



**Client Donations for Contraceptives:
An Innovative Approach to Sustainable Financing in Turkey**

Fahreddin TATAR, Ph.D.

Jeffry SINE, Ph.D.

Contents

INTRODUCTION	1
MOH's RESPONSE TO PHASEOUT	3
MOH's Funding and Procurement Performance.....	3
Targeting Strategy and the Pilot Study	4
Pilot Implementation: Design	5
VOLUME AND SCOPE OF DATA.....	9
FINDINGS	10
Donation Rates	11
Optimum Price Structure and National Revenue Projection.....	15
Client Reactions to Donation Policy	16
Provider Attitudes Toward Donation Policy	17
CONCLUSIONS	18
REFERENCES	20

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INTRODUCTION

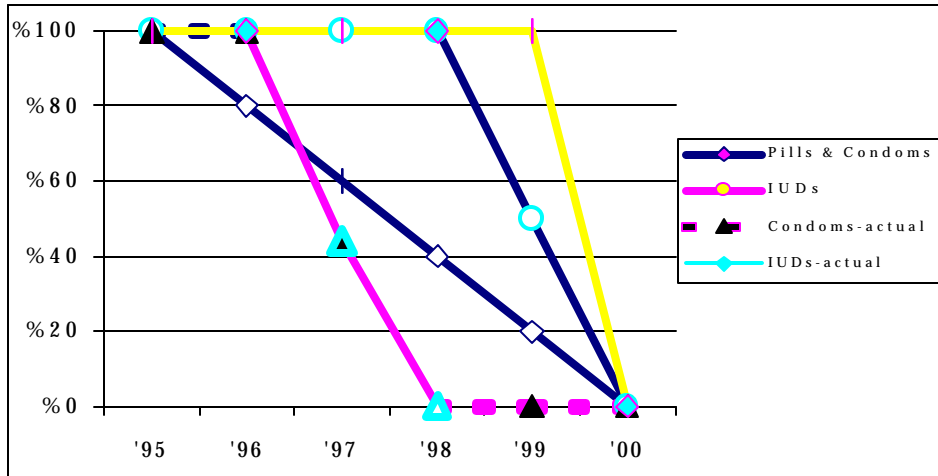
Since the 1960s, the Ministry of Health (MOH) of Turkey has enjoyed the benefits of external assistance for its family planning (FP) program especially from the U.S. Agency for International Development (USAID). The MOH has since developed an FP program that operates through a widespread network of facilities across the entire country. Today, the MOH dispenses about 70 percent of all intra-uterine devices (IUDs) and about 30 percent of all oral contraceptives (OCs) and condoms in the country.

MOH's FP service provision has traditionally been based on free and universal access. The only exception has been that some of the facilities have in recent years started to collect donations from better-off IUD clients as a result of spontaneous trend.

In 1995, the Government of Turkey (GOT) and USAID signed an agreement whereby USAID's assistance for the FP program would be phased out in five years. This meant that Turkey would have to develop a self-sustaining financing policy to bridge the resource gap created by the departure of USAID's assistance. The MOH has since been continuing its efforts to develop and implement a new policy.

According to the phaseout plan, USAID would donate 20 percentage points less condoms and OCs in each year of the phaseout period. IUD donations, however, would fully continue until the fourth year, when they would be lowered to 50 percent of the forecasted consumption of that year. In 2000, total responsibility would pass onto the GOT. However, there was a diversion from the original phaseout in the implementation stage (Figure 1). Although this has caused confusion, the MOH was quick to respond to the plan by initiating its first-ever contraceptive commodity procurement in 1996.

Figure 1
Original Phaseout Plan and its Amended Implementation Plan



After the failure of this first attempt due to administrative complications, the MOH continued its efforts to mobilize budgetary and nonbudgetary public funds to compensate for the funding gap created by the phaseout. However, all the efforts yielded only partial success, leaving a financing gap still to be bridged through other means. Stakeholders under the leadership of the MOH have since continued efforts to come up with a solution to bridge the gap on sustainable footings. By the end of 1998, the parties, having assessed all the possible options, reached a consensus that the publicly subsidized commodities would be targeted to those in greatest need, and the better-off clients would be asked to make a donation for the commodities they use. In that way, the funding gap created by the phased departure of USAID assistance would be fully bridged, making it possible to continue the public sector program in its current scope and capacity.

This paper aims to describe the chosen targeting strategy and the pilot study for the targeting strategy, and present the preliminary results of the pilot study. The MOH's response to the phaseout that eventually led to the adoption of the targeting strategy and the resultant pilot study is now presented.

