somewhat different goals." Writing about Zambia, Lake and Musumali (1999) note that, according to Cassels (1997), health sector SWAPs work best in a stable macroeconomic environment. Given that a stable environment does not exist in Zambia, the authors conclude that "in such a climate, the need to maintain dialogue, openness and trust between…partners…in relation to intra-sectoral resource allocation decisions is essential for continued progress." Walt et al. (1999) list eight actions that should be taken if health sector SWAPs are to be effective (see Box 8).

Box 8. Ingredients for Successful Health SWAPs

- *The MOH needs to develop a vision or health policy, including implementation and expenditure plans, a core group of officials must truly own the plans.*
- *The MOH needs to be prepared to devote substantial resources, time, and energy to coordinating and managing external resources.*
- *Focusing on a specific, commonly perceived problem is helpful for beginning the process of positive management of resources.*
- *The first steps are likely to meet with skepticism; therefore, early success is crucial.*
- *Building the knowledge base of the MOH will help establish the agency s authority and reputation, which are essential factors in negotiations with donors.*
- *Attempts to influence donors are more likely to be successful than attempts to control them.*
- *Internal MOH coordination is as important as external coordination.*

Source: Walt et al., 1999.

Discussion

The countries that agreed to the ICPD *Programme of Action* face a tremendous challenge in implementation. Additional funds will help; however, in the face of scarce resources, countries need to find ways to make existing resources go further. At the same time, several countries are already implementing health sector reform, a set of sweeping initiatives that affects all components of health, including reproductive health.

Given the trend toward health sector reform worldwide, reproductive health care program managers, donors, and international technical assistance organizations must understand the reform initiatives and work within them to implement reproductive health programs. This paper has highlighted several challenges in the design and implementation of reproductive health programs in the context of health sector reform, including setting priorities, costing integrated services, determining new approaches for financing and providing services, and redefining the roles of central MCH and family planning divisions (see also Merrick, 1999).

Health sector reform calls for difficult policy decisions. Thus, while implementation includes many technical inputs, the success of reform ultimately rests on political and policy considerations. Glassman et al. (1999) note that the most powerful actors in the health sector, including reproductive health, are often satisfied with the status quo despite problems with distribution of services, access, quality, and efficiency. Moreover, "one of the most important and complex problems in the process of health reforms is the management of…short-term, concentrated costs, and of the powerful groups affected" (p. 115). Thus, forging policy dialogue among all stakeholders involved in all components of the health sector and those involved in local government is crucial in laying the foundation for successful reform.

> *Whether reproductive health services are being delivered effectively can be an excellent measure of how well the entire health system is working.*
>
> Source: Merrick, 1999.

The evidence provided in this paper shows few current examples of successful reform that have had a favorable effect on reproductive health programs. The exception is Zambia, although the reform process there is not without problems. Evidence from the Bamako Initiative, however, indicates that reforms can succeed and that additional reproductive health services could be added at little cost to the minimum services packages already supported under that initiative.

Brazil offers an instructive example of the mixed effects of health reform on reproductive health services (Correa et al., 1999). In the late 1980s, political turmoil and economic crisis hampered both health sector reform and reproductive health activities; since 1994, however, the situation has improved. Reproductive health and rights gained visibility and legitimacy after the 1994 ICPD and the 1995 Fourth World Conference on Women; in response, the unified health system has undergone reform. The government has approved additional financing for health care and has accelerated the decentralization of services. As a result, reproductive health care is increasingly being integrated with municipal-level primary health services (previously it had been floundering as a standalone program known as PAISM, Programa Assistencia Integral a Saude da Mulher). Adolescent reproductive health programs in Brazil, however, have not fared so well. According to a recent study of adolescent reproductive health in Sao Paulo, the consequences of structural adjustment policies and health sector reform (i.e., higher numbers of uninsured persons, cuts in public spending for health, reduction in health care personnel, and shortage of medical supplies) have impeded implementation of high quality health services for adolescents (Gogna, 2000).

In Brazil, the major principles underlying health reform universal access, comprehensive care, equity, decentralization, and social accountability have proved to be a prerequisite for effective implementation of a comprehensive reproductive health approach.

Correa et al., 1999.

The paper also shows that health sector reform is complex and requires time, political commitment, an initial investment of resources, and a favorable policy environment. Reform affects every administrative, managerial, and operational aspect of the health service delivery system, including "vertical" programs such as family planning, MCH, and HIV/AIDS. Without proper planning and implementation, health sector reform is unlikely to be entirely successful and may even waste resources. Clearly, wasting resources in the health care sector will adversely affect the provision of reproductive health services.

The recent reform epidemic has been driven by rhetoric, incomplete theorizing, and little evidence.

Source: Maynard and Bloor in Koivusalo and Ollia, 1997:160.

It is imperative that the reform process, particularly as it relates to reproductive health services, be monitored and evaluated. Knowles et al. (1997) have developed a handbook for evaluating system performance. Used in conjunction with other indicators that measure progress and outcomes in reproductive health (Bertrand and Tsui, 1995), the indicators in the handbook could help monitor the impact of reproductive health programs in the context of health sector reform.