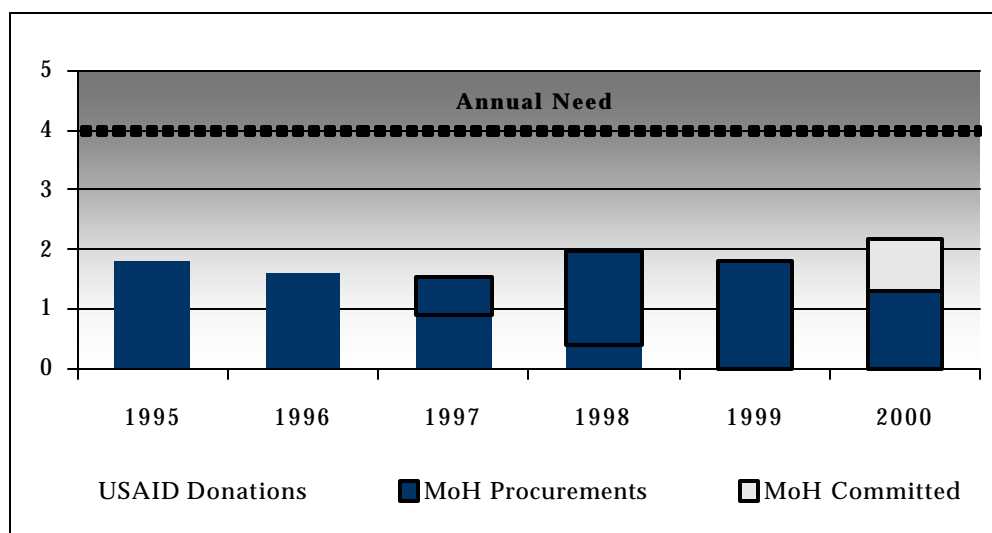
MOH's RESPONSE TO PHASEOUT

MOH's Funding and Procurement Performance

MOH's failed attempt to procure commodities in 1996 was followed by a successful attempt in 1997. However, funds that were mobilized in 1997 were not adequate to meet the GOT's responsibility that year. The situation was further exacerbated in 1997 when the original phaseout plan was amended, resulting in only a 44-percent condom donation by USAID rather than the planned 60 percent. And according to the amendment, USAID would send no more condoms in 1998 (see Figure 1).

As seen from Figure 2, the MOH has since 1997 increased its funding for contraceptive commodities to keep its FP program afloat. Since the total of donated and procured commodities was inadequate to meet the annual requirements, the field began to experience stock outs in the second half of 1998. Since then, the program has been under pressure to ration commodities at all levels.

Figure 2
Funding for Contraceptives by Sources (Million \$)



Sources:

1. USAID's Family Planning and Reproductive Health Assistance in Turkey. 1999 Annual Report
2. Forecast of Public Sector Budget Requirements for Contraceptive Commodities in Turkey: 1999 - 2001
3. MOH's internal records

The MOH, faced with insufficient funding, has had to mobilize some funding from unsustainable sources. There have been two main sources of funding for contraceptives: (1) a general budget line item allocated to the Maternal and Child Health (MCH)/FP General Directorate to procure consumable goods and services for MCH/FP centers nationwide; and (2) an extra-budgetary source called the Minister's Special Fund. Use of this fund, which is at the sole discretion of the minister, is for emerging but not recurring expenditures, such as FP commodities. Although a

significant proportion of the total funds for contraceptives has so far come from this source, it is considered to be unreliable because of competing demands for its use. In a health policy environment where politics is a major factor and curative services have an incomparable priority over preventive care in general, and reproductive health care in particular, reliance on such a source is considered to be at odds with the concept of sustainable financing.

The MOH has, therefore, focused its efforts on developing a sustainable financing policy for contraceptives. A two-plank strategy was adopted. On the one hand, the MOH has tried to mobilize a larger amount of funds through especially the regular budget line item to avoid disruption in the flow of services. On the other, the MOH began to consider a strategy whereby fewer free or near free contraceptives are targeted to those clients in most need. This strategy has been the subject of debate in a wider policymaking circle, which includes various governmental and nongovernmental actors. With this the MOH has aimed at creating a wider ownership for the problem and securing assistance to generate a policy response in a multisectorial manner. (A comprehensive account of these efforts is found in POLICY's "Case Study for Contraceptive Self-reliance Efforts in Turkey: Prospects and Lessons Learned", November, 1999.)

All these efforts have yielded two main outcomes. First, the Ministry of Finance (MOF) has allocated about \$2.5 million for contraceptive commodities in the FY 2000. Second, parties reached a consensus on a targeting strategy for free contraceptive commodities. Pilot testing of the targeting strategy and its national implementation has been the condition for continuation of the budgetary allocation by the MOF. The targeting strategy is described in the next section.

Targeting Strategy and the Pilot Study

In collaboration with other relevant governmental bodies, such as the MOF, the Ministry of Labor and Social Security, and the State Planning Organization, the MOH has adopted a targeting strategy based on *willingness to pay*. The plan implicitly assumes that those willing to pay are also *able to pay*. The reason why the MOH decided on a plan based on *willingness to pay* rather than *ability to pay* is twofold. First, the MOH is sensitive not to deter the existing and potential FP clients from using FP services. Second, there is no readily available mechanism whereby mandatory user fees could be collected at the primary health care level. This plan allows for those who are *unwilling to pay* to receive their commodities for free, without any attempt to distinguish between nonpayers who are able to pay and those who are unable to pay.

Together with its policymaking partners, the MOH decided on a two-stage implementation strategy, which would first be pilot tested and then initiated nationally only after the design for implementation is reviewed in the light of pilot study findings. The following section presents details of the design for implementation.

Pilot Implementation: Design

Objectives of the pilot study are threefold:

- Assess clients' response to being asked to make a donation to the Health and Social Assistance Foundation (HSAF) for contraceptive supplies received at MOH health care facilities.
- Assess attitudes about and compliance with targeting plan components among providers and managers at MOH health care facilities and local public health administrative offices.
- Assess the targeting plan mechanism with respect to its ability to raise and centralize funds to substantially close the MOH's financing gap for contraceptive commodities.

In the absence of a readily available governmental mechanism to collect user fees at the primary health center (PHC) level, the HSAF, the only available nationwide mechanism to serve the purpose, came to the fore. In order to base the targeting strategy on sound grounds, the POLICY Project conducted a feasibility study of the HSAF to (1) learn about the HSAF and how its mechanism works, and (2) identify the potential strengths and pitfalls of using the HSAF as a mechanism to raise resources for MOH central contraceptive procurement needs.

The HSAF is basically a nongovernmental organization (NGO), running parallel to the MOH. It collects donations from better-off clients of MOH facilities. The donation revenue is used to supplement insufficient operating budgets at the facilities as well as at the provincial and central levels. The feasibility study sheds light on the merits and disadvantages of the HSAF as a donation collection agent in the targeting plan. One of the most significant advantages of using the HSAF as a donation collection agent is that it extends a widespread and already accepted practice of collecting donations from clients for PHC services to FP commodities. Moreover, it helps overcome a legislative barrier to charging public sector clients at the PHC level. It also taps a defined and largely smoothly running administrative mechanism. The prices set by the HSAF are much lower than commercial market prices. While this provides subsidies to clients who pay donations, the poor are protected by a well-functioning exemption policy. Introduction of donation policy through the HSAF has widespread administrative support, in part because managers and providers are concerned about continuing to provide FP services.

There are also some constraints to utilizing the HSAF in the targeting plan. First, contrary to current practice, most revenue would have to be centralized. Currently, about 50 percent of revenue is retained by the facility where it is generated; 40 percent is retained by the HSAF branch at the provincial level; and only 10 percent is centralized at HSAF Headquarters (HQ). Under the targeting strategy, facilities would retain only 20 percent of the revenue generated from contraceptive commodities; 10 percent would be retained by the provincial HSAF branch; and 70 percent would be centralized at HSAF HQ for commodity procurement.

Second, pockets of potential resistance from lesser developed regions and poor settlements in large metropolitan areas may be encountered when the plan is implemented nationwide. The current HSAF system has been established to reuse

most of the donation revenue at the facility and provincial levels. Therefore, there is a need to develop a mechanism to centralize most of the revenues, and then turn these funds into procured commodities.

Preference for the HSAF has also been necessitated by two additional factors. First, there is a widely held perception in health-policy quarters that instituting a governmental/legal system to collect user fees at the PHC level would face steep political and professional obstacles. Second, establishing and administering a new fee collection system would not be cost effective.

The pilot study is being conducted in four regions: one control and three intervention regions. The number of facilities participating in the study and their expected caseloads, derived from 1999 service delivery data, are shown in Table 1.

Table 1
Facilities and Expected Caseloads by Region in Six Months

Region	Number of Facilities	Expected Caseloads			
		IUDs	OCs	Condoms	Total
High Price Region	50	2,815	4,32	11,458	18,593
Medium Price Region	23	0,927	2,184	4,895	8,006
Low Price Region	66	6,081	13,251	22,878	42,210
Sub-total	139	9,823	19,755	39,231	68,809
Control Region	34	3,818	7,186	12,353	23,357
Total	173	13,641	26,941	51,584	92,166

High Price Region, Medium Price Region, and Low Price Region have been designated as intervention regions where clients of all MOH PHC facilities in a geographically and administratively confined area are asked to make a donation for the contraceptives they receive. Regions have been defined in a way in order that contamination, cross-boundary client flows between regions due to differential donation levels, is minimized. Utmost care has been given to select regions that more or less reflect general characteristics of the entire country. Nonetheless, no claim can be made that the selected regions statistically represent the entire country.

Prior to adoption of the targeting strategy and the resultant implementation of the pilot study, there had been no charges for contraceptive commodities. The only relevant charge collected in many PHCs has been for IUD insertion services. Thus, it is entirely new to charge for contraceptive commodities in MOH's PHC facilities. The amount of charges being tested in the pilot study is shown in Table 2.

Table 2
Amount of Donations Tested in Three Pilot Intervention Regions and Average Market Prices (US\$)

	Client Donations in the Pilot Study			Market Prices	
	High Price	Medium Price	Low Price	Average	Range
IUD	4.51	3.38	2.26	14.50	4.60 – 29.00
OCs (2 cycles)	2.26	1.50	1.13	6.00	3.29 – 8.60
Condoms (12 pieces)	1.13	0.75	0.38	6.67	2.69 – 10.77