Countries need more information on the capability of various types of providers, such as government, NGOs, and private sector groups, to sustain improvements in efficiency and quality. More information is also needed on the effect of cost-recovery initiatives on access to and use of reproductive health services. Further evaluation of the impact of cost-recovery initiatives on the provision of reproductive health services is critical. Experience with the Bamako Initiative offers some examples of successful provision of services at the primary health care level. Countries should document and share their experiences in making programs more efficient.

It would be helpful to know from other countries' experiences if there are ways to phase in key reforms. For example, countries with low service utilization and empty shelves might be helped by cost recovery. Could such a reform be implemented first and then another reform phased in? Could health sector reform be implemented in a specific geographic area before it is implemented nationwide? Countries also need more information on what reproductive health components have been successfully integrated into essential services packages.

Much more information is needed on the costs and cost-effectiveness of the various mechanisms for improving the efficiency of reproductive health programs. We are beginning to collect such information, but well-designed cost studies will be beneficial to governments and donors making important decisions on extending and improving reproductive health care.

It is too soon to say whether health sector reform will promote efficient, effective, and equitable reproductive health care delivery, or whether the reforms will result in the neglect of reproductive health in the face of other pressing health care issues. Koivusalo and Ollila (1997:139) contend that access and equity are the goals of health sector reform; however, reform activities have thus far emphasized an increase in efficiency. Thus, equity and access often get lost in the details of programs designed to increase efficiency. In that light, it is imperative that those involved in reproductive health programs, at both the national and international levels, invite client advocates "to sit at the table" when decisions on reforms are made. In addition to promoting more efficient programs and services for reproductive health, those involved in decision making must ensure that equity and access remain the primary goals of reform programs if the ICPD *Programme of Action* is to be implemented.

Appendix

Illustrative Maternal Child Health and Nutrition Services for Essential Package to Reduce Maternal Mortality Rate, Infant Mortality Rate, Low Birth Weight, Under-Five Mortality, and Unwanted Pregnancy

Intervention	Community/ household (outreach workers)	Clinic (or lowest-level fixed-site facility)[12]	Health center (a) outpatient surgery only (b) in-patient surgery	District hospital (referral services)
Family planning	Community counseling Distribution of condoms and oral contraceptives	Manage/refer problems Provide injectables	Manage/refer problems IUDs, Norplant Surgical contraception (b)	Infertility
RTI control and management	Information on safe sex Recognition of symptoms	Counseling Symptomatic screening Symptomatic treatment	Testing Full treatment of asymptomatic problems	Diagnostic procedures Specialized treatment HIV screening
Ante/postnatal care, normal deliveries, management of emergencies	Register pregnancies Home deliveries Recognize problems and arrange transport	Antenatal check-ups TT vaccination Obstetric first aid IV fluids, antibiotics	Basic obstetric care Emergency obstetric care (b) Postabortion care	Comprehensive emergency obstetric care Ectopic pregnancy
Nutrition	Identify, treat anemia Counsel pregnant women Vitamin A, iron folate	Manage supplementation program		
Management of child illness	Feeding advice, vitamin A Home treatment for fever/ malaria/diarrhea Care seeking (early recognition and referral)	Assess and classify ORT and feeding for diarrhea Antibiotics for ARI Antimalaria drug for fever (in malaria areas)	Assess and classify cough, diarrhea, fever, nutritional status Treat cough, fever, malaria, diarrhea, blood in stool, ear problems Referral of severe cases	Manage severe cases
Immunizations	Maintain registers	Immunization (EPI plus)		
Disease control	Water, sanitation Identify TB suspects and provide DOT[13] to cases Manage malaria cases	Identify TB suspects and provide DOT to cases Manage malaria	Diagnose and treat cases Secondary drugs for malaria Manage drug complications	Manage severe cases
Curative care	Treatment of cuts, bruises, fever, stomachaches	Antibiotics, IV fluids	Other surgery (specify)	

[12] Services offered at lower level would normally be offered at higher levels as well, when appropriate, and are not repeated in upper-level cells.
[13] DOT—directly observed treatment.

Technical and Physical Inputs to Delivery of Essential Services Packages				
Requirements	**Community**	**Clinic (fixed facility)**[14]	**Health center**	**District hospital**
Facility	Home storage of medicines, supplies; temporary sites for meetings, special clinics	Permanent structure (including water/ electricity supply), waiting area, storage, office and examination room, observation room	Permanent structure with waiting area, offices, examination rooms, surgical rooms, wards for observation/overnights	Upgraded to manage referrals of obstetric emergencies and other cases
Staff	One trained nurse assistant per 1,500 population; one supervisor nurse per six nurse assistants	One trained nurse midwife; one public health assistant; supervisors for outreach nurses	Physician trained in basic surgery, surgical nurses, midwife, public health nurses	Physician/surgeon on 24-hour call, surgical nurses, etc.
Equipment	Registry book; supply case basic kit (blood pressure, thermometer, etc.) for each nurse	Furniture, medical kits, oxygen, blood supply, refrigeration for vaccines, stove, sterilizer	Furniture, beds, linens, surgical theater equipment, medical kits, stove, sterilizer	
Medicines	Medicines for basic first aid; oral contraceptives, condoms, iron folate, etc.	Vaccines, medicines	Surgical supplies	
Transport	Appropriate for areas to be covered (bicycles, etc.)	Appropriate for area to be covered (motor vehicle?)	Same	Ambulance

Source: World Bank, 1999.