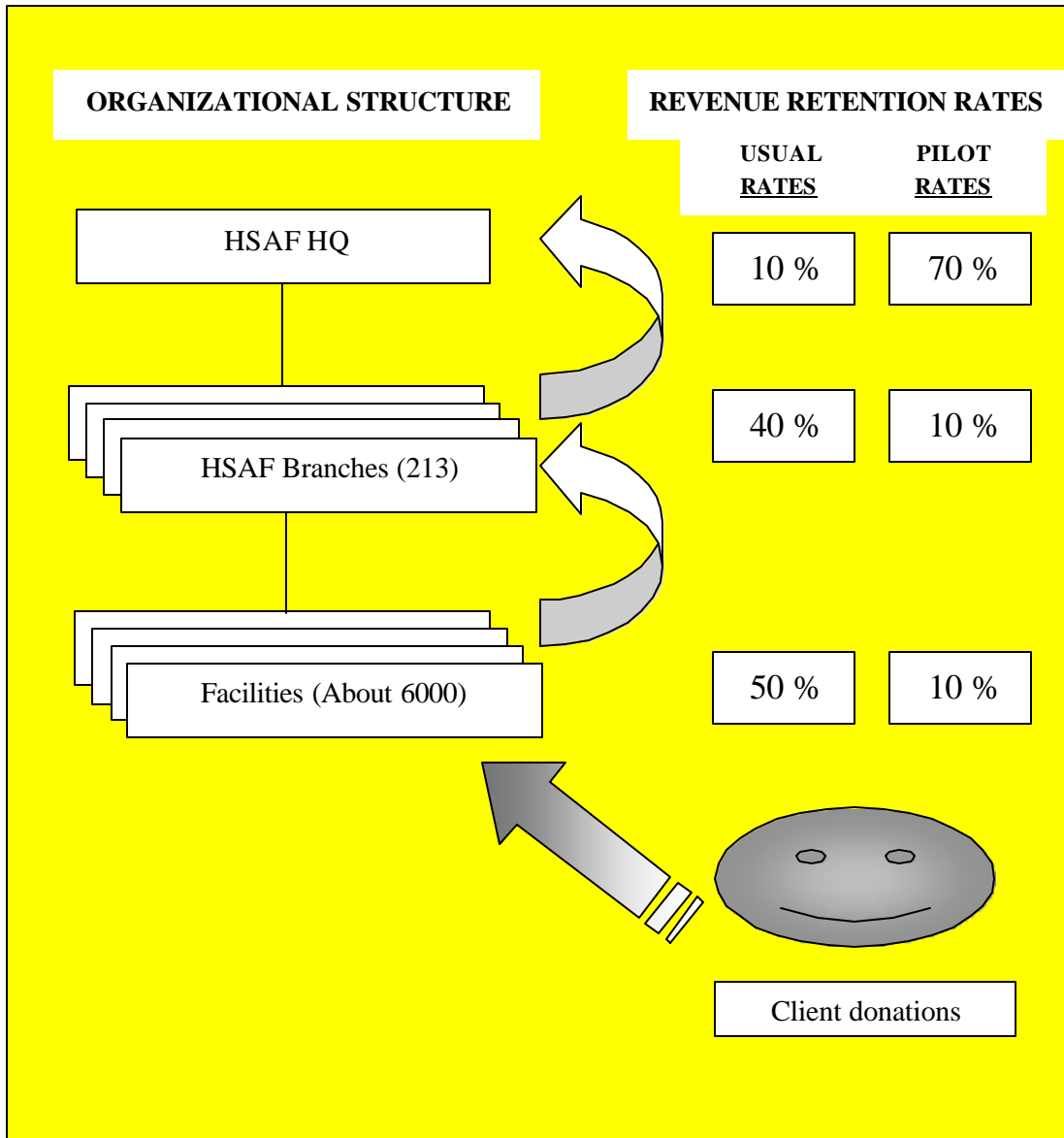
HSAF HQ in Ankara conducts its operations through its network of about 213 branches across the country. There is one HSAF branch in almost every provincial health directorate (PHD). The remainder of the branches are located in PHC facilities as well as hospitals in large metropolitan cities. The majority of the nonbranch PHC facilities (more than 6,000) are affiliated primarily with HSAF branches located in PHDs. Revenue generating facilities retain and spend about 50 percent of all the revenue they collect and transfer the balance to the relevant HSAF branch. HSAF branches in turn retain about 40 percent of the total revenue generated by facilities and transfer the remaining 10 percent to the HSAF HQ (Figure 3).

The current HSAF data system deals only with monetary flows. In the targeting/pilot design, however, the system has been modified to also include service-related data, thus enabling the program management to monitor changes in donation payment patterns by method across the provinces and regions. This would in turn provide program management with data to revise the pricing policy as and when required. Accordingly, the system would rely on newly introduced *facility reporting forms* and *foundation branch reporting forms* for this purpose. During the six-month pilot period, however, facilities are required to also fill out a “Client Tracking Form,” designed to provide additional data to mainly monitor changes in volume of demand by method, facility, and region.

One of the most critical aspects of the targeting strategy/pilot study is the change of retention levels. The entire targeting endeavor has been guided by the immediate need to develop a sustainable financing policy whereby centrally available funds could be supplemented to the maximum possible extent by revenues from client donations. This plan has therefore necessitated a change in the way the donation revenue is retained at different levels. As has already been mentioned, according to the current practice about 90 percent (50 percent at the facility and 40 percent at the branch) is retained at the facility/provincial level. The use of locally retained funds for the repurchase of contraceptive commodities is not feasible due to various effectiveness and efficiency considerations. Therefore, insofar as donation revenue exclusively from contraceptive commodities is concerned, a new revenue sharing plan had to be adopted. According to the new plan, facilities retain only 20 percent of the revenue they generate from contraceptive donations. A further 10 percent is retained

by the HSAF branch and 70 percent centralized for commodity procurements (Figure 3).