[14] *Services offered at lower level would normally be offered at higher levels as well, when appropriate, and are not repeated in upper-level cells.*

References

AbouZahr, Carla. 1998. "Disability Adjusted Life Years (DALYs), Burden of Disease and Reproductive Health." *African Journal of Reproductive Health* 2(2): 204–210.

Adeyi, Olusoji, James Christopher Lovelace, and Dena Ringold. 1998. "In Defense and Pursuit of Equity and Efficiency." *Social Science and Medicine* 47(12): 1899–1900.

Agyepong, Irene A. 1999. "Reforming Health Service Delivery at the District Level in Ghana: The Perspective of a District Medical Officer." *Health Policy and Planning* 14(1): 59–69.

Aitken, Iain W. 1999. "Implementation and Integration of Reproductive Health Services in a Decentralized System." Pp. 111–136 in *Myths and Realities about the Decentralization of Health Systems,* edited by Riitta-Liisa Kolehmainen-Aitken. Boston: Management Sciences for Health.

Akin Econometrics. 1998. "Health Resource Planning in Uganda." Unpublished paper. Washington, DC: The Futures Group International, POLICY Project.

Akin, J.S., D.K. Guilkey, and E.H. Denton. 1995. "Quality of Services and Demand for Health Care in Nigeria: A Multinomial Probit Estimation." *Social Science and Medicine* 40: 1527–1537.

Alderman, H. and V. Lavy. 1996. "Household Response to Public Health Services: Cost and Quality Tradeoffs." *World Bank Research Observer* 11: 3–22.

Anand, Sudhir, and Kara Hanson. 1997. "Disability-Adjusted Life Years: A Critical Review." *Journal of Health Economics* 16: 685–702.

Asenso-Okyere, W.K., Adote Anum, Issac Osei-Akoto, and Agustina Adukonu. 1998. "Cost Recovery in Ghana: Are There Any Changes in Health Seeking Behaviour?" *Health Policy and Planning* 13(2): 181–188.

Ashford, Lori and Carolyn Makinson. 1999. *Reproductive Health in Policy and Practice. Case Studies from Brazil, India, Morocco and Uganda.* Washington, DC: Population Reference Bureau.

Askew, Ian, Goli Fassihian, and Ndugga Maggwa. 1998. "Integrating STI and HIV/AIDS Services at MCH/Family Planning Clinics." Pp.199–216 in *Clinic-Based Family Planning and Reproductive Health Services in Africa: Findings from Situation Analysis Studies,* edited by K. Miller, R. Miller, I. Askew, M.C. Horn, and L. Ndhovu. New York: Population Council.

Bailey, W., M. Clyde, S. Smith, J. Jackson, A. Lee, P. Oliver, and J. Munroe. 1994.

"Mapping Study and Private Physicians' Survey: Opportunities for Expanded Family Planning Services in Jamaica." Kingston, Jamaica: UWI and The Futures Group International.

Barnett, Barbara. 1998. "Fees for Other Services Help Pay for Family Planning." *Network* 8(2): 8.

Behrman, Jere R. and James C. Knowles. 1998. "Population and Reproductive Health: An Economic Framework for Policy Evaluation." *Population and Development Review* 24(4): 697–737.

Bennet, Sara, and E. Ngalande-Banda. 1994. "Public-Private Roles in Health: A Review of Experience in Sub-Saharan Africa." In *Annotated Bibliography for WHO, Division of Strengthening Health Services,* by Ole Teglgaard. Geneva: World Health Organization.

Berman, Peter (ed.). 1995. *Health Sector Reform: Making Health Development Sustainable.* Boston: Harvard University School of Public Health.

Berman, Peter, A. K. Nandakumar, Jean-Jacques Frere, Hassan Salah, Maha El-Adawy, Sameh El-Saharty, and Nabil Nassar. 1997. *A Reform Strategy for Primary Care in Egypt.* Technical Report 9. Bethesda, MD: Abt Associates, Inc., Partnerships for Health Reform Project.

Bertrand, J., K. Hardee, R. Magnani, and M. Angle. 1995. "Access, Quality and Medical Barriers in Family Planning Programs." *International Family Planning Perspectives* 21(2): 64–74.

Bertrand, Jane and Amy Tsui. 1995. *Indicators for Reproductive Health Evaluation.* Chapel Hill, NC: University of North Carolina, The EVALUATION Project.