Figure 3
Organizational Structure of the HSAF and Average Rates of Revenue Retention



The targeting strategy has introduced a significant change for non-HSAF affiliated facilities. Some large-scale facilities had never collected donations for the HSAF. Others had in time ceased to collect client donations under the HSAF banner. The majority of such facilities have been operating their own stand-alone associations to generate funds from client donations. From the facility's perspective, this approach is far superior to operating under an HSAF system or PHD-level association, since all of the revenues are reused at the facility where the money is collected. Under the

targeting plan, such facilities also have been asked to collect and transfer contraceptive donations according to the modified HSAF rules.

VOLUME AND SCOPE OF DATA

Completion date for the pilot study is December 5, 2000; therefore, the findings and associated assessments presented in this paper are limited both in scope and power to the available data gathered and analyzed thus far. Tables 3 and 4 present a comparative account of expected and actualized account of the scope and volume of data used in this paper.

It should be noted that facilities do not transfer forms regularly during a predefined time period or interval. Instead, they transfer data forms with the money and HSAF receipt books.¹ Therefore, the frequency of form/data transfers varies from one facility to another and even over time for the same facility depending on the volume of services rendered in a given time period. This is why there are many facilities from which data have not been received and the volume of data received are less than would otherwise be expected in the past four months.

Table 3
Total Number of Pilot Facilities and the Number of Facilities That Have Transferred Forms by Region (as of end of September 2000)

Regions		Health Centers			MCH/FP Centers			All Facilities		
		Total	Form received		Total	Form received		Total	Form received	
			N	% of Total		N	% of Total		N	% of Total
Intervention regions	High Price	49	15	31	1	1	100	50	16	32
	Medium Price	22	2	9	1	1	100	23	3	13
	Low Price	64	34	53	2	2	100	66	36	55
	Total	135	51	38	4	4	100	139	55	40
Control region*		26	N/A	N/A	8	N/A	N/A	34	N/A	N/A

*Facilities in the control region transfer forms on a monthly basis. All facilities in the region have transferred forms for the first three months.

¹ Clients are issued an official HSAF receipt for the donation they make. The preprinted receipts come in the form of books of a hundred pages each.

Table 4
 Comparison of the Volumes of Data (Number of Visits):
 Expected Volume in Six Months vs. Actual Volume as of mid-October 2000*

Region	OCs		Condoms		IUDs		Total	
	Expected Total 6 months	Now	Expected Total 6 months	Now	Expected Total 6 months	Now	Expected Total 6 months	Now
High	4,320	1,356 (31%)	11,458	2,688 (23%)	2,815	1,312 (47%)	18,593	5,356 (29%)
Medium	2,184	399 (18%)	4,895	850 (17%)	927	292 (31%)	8,006	1,541 (19%)
Low	13,251	4,672 (35%)	22,878	6,906 (30%)	6,081	2,101 (35%)	42,210	13,679 (32%)
Total	19,755	6,427 (33%)	39,231	10,444 (27%)	9,823	3,705 (38%)	68,809	20,576 (30%)
Control	8,121	4,319 (53%)	12,353	4,319 (53%)	3,818	1,742 (46%)	24,292	12,360 (51%)

*Figures in brackets show percentages of cases received thus far in the total expected cases during the entire pilot study.

FINDINGS

The technical objectives of the pilot study have already been mentioned. The design of the study allows the assessment of only a selection of these objectives at this stage. The entire set of objectives can only be achieved when the pilot study intervention is completed. The set of issues assessed in this paper is as follows:

- Donation payment rates by facility, facility types, region, and method
- National revenue projection under certain assumptions
- Client reactions to the donation policy based on indirect assessment by providers
- Provider attitudes based on ad hoc interviews in monitoring visits
- Assessment of the mechanisms/procedures

One of the main policy concerns in adopting and implementing the targeting strategy has been in the locus of impact of donation policy on demand. Specific questions are

1. Would this policy cause a decrease in the total and method-specific volume of demand?
2. What behavioral response would the dropouts take should there be a decrease in demand? Possible responses include
 - a. Abandoning FP practice altogether;
 - b. switching to a traditional method;
 - c. switching to another modern method but still utilizing the MOH facilities for FP purposes;
 - d. switching to another modern method but going to a non-MOH provider; and

- e. continuing with the same method but changing to a non-MOH provider.

The first two questions can be answered only when all the data for the entire pilot study period are collected and analyzed. At this stage, however, a preliminary assessment can be offered, especially for the general demand impact of donation policy using the trends in the volume of dispensed commodities.

As shown in Table 5, in the first four months of the pilot intervention the overall demand seems to have, on average,² decreased by 20 percent, 19 percent, and 3 percent for OCs, condoms, and IUDs, respectively. Given that in such a natural experiment, marginal decrease (or increase) in use could be attributable to other factors, the low IUD figure (3 percent) can be neglected. Insofar as OCs and condoms are concerned, however, the rates are considerably higher. The main reason for this occurrence seems to be in the fact that IUD users have already been making donations for IUD insertions, whereas donations for OCs and condoms are new. Another possible explanation may be related to the differences in the couple years of protection and associated total costs between the methods concerned.