Brambila, Carlos, Clara Luz Barrios, and Roberto Luis Santamaria. 1997. *Cost Analysis of Reproductive Health Services Provided by the Ministry of Health, Guatemala.* Guatemala City: Population Council.

Bruce, J. 1990. "Fundamental Elements of the Quality of Care: A Simple Framework." *Studies in Family Planning* 21(2): 61–91.

Bureau of the Census. 1998. "International Database: Data Access Spreadsheet." (www.census.gov/ipc/www/idbsprd.html)

Burnham, Gilbert and Wayne Stinson. 1998. "Assessing the Quality of the Supervision of Reproductive Health Services in Uganda." *QA Brief* 7(1): 11–15.

Buse, Kent. 1999. "Keeping a Tight Grip on the Reins: Donor Control over Aid Coordination and Management in Bangladesh." *Health Policy and Planning* 14(3): 219–228.

Cassels, A. 1995. "Health Sector Reform: Key Issues in Less Developed Countries." *Journal of International Development* 7(3): 329–347.

Cassels, A. 1997. *A Guide to Sector-Wide Approaches for Health Development.* Geneva: World Health Organization.

Correa, Sonia, Sergio Piola, and Margareth Arilha. 1999. "Brazil Case Study." Pp. 25–26 in *Reproductive Health in Policy and Practice. Case Studies from Brazil, India, Morocco and Uganda,* edited by Lori Ashford and Carolyn Makinson. Washington, DC: Population Reference Bureau.

Costello, Marilou. 1997. "Integrating RTI Services in Public Sector Health Clinics in the Philippines." Pp. 151–155 in *Improving Reproductive Health: International Shared Experience.* Bogor, Indonesia.

Dayaratna, Varuni, William Winfrey, William McGreevey, Karen Hardee, Janet Smith, Elizabeth Mumford, Jeffrey Sine, and Ruth Berg. 2000. *Reproductive Health Interventions: Which Ones Work and What Do They Cost?* POLICY Occasional Papers No. 5 (forthcoming). Washington, DC: The Futures Group International, POLICY Project.

Dehne, K. and R. Snow. 1998. "Integrating STD Management into Family Planning Services: What Are the Benefits?" Unpublished paper. Heidelberg: Department of Tropical Hygiene and Public Health, University of Heidelberg, Germany.

Dillinger, William. 1994. *Decentralization and Its Implications for Urban Service Delivery.* Washington, DC: Urban Management Programme of UNDP/ UNCSH/World Bank.

Diop, Francois, Abdo Yazbeck, and Ricardo Bitran. 1995. "The Impact of Alternative Cost Recovery Schemes on Access and Equity in Niger." *Health Policy and Planning* 10(3): 223–240.

Diop, Irdrissa, B. Babacar Ba, Kalidou Sow, Alioune Zeiman Mbaye, Oscar Camara, Alioune Ndiaye, Oumar Diallo, and Pape Mody. 1998. "Evaluation du processus de planification dans le contexte de la regionalisation." Washington, DC: The Futures Group International, POLICY Project.

Ekwempu, C.C., D. Maine, M.B. Olorukoba, E.S. Essien, M.N. Kisseka. 1990. "Structural Adjustment and Health in Africa." *The Lancet* 336: 56–57.

Farrell, Marguerite, Kokila Agarwal, and Harry Cross. 1998. "Reproductive Health Case Study: India." Washington, DC: The Futures Group International, POLICY Project.

Finger, William R. 1998. "Commercial Sector Can Improve Access." *Network* 8(2): 12–15.

Forman, Shepard and Romita Ghosh. 1999. "The Reproductive Health Approach to Population and Development." Paying for Essentials. A Policy Paper Series. New York: New York University, Center on International Cooperation.

El Gebaly, Hassan, Ron Hess, Carol Brancich, and Cynthia Waszak. 1998. "Egypt's Gold Star Program. Improving Care and Raising Expectations." Pp. 20–21 in "Family Planning Programs: Improving Quality," by A.J. Kols, and J.E. Sherman, *Population Reports,* Series J, No. 47. Baltimore: Johns Hopkins University School of Public Health, Population Information Program.

Gilson, Lucy. 1998. "In Defense and Pursuit of Equity." *Social Science and Medicine* 47(12): 1891–1896.

Glassman, Amanda, Michael R. Reich, Kayla Laserson, and Fernando Rojas. 1999. "Political Analysis of Health Reform in the Dominican Republic." *Health Policy and Planning* 14(2): 115–126.

Gogna, Monica. 2000. "Comparative Analysis of Case Studies." In *Reproductive Health Programs for Adolescents: The Cases of Buenos Aires, Mexico D.F., and Sao Paulo,* by CEDES, El Colegio de Mexico, and NEPO/ UNICAMP. Buenos Aires: CEDES.

Haberland, Nicole, Kate Miller, Judith Bruce, and Goli Fassihian. 1998. "Unutilized Capacity and Missed Opportunities in Family Planning Services." Pp. 127–139 in *Clinic-Based Family Planning and Reproductive Health Services in Africa: Findings from Situation Analysis Studies,* edited by K. Miller, R. Miller, I. Askew, M.C. Horn, and L. Ndhovu. New York: Population Council.

Hanson, Kara and Peter Berman. 1998. "Private Health Care Provision in Developing Countries: A Preliminary Analysis of Levels and Composition." *Health Policy and Planning* 13(3): 195–211.

Hardee, K., B. Janowitz, J. Stanback, and M. Villinski. 1998. "Studying Service Practices: What Have We Learned?" *International Family Planning Perspectives* 24(2): 84–90.

Hardee, K., K. Agarwal, N. Luke, E. Wilson, M. Pendzich, M. Farrell, and H. Cross. 1999. "Post-Cairo Reproductive Health Policies and Programs: Case Studies of Eight Countries." *International Family Planning Perspectives* 25 (Supplement): s52–s59.

Hardee, Karen and Brian Gould. 1993. "A Process for Service Quality Improvement in Family Planning." *International Family Planning Perspectives* 19(4): 147–152.

Hardee, Karen and Kathryn M. Yount. 1995. *From Rhetoric to Reality: Delivering Reproductive Health Promises through Integrated Services.* Working Paper No. WP95-01. Research Triangle Park, NC: Family Health International.

Heiby, James. 1998. "Quality Assurance and Supervision Systems." *QA Brief* 7(1): 1–3.

Hollister, Robert M. 1998. "Decentralization in National AIDS Control and Prevention Programs." Staff Working Paper. Research Triangle Park, NC: Research Triangle Institute, Center for International Development.

HOPE Enterprise, Ltd. 1998. *Report of Mapping Survey Study and Personal Choice Distribution Check.* Washington, DC: The Futures Group International, SOMARC III Project.

Hotchkiss, David R., Jeffrey J. Rous, Keshav Karmacharya, and Prem Sangraula. 1998. "Household Expenditures in Nepal: Implications for Health Care Financing Reform." *Health Policy and Planning* 13(4): 371–383.

Hubacher, D., M. Holtman, M. Fuentes, G. Perez-Palacios, and B. Janowitz. 1999. "Increasing Efficiency to Meet Future Demand: Family Planning Services Provided by the Mexican Ministry of Health." *International Family Planning Perspectives* 25(3): 119–124, 138.

Janowitz, B., K. Jamil, J. Chowdhury, B. Rahman, and D. Hubacher. 1996. *Productivity and Costs for Family Planning Service Delivery in Bangladesh: The Government Program.* Research Triangle Park, NC: Family Health International.

Janowitz, Barbara, David Hubacher, Tom Petrick, and N. Dighe. 1994. "Should the Recommended Number of IUD Revisits Be Reduced?" *Studies in Family Planning* 25(6): 362–367.

Janowitz, Barbara, Diana Measham, and Caroline West. 1999. *Issues in the Financing of Family Planning Services in Sub-Saharan Africa.* Research Triangle Park, NC: Family Health International.

Kenney, Genevieve. 1993. *Assessing Legal and Regulatory Reform in Family Planning: Manual on Legal and Regulatory Policy.* Policy Paper Series No. 1. Washington, DC: The Futures Group International.

Khan, M.E., Saumya Rama Rao, R.B. Gupta, Bella Patel, Leila Caleb, Jayanti Tuladhar, and John Townsend. 1997. "Integrating RTI Services in Primary Health Care System: Observations from an Operations Research in Uttar Pradesh, India." Pp. 169–186 in *Improving Reproductive Health: International Shared Experience.* Bogor, Indonesia.

Knippenberg, Rudolf, Agnes Soucat, Kayolde Oyegbte, Malick Sieve, Denis Broun, Kasu Pangu, Ian Hopwood, Robert Grandcourt, Kiari Liman Tirguiri, Ibrahima Fall, Savina Ammassari, and Eusebe Alihonou. 1997. "Sustainability of Primary Health Care, Including Expanded Program of Immunization in Bamako Initiative Programs in West Africa. A Field Assessment of Five Years in Benin and Guinea." *International Journal of Health Planning and Management* 12 (Supplement 1): s59–s228.

Knowles, James. 1999. Personal communication. July 18.

Knowles, James, Charlotte Leighton, and Wayne Stinson. 1997. *Measuring Results of Health Sector Reform for System Performance: A Handbook of Indicators.* Special Initiative Report No. 1. Bethesda, MD: Abt Associates, Inc., Partnerships for Health Reform Project.

Kolehmainen-Aitken, Riita-Liisa and William Newbrander. 1997. *Decentralizing the Management of Health and Family Planning Programs.* Boston: Management Sciences for Health.

Kols, A.J. and J.E. Sherman. 1998. "Family Planning Programs: Improving Quality." *Population Reports,* Series J, No. 47. Baltimore: Johns Hopkins University School of Public Health, Population Information Program.

Koivusalo, Meri and Eeva Ollila. 1997. *Making a Healthy World.* London: Zed Books.

Kumaranayake, Lilani. 1997. "The Role of Regulation: Influencing Private Sector Activity within Health Sector Reform." *Journal of International Development* 9(4): 641–649.