Table 5
Demand Impact of Donation Policy Over Four Months

	OCs	Condoms	IUDs
High Price Region	- 0.15	- 0.23	- 0.11
Medium Price Region	- 0.22	- 0.13	- 0.19
Low Price Region	- 0.24	- 0.25	- 0.12
Average	- 0.20	- 0.22	- 0.13
Control Region	0.08	- 0.03	- 0.10
Net impact	- 0.20	- 0.19	- 0.03

In order to answer the question concerning the behavioral response the dropouts would take with a decrease in demand, additional data would be needed. Given the time and cost implications, this would only be necessary if the rate of dropouts deems it necessary at the end of the pilot study. Dropout rates will be assessed on the basis of pilot study data set, which allows OC and condom users from the first two months of the pilot study to be matched to see who returns and who does not in each successive month for condom users and each successive two months for OC users. No analysis has been conducted at this stage to assess the dropout rates due to the inadequate length of time elapsed since the beginning of the pilot study.

Donation Rates

Current data provide some insights into the general and method-specific donation patterns. These data also provide, under certain assumptions, a basis for early projections of national revenue potential from donations. Preliminary findings are presented in the following tables and figures.

² The prices being implemented in three regions do not seem to have created a difference in terms of demand effect. Therefore, only average figures have been used here.

Table 6
Distribution of Donation Payment Rates by Region and Facility Type

Region	Type of facilities	Full payment		Partial payment		No-payment		TOTAL	
		N	%	N	%	N	%	N	%
High^a	MCH/FP Centers	1,059	68	245	16	252	16	1,566	100
	Health Centers	1,583	42	694	18	1,520	40	3,797	100
	Total	2,642	49	939	18	1,772	33	5,353	100
Medium^b	MCH/FP Centers	750	82	27	3	140	15	917	100
	Health Centers	370	59	44	7	210	34	624	100
	Total	1,120	73	71	5	350	23	1,541	100
Low^c	MCH/FP Centers	428	63	38	6	216	32	682	100
	Health Centers	6,775	52	879	7	5,339	41	12,993	100
	Total	7,203	53	917	7	5,555	41	13,675	100
TOTAL	MCH/FP Centers	2,237	71	310	10	608	19	3,115	100
	Health Centers	8,728	50	1,617	9	7,069	41	17,414	100
	Total	10,965	53	1,927	9	7,677	37	20,569	100

^a $X^2 = 348.952$ $df = 2$ $p = 0.000$

^b $X^2 = 94.713$ $df = 2$ $p = 0.000$

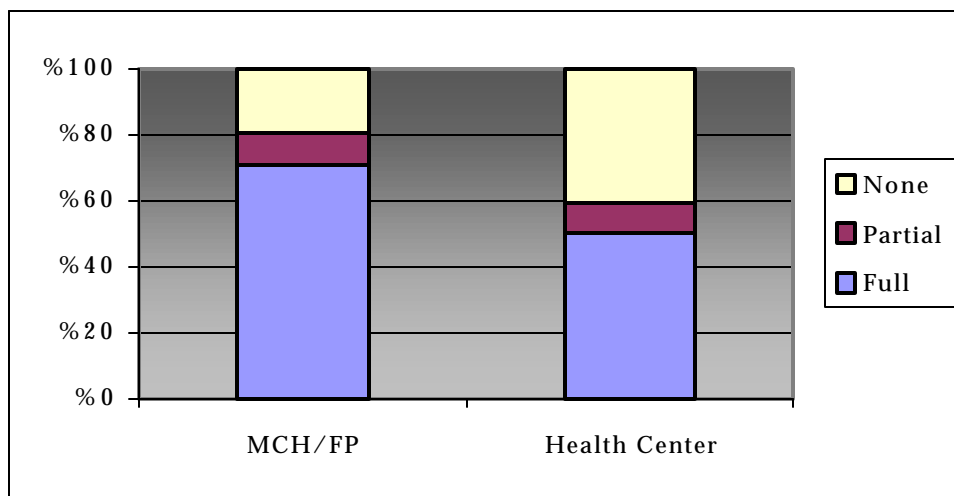
^c $X^2 = 29.388$ $df = 2$ $p = 0.000$

Table 7
Distribution Donation Payment Rates by Region

Region	Full payment		Partial payment		No-payment		TOTAL	
	N	%	N	%	N	%	N	%
High	2,642	49	939	18	1,772	33	5,353	100
Medium	1,120	73	71	5	350	23	1,541	100
Low	7,203	53	917	7	5,555	41	13,675	100
Total	10,965	53	1,927	9	7,677	37	20,569	100

$X^2 = 801.216$ $df = 4$ $p = 0.000$

Figure 5
Distribution of Donation Payment Status by Facility Type



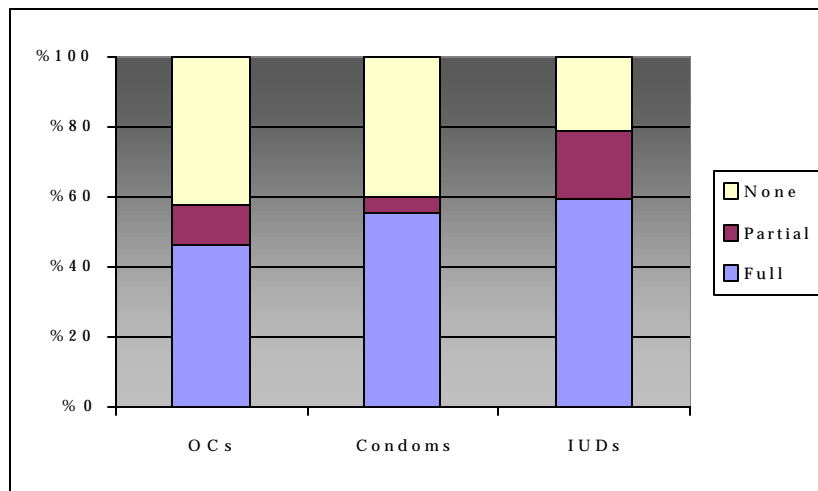
As seen from Table 8 and Figure 6, the highest rates of full (60 percent) and partial (19 percent) payment are for IUDs. The reason for this may be that clients had already been used to making donations for IUD insertions in most facilities. Most facilities included in this assessment already administered an IUD-insertion charge of \$1.50 on average. Condoms have a higher rate of full payment than OCs, partly because overall condom prices per visit are the lowest of all three methods. OCs in return have a higher rate of partial payment than condoms, which also can be explained by the fact that prices for OCs are higher than condoms.

Table 8
Distribution of Donation Payment Status by Method

	Full		Partial		No payment		Total	
	N	%	N	%	N	%	N	%
OCs	2,986	47	727	11	2,708	42	6,421	100
Condoms	5,766	55	499	5	4,179	40	10,444	100
IUDs	2,213	60	701	19	790	21	3,704	100
Total	10,965	53	1,927	9	7,677	37	20,569	100

$\chi^2=1028.485$ $df = 4$ $p = 0.000$

Figure 6
Distribution of Donation Payment Status by Method



Optimum Price Structure and National Revenue Projection

The pilot study has also aimed at generating data to allow decision makers to develop a price structure to be implemented nationwide and to calculate and project potential national revenue. Development of a pricing structure could be done reasonably only after the completion of the pilot study.

Insofar as a national revenue projection is concerned, various scenarios could be developed under certain assumptions. Here, the calculations according to a scenario have been presented as an example. The exercise here aims at generating a ratio that shows the percentage of MOH's total contraceptive bill that could be met through client donations rather than actual dollar value of potential revenue. Main premises of the scenario are as follows:

- The high price set currently being tested would be adopted nationwide.
- The current data set represents almost only urban facilities. Urban facilities represent the majority both in terms of the total number of facilities and total FP client population of MOH facilities in the country. Therefore, current distribution of clients by payment status is taken to be applicable nationwide.
- Distribution of clients by payment status would be similar to that of all clients irrespective of differences between pilot regions.
- It is assumed that partial payments correspond on average to one-half of the full price.
- All OCs users are assumed to receive two cycles per visit.
- Direct unit cost of condoms and OCs to the MOH at the central level would be similar to the average unit prices achieved in the procurements since 1996. Unit costs for IUDs are based on estimates in the absence of a previous procurement experience.

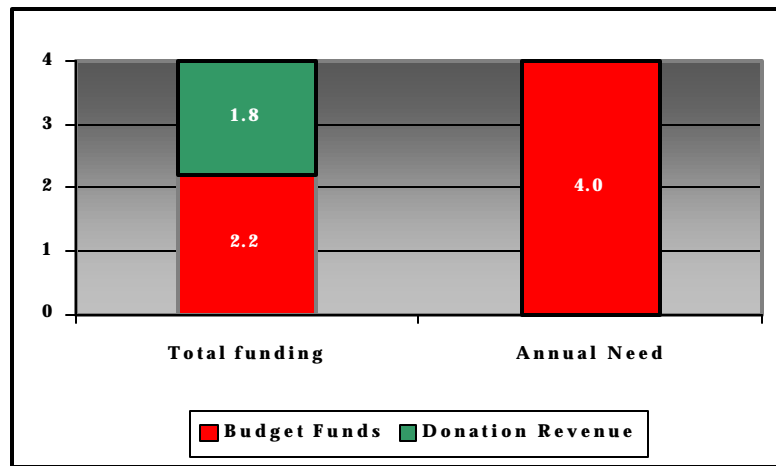
- Annual total volume and the mix of contraceptive commodities dispensed by the MOH in 1999 are taken as a basis for calculations.
- The rate of total revenue retention at all levels is taken to be 30 percent, meaning that of all revenue generated at the facility-level 70 percent is reused at the central level to procure commodities.

It is estimated that 44 percent of total annual direct contraceptive commodity cost incurred by the MOH could be recovered through this scheme. As has already been stressed, this is an early projection that should be treated with caution within the limits of the premises outlined above.

Given this early projection and the total regular budgetary funding secured in the last two years, the MOH can reach the goal of self-reliance in a sustainable manner by implementing the targeting strategy (Figure 7). Even if the fact that the unit costs are declining is not considered, the total funding base (potential donation revenue plus budget funding) slightly exceeds the total annual funding requirement for contraceptives. This scenario presents the opportunity to decide on a lower price set with lower demand effects.

Figure 7

Outlook of the MOH's Contraceptive Funding with the Targeting Strategy (Million \$)



Client Reactions to Donation Policy

Facility visits by the pilot study team have allowed them to ask the facility health staff about the reactions of users to the donation policy. The following is a brief account of the answers received from the staff:

- IUD users have, in general, not shown a significant discomfort with the policy, since they had already been accustomed to making donations for IUD insertion services (not for the IUD itself) in almost all the facilities across the pilot regions. This is evident from the higher rates of payment for IUDs compared to other methods in all regions. However, in facilities where newly prescribed

IUD charges exceeded the old levels, users often reportedly questioned the reason for the unprecedented price increase.