Kutzin, J. 1995. *Experience with Organizational and Financing Reform of the Health Sector.* Current Concerns SHS Paper No. 8 (SHS/CC/94.3). Geneva: World Health Organization.

Lake, Sally and Cosmas Musumali. 1999. "Zambia: The Role of Aid Management in Sustaining Visionary Reform." *Health Policy and Planning* 14(3): 254–263.

Levin, Ann, Tania Dmytraczenko, Freddie Ssengooba, Mark McEuen, Florence Mirembe, Margaret Nakakeeto, Olico Okui, and Peter Cowley. 1999. "Costs of Maternal Health Care Services in Masaka District, Uganda." Special Initiatives Report 16. Bethesda, MD: Abt Associates, Inc., Partnerships for Health Reform Project. (Summarized in *Health Sector Reform and Priority Health Services*, edited by C. Leighton. Bethesda, MD: Abt Associates, Inc., Partnerships for Health Reform Project.)

Levy-Bruhl, Daniel, Agnes Soucat, Raimi Osseni, Jean-Michel Ndiaye, Boubacar Dieng, Xavier de Bethune, Alpha Telli Diallo, Mamadou Donde, Mohamed Cisse, Yarou Moussa, Kandjoura Drame, and Rudolf Knippenberg. 1997. "The Bamako Initiative in Benin and Guinea: Improving the Effectiveness of Primary Health Care." *International Journal of Health Planning and Management* 12 (Supplement 1): s49–s79.

Litvack, Jennie I. and C. Bodart. 1993. "User Fees Plus Quality Equals Improved Access to Health Care: Results of a Field Experiment in Cameroon." *Social Science and Medicine* 37(3): 369–383.

Lynam, P.F., L.M. Rabinowitz, and M. Shobowale. 1993. "Using Self-Assessment to Improve the Quality of Family Planning Clinic Services." *Studies in Family Planning* 24(4): 252–260.

Maine, Deborah (ed.). 1997. "Prevention of Maternal Mortality Networks." *International Journal of Gynecology & Obstetrics* 59 (Supplement 2).

MAQ Task Force. 1997. *Recommendations for Updating Selected Practices in Contraceptive Use.* Volume II. Chapel Hill, NC: INTRAH.

Marquez, Lani and Chinwe Madubuike. 1998. "Country Experience in Organizing for Quality." *QA Brief* 7(1): 6–19.

McGinn, Therese, Deborah Maine, James McCarthy, and Allan Rosenfield. 1996. "Setting Priorities in International Reproductive Health Programs: A Practical Framework." New York: Center for Population and Family Health, Columbia University.

McGirr, Nancy, Linda Lacey, and Cynthia Woodsong. 1994. *Decentralization of Population and Family Planning Programs: Worldwide Experience.* Washington, DC: The Futures Group International, OPTIONS II Project.

McGreevey, William. 1999. "Financing Reproductive Health Services in Developing Countries: Issues and Options." Unpublished paper. Washington, DC: The Futures Group International, POLICY Project.

McPake, Barbara. 1993. "User Charges for Health Services in Developing Countries: A Review of the Economics Literature." *Social Science and Medicine* 36(11): 1397–1405.

Merrick, Tom. 1999. "Delivering Reproductive Health Services in Health Reform Settings: Challenges and Opportunities." Work in Progress.

Miller, K., R. Miller, I. Askew, M.C. Horn, and L. Ndhovu (eds.). 1998. *Clinic-Based Family Planning and Reproductive Health Services in Africa: Findings from Situation Analysis Studies.* New York: Population Council.

Mills, A. 1990. *Health System Decentralization: Concepts, Issues, and Country Experience.* Geneva: WHO.

Mitchell, Marc D. (ed.). 1994. "Managing Integrated Services." *The Family Planning Manager* (3): 1–22.

Mitchell, Marc D., Joan Littlefield, and Suzanne Gutter. 1999. "Costing of Reproductive Health Services." *International Family Planning Perspectives* 25 (Supplement): s17–s21.

Munro, Michelle. 1999. "Health Sector Reform in Zambia: Benefits and Constraints for Service Delivery." In *Report on the Meeting on the Implications of Health Sector Reform on Reproductive Health and Rights.* December 14–15, 1998. Washington, DC: Center for Health and Gender Equity and the Population Council.

Murray, Christopher J.L. and Arnab K. Acharya. 1997. "Understanding DALYs." *Journal of Health Economics* 16: 703–730.

Ngalande-Banda, E. and G. Walt. 1995. "The Private Health Sector in Malawi: Opening Pandora's Box?" *Journal of International Development* 7(3): 403–422.

Nicholas, David. 1999. "Organizing for Quality: Options for Country Programs." *QA Brief* 8(1): 1–5.

Noman, Akbar. 1997. "Sector Investment Programs in Africa." Mimeo. Washington, DC: World Bank, Africa Department.

Paalman, Maria, Henk Bekedam, Laura Hawken, and David Nyheim. 1998. "A Critical Review of Priority Setting in the Health Sector: The Methodology of the 1993 World Development Report." *Health Policy and Planning* 13(1): 13–31.

Paterson, Mary. 1999. Presentation on the Primary Health Care Reform Project in Egypt made at USAID, Washington, DC, October 6. Bethesda, MD: Abt Associates, Inc.

Pendzich, Margaret. 1998. "Reproductive Health Case Study: Bangladesh." Washington, DC: The Futures Group International, POLICY Project.

Peters, David and Shiyan Chao. 1998. "The Sector-Wide Approach in Health: What Is It? Where Is It Leading?" *International Journal of Health Planning and Management* 13: 177–190.

POLICY Project. 1998a. "Operational Policies for Reproductive Health Service Delivery in Uttar Pradesh." Unpublished summary. Washington, DC: The Futures Group International.

POLICY Project. 1998b. "Setting Reproductive Health Program Priorities: Reproductive Health Profile Briefing Book." Washington, DC: The Futures Group International.

Population Council. 1999. *Strengthening Reproductive Health Services in Africa through Operations Research.* Final Report of the Africa Operations Research and Technical Assistance Project II. New York: Population Council.

Potts, Malcolm, Julie Walsh, Jana McAninch, Nobuko Mizoguchi, and Timothy J. Wade. 1999. "Paying for Reproductive Health Care: What Is Needed, and What Is Available?" *International Family Planning Perspectives* 25 (Supplement): s10–s16.

Pratt, R., S. Acharya, F. Lubis, B. Pillsbury, M. Rana, P. Ship, and M.R. Pandey. 1989. *Evaluation of the USAID/Nepal Integrated Rural Health/Family Planning Services Project No. 367-0135.* Population Technical Assistance Project, Report No. 88-004-075. Arlington, VA: Dual and Associates.

PROMEDICA and Population Council. 1995. "Acceptability and Cost-Effectiveness of Postpartum and Postabortion Family Planning in a Health Maintenance Organization in Bahia." In *INOPAL II Project Final Report.* New York: Population Council.

Rannan-Eliya, Ravindran and Nishan de Mel. 1997. Resource Mobilization for the Health Sector in Sri Lanka. Boston, MA: Harvard University; Washington, DC: Health and Human Resources Available for Africa Project.

Roemer, M.I. 1991. *National Health Systems of the World.* Vol. 1. New York: Oxford University Press.

Russell, Steven. 1996. "Ability to Pay for Health Care: Concepts and Evidence." *Health Policy and Planning* 11(3): 219–237.

Sadasivam, Bharati. 1999. *Risks, Rights and Reforms. A 50 Country Survey Assessing Government Actions Five Years after the International Conference on Population and Development.* New York: Women's Environment and Development Organization.

Saltman, R. and C. von Otter. 1995. *Implementing Planned Markets in Health Care.* Buckingham: Open University Press.

Shaw, R. and C.C. Griffin. 1995. *Financing Health Care in Sub-Saharan Africa through Fees and Insurance.* Washington, DC: World Bank.

Shelton, James, Marcia Angle, and Roy Jacobstein. 1992. "Medical Barriers to Access to Family Planning." *Lancet* 340(8831): 1334–1335.

Simmons, George B., D. Balk, and K.K. Faiz. 1991. "Cost-Effectiveness Analysis of Family Planning Programs in Rural Bangladesh: Evidence from Matlab." *Studies in Family Planning* 22(2): 83–101.

Simmons, R., M.A. Koenig, and A.A. Huque. 1990. "Maternal-Child Health and Family Planning: User Perspectives and Service Constraints in Rural Bangladesh." *Studies in Family Planning* 21(4): 187–196.

Smith, Janet. 1999. "The Impact of Health Sector Reform on Service Delivery and Logistics Systems: Synthesis of a Literature Review for the FPLM Project." Draft. Arlington, VA: John Snow, Inc.

Soucat, Agnes, Daniel Levy-Bruhl, Xavier de Bethune, Placide Gbedonou, Jean-Pierre Lamarque, Ousmane Bangoura, Ousmane Camara, Timothee Gandaho, Christine Ortiz, Miloud Kaddar, and Rudolf Knippenberg. 1997a. "Affordability, Cost-Effectiveness and Efficiency of Primary Health Care: The Bamako Initiative Experience in Benin and Guinea." *International Journal of Health Planning and Management* 12 (Supplement 1): s81–s108.

Soucat, Agnes, Daniel Levy-Bruhl, Placide Gbedonou, Kandjoura Drame, Jean-Pierre Lamarque, Souleymane Diallo, Raimi Osseni, Paul Adovohekpe, Christine Ortiz, Christophe Debeugny, and Rudolf Knippenberg. 1997b. "Local Cost Sharing in Bamako Initiative Systems in Benin and Guinea: Assuring the Financial Viability of Primary Health Care." *International Journal of Health Planning and Management* 12 (Supplement 1): s109–s135.