- Insofar as OCs and condoms are concerned, charging through donations is totally new, causing various reactions from users. The question “Why?” has been the most preferred type of reaction. This and similar questions have usually been effectively answered by staff who have mostly adopted the reasoning shared with them at the prepilot orientation sessions. There have been users who have protested the policy verbally. However, there is no evidence as to the eventual behavior of these clients (pay, walk away, or get exemption). Similarly, there is no indication as to the distribution of these protesters across socioeconomic groups. There have also been users who have expressed gratitude for the free-of-charge services thus far, and accepted the policy as normal. Overall, it could be stated that nurses/midwives in charge of FP services have played a highly critical role in balancing the reactions of users in order that no undesired outcomes occur. There may be numerous reasons behind the high level of motivation shown by the nurses/midwives; however, two seem to be the most outstanding: (1) assessment of users’ ability to pay has been explicitly left to the nurses/midwives; and (2) almost all facilities have voluntarily decided that the amount of donation revenue retained at the facility (20 percent) is to be used for the FP unit.

Provider Attitudes Toward Donation Policy

Staff involved in the pilot study can be grouped in three categories: (1) health facility staff, (2) provincial health directorates’ staff, and (3) foundation staff.

- Visits to monitor facilities have yielded insight into the general attitudes of the facility staff toward the donation policy. Accordingly, the nurse/midwives who deal with the users face-to-face and who determine payment status are on the whole highly positive about the policy. This observation has been supported by the fact that, in the majority of the facilities, nurse/midwives have preferred to collect the donations and issue the foundation receipts themselves. At the outset, the number of the facilities that would adopt this approach was much lower.

It has also been observed that relevant physicians and the head doctors of the facilities have developed a more positive attitude toward the policy. Although there are still those physicians with negative attitudes toward the policy, no evidence exists that they have tried to circumvent the successful implementation of the policy at their facilities directly.

- From the very beginning, staff at the provincial health directorates have continued their support and efforts for the successful implementation of the pilot study.
- HSAF staff at the branch level have successfully played the role that has been tailored for them in the design of the pilot study.

It should be noted that the pilot study is being conducted under direct supervision and care of the pilot study coordination teams at both central and provincial levels. It is important to assess the role that this direct and intense care may have played. Such an assessment would provide critical insights in the development of strategies for the rollout of the targeting strategy nationwide.

It has been observed that the majority of facilities have fully complied with the prescribed approaches to the form and money handling and transfers. Problems in this area have been solved by collective efforts of pilot study coordination teams at both central and provincial levels. A comprehensive assessment of the organizational and managerial processes will be carried out at the end of the pilot study.

CONCLUSIONS

This paper has discussed the preliminary results of the pilot study being conducted in Turkey in order to assess various aspects of the targeting strategy for free and subsidized contraceptive commodities dispensed at the MOH's PHC facilities. Some assessments have been based on data received from 40 percent of all pilot facilities, representing only 30 percent of the total expected caseload during the entire study.

The assessment indicated that there has been a decrease in the number of OCs and condoms dispensed in all three pilot intervention regions. Although this finding will be subjected to further analysis at the end of the pilot study, the data from the control region have also shown that this impact (decrease in demand) in the pilot intervention regions could be attributable to the pilot study intervention.

Of all users continuing to receive contraceptive commodities from MOH facilities, 53 percent have made the full donation requested. Although an additional 9 percent have made only a partial donation, the total number of payers has reached 62 percent, which is especially noteworthy where donations are collected on a *willingness to pay* basis.

Payment rates are significantly higher at MCH/FP centers than at health centers. Full payment rates at MCH/FP centers are 71 percent compared to 50 percent. The total percentage of full and partial payers in MCH/FP centers has reached to 81 percent, whereas the same figure for health centers has only been 59 percent.

IUD clients rank first in terms of payment rates with 60 percent and 19 percent for full and partial payment categories respectively (total 79 percent). OC and condom users have lower rates, with full and partial payment rates of 60 and 58 percent, respectively.

Given the preliminary results based on certain assumptions, the MOH may raise as much as 44 percent of its annual funding requirement through client donations. Given the regular and sustainable current funding base and the decreasing unit commodity costs, the MOH can select a donation price set that is lower than the high price set for national implementation.

Clients' reactions toward the donation policy have been assessed on the basis of the providers' accounts, and generally have been of compliance and little complaint. This has been more evident in the reactions of IUD users, who have already been asked to make donations for IUD-insertion services. OC and condom users have often questioned the reason behind the introduction of donations for these commodities. Explanations offered by the immediate providers (midwives/nurses) have usually resulted in a softened reaction and resultant compliance with the policy, thus indicating that the operational success of the targeting strategy depends largely on the motivation (attitudes and behavior) of this particular staff.

Providers' attitudes and reactions to the policy have been of vital importance. Provincial health directorate staff and HSAF staff at the provincial level have been highly supportive, making it possible to successfully implement the study. Although positive in general, some facility-level staff have maintained a negative stance toward the idea of collecting donations for FP commodities mostly on ideological grounds. However, even the most vociferous of opponents has not shown any negative reaction that would eventually affect the implementation of the donation policy.

In sum, on the basis of the preliminary assessment the ambitious attempt of formulating a financing policy based partially on donation revenue for contraceptive commodities stands a high chance of success in Turkey.

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