Soucat, Agnes, Timothee Gandaho, Daniel Levy-Bruhl, Xavier de Bethune, Eusebe Alihonou, Christine Ortiz, Pacide Gbedonou, Paul Adovohekpe, Ousmane Camara, Jean-Michel Ndiaye, Boubacar Dieng, and Rudolf Knippenberg. 1997c. "Health Seeking Behavior and Household Health Expenditures in Benin and Guinea: The Equity Implications of the Bamako Initiative." *International Journal of Health Planning and Management* 12 (Supplement 1): s137–s163.

Stanback, John, Jason B. Smith, Barbara Janowitz, and F. Diadhiou. 1994. "Safe Provision of Oral Contraceptives: The Effectiveness of Systematic Laboratory Testing in Senegal." *International Family Planning Perspectives* 20(4): 147–149.

Stanback, John, Andy Thompson, Karen Hardee, and Barbara Janowitz. 1997. "Menstruation Requirements: A Significant Barrier to Contraceptive Access in Developing Countries." *Studies in Family Planning* 28(3): 245–250.

Standing, Hilary. 1997. "Gender and Equity in Health Sector Reform Programmes: A Review." *Health Policy and Planning* 12(1): 1–18.

Starrs, Ann. 1998. *The Safe Motherhood Action Agenda: Priorities for the Next Decade—Report on the Safe Motherhood Technical Consultation 18–23 October 1997, Colombo, Sri Lanka.* New York: Family Care International in collaboration with the Inter-Agency Group for Safe Motherhood.

Stinson, Wayne, Lynette Malianga, Lani Marquez, and Chinwe Madubuike. 1998. "Quality Supervision." *QA Brief* 7(1): 4–6.

Technical Guidelines Working Group (TGWG). 1994. *Recommendations for Updating Selected Practices in Contraceptive Use: Results of a Technical Meeting.* Chapel Hill, NC: INTRAH.

Twahir, A., G.N. Maggwa, and I. Askew. 1996. *Integration of STI and HIV/AIDS Services with MCH-FP Services: A Case Study of the Mkomani Clinic Society in Mombasa, Kenya.* New York: The Population Council, Operations Research and Technical Assistance, Africa Project II.

UNFPA. 1999. *Report of the 1998 UNFPA Field Inquiry. Progress in the Implementation of the ICPD Programme of Action*. New York: United Nations Population Fund.

United Nations. 1999. *Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development.* Twenty-first Special Session of the United Nations General Assembly, Agenda item 8, Document A/S-21/5/Add.1. New York: United Nations.

USAID. 1999. *Integration of Family Planning/MCH with HIV/STD Prevention, Programmatic Technical Guidance: Priority for Primary Prevention with a Focus on High Transmitters.* Washington, DC: USAID.

Vandemoortele, Denis Broun and Rudolf Knippenberg. 1997. "Epilogue." *International Journal of Health Planning and Management* 12 (Supplement 1): s165–s168.

Vernon, R, G. Ojeda, and R. Murad. 1990. "Incorporating AIDS Prevention Activites into a Family Planning Organization in Colombia." *Studies in Family Planning* 21(6): 335–343.

Visaria, Leela, Shireen Jejeebhoy, and Tom Merrick. 1999. "From Family Planning to Reproductive Health: Challenges Facing India." *International Family Planning Perspectives* 25 (Supplement): s44–s49.

Walley, John. 1997. "The Implementation of Integrated Mother and Child Health and Family Planning Services." *Tropical Doctor* (April): 69–72.

Walt, Gill, Enrico Pavignani, Lucy Gilson, and Kent Buse. 1999. "Managing External Resources in the Health Sector: Are There Lessons for SWAPs?" *Health Policy and Planning* 14(3): 237–284.

Winfrey, William, Laura Heaton, Tamara Fox, and Susan Adamchack. 2000. "Factors Influencing the Growth of the Commercial Sector in Family Planning Service Provision." Working Paper Series No. 6. Washington, DC: The Futures Group International, POLICY Project.

World Bank. 1993. *World Development Report 1993: Investing in Health.* New York: Oxford University Press.

World Bank. 1998. *Assessing Aid: What Works, What Doesn't, and Why.* New York: Oxford University Press.

World Bank. 1999. *Costing of Essential Primary Care Packages—Including Reproductive and Child Health.* Washington, DC: World Bank, Health Development Network

World Health Organization (WHO). 1996. *Improving Access to Quality Care in Family Planning. Medical Eligibility Criteria for Initiating and Continuing Use of Contraceptive Methods.* Geneva: World Health Organization, Division of Family Health and Special Programme on Research, Development and Research Training in Human Reproduction.

Wouters, Annemarie, O. Adeyi, and R. Marrow. 1993. *Quality of Health Care and Its Role in Cost Recovery with a Focus on Empirical Findings about Willingness to Pay for Quality Improvements.* HFS Major Applied Research Paper No. 8. Bethesda, MD: Abt Associates, Inc.

Yesudian, C.A.K. 1994 “Behavior of the Private Sector in the Health Market in Bombay.” *Health Policy and Planning* 9(1): 72-80.