# Creating options in family planning for the private sector in Latin America

*Suneeta Sharma,*[1] *James N. Gribble,*[1] *and Elaine P. Menotti*[2]

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**ABSTRACT** *The countries of Latin America and the Caribbean are facing the gradual phaseout of international-donor support of contraceptive commodities and technical and management assistance, as well as an increased reliance on limited public sector resources and a limited private sector role in providing contraceptives to the public. Therefore, those nations must develop multisectoral strategies to achieve contraceptive security. The countries need to consider information about the market for family planning commodities and services in order to define and promote complementary roles for the public sector, the commercial sector, and the nongovernmental-organization sector, as well as to better identify which segments of the population each of those sectors should serve. While it is unable to mandate private sector participation, the public sector can create conditions that support and promote a greater role for the private sector in meeting the growing needs of family planning users. Taking steps to actively involve and expand the private sector's market share is a critical strategy for achieving a more equitable distribution of available resources, addressing unmet need, and creating a more sustainable future for family planning commodities and services. This paper also discusses in detail the experiences of two countries, Paraguay and Peru. Paraguay's family planning market illustrates a vibrant private sector, but with limited access to family planning commodities and services for those who cannot afford private sector prices. In Peru a 1995 policy change that sought to increase family planning coverage had the effect of restricting access for the poor and leaving the Ministry of Health unable to pay for the growing need for family planning commodities and services.*

**Key words** Contraception, delivery of health care, family planning services, health services accessibility, marketing of health services, private sector, social marketing, Latin America, Caribbean region.

[1] Futures Group, POLICY Project, Washington, D.C., United States of America. Send correspondence to: Suneeta Sharma, POLICY Project, Futures Group, One Thomas Circle, N.W., Suite 200, Washington, D.C. 20005, United States of America; telephone: 202-775-9680; fax: 202-775-9694; e-mail: ssharma@futuresgroup.com

[2] University of Michigan Center for Population Planning, University of Michigan Population Fellows Program, Ann Arbor, Michigan, United States of America, and Futures Group, POLICY Project, Washington, D.C., United States of America.

Over the past three decades, international donors have supported family planning programs in the countries of Latin America and the Caribbean (LAC) through contraceptive commodity donations and technical and management assistance to ministries of health (MOHs) and nongovernmental organizations (NGOs). At the same time, MOHs in many LAC countries have invested their own resources in information and education campaigns on the value of family planning and in building their capacity to deliver services so as to ensure that donated commodities could be provided free to all those who wanted them. Also, with donor assistance, NGOs have ex-

panded social marketing programs for family planning commodities. As a result of these various activities, the demand for contraceptives in the LAC countries has increased.

However, in more-recent years, international donors have been gradually reducing their donations and assistance to the LAC countries, producing a gap between the remaining donor support and the government funds that are available to meet the demand for family planning commodities and services. This shortfall in needed resources is a critical problem in the LAC countries. Exacerbating the problem is the limited involvement by the private sector in the family planning market in the LAC nations, due to the public sector's dominance, with the public sector having relied primarily on donated commodities and other types of support from donors.

While many LAC countries hold on to the lofty goal of government provision of free family planning commodities and services for all people, such a goal is no longer achievable due to the limited financial resources. Providing free family planning commodities and services in the public sector may, in the medium term, achieve high coverage, but it is not financially feasible in the face of donor phaseout. Further, it tends to discourage the growth and long-term sustainability of private sector provision of family planning commodities and services (1). Therefore, a challenge that LAC countries must confront is acknowledging that this overreliance on the public sector is no longer sustainable.

"Contraceptive security" exists when individuals are able to choose, obtain, and use contraceptives whenever they need them. To achieve contraceptive security and to respond to the family planning needs of all the men and women in their countries, the LAC nations will need to find ways to mobilize all potential sources for procuring and providing contraceptives. Thus, involving the private sector is one of the critical strategies necessary for achieving a more equitable distribution of available resources and creating a more sustainable future for family planning commodities and services.

This paper addresses the role of the private sector in providing family planning commodities and services in LAC countries, with case studies of Paraguay and Peru. The paper also examines how the family planning market is structured, why the private sector should be more involved, and what effect public policy has on market structure.

## MARKET SEGMENTATION: HOW THE FAMILY PLANNING MARKET IS STRUCTURED

Market segmentation analysis examines how the market for family planning is structured, and helps to identify the extent to which different providers serve various population segments. In most countries, family planning commodities and services are provided through the public sector (MOH and social security) and the private sector (2). The private sector includes NGOs that are either for-profit or nonprofit, social marketing (selling contraceptives at partially subsidized prices), and the commercial sector, which is made up of private hospitals and clinics, private physicians and nurses, and commercial pharmacies and shops. For a given sector, its family planning market results from the interactions among contraceptive methods, consumers (women of reproductive age, that is, 15 to 49 years old), and the providers that belong to that sector.

To determine which sources of family planning commodities and services reach a given population segment, the population is divided into quintiles based on a standard of living index. (A standard of living index is developed by a factor analysis of household assets, rather than of income or consumption.) This market information helps establish a better match between current and potential users and the appropriate source of contraceptives, taking into account the users' location, needs, preferences, and ability to pay. If one assumes that a priority of the public sector is to provide services to those most in need and who cannot afford to pay for family planning commodities and services through any other source, then public resources should be focused on the lowest two quintiles. People in the middle and the two highest quintiles should be able to pay for family planning commodities and services provided by NGOs, social marketing programs, and the commercial sector.

Family planning market segmentation analyses conducted in LAC countries show that there are inappropriate market structures in many of the nations. For example, in Bolivia the two wealthiest quintiles account for 55% of family planning users served by the *Ministerio de Salud y Deportes* (Ministry of Health and Sports, or MHS), while the poorest two quintiles account for only 30% of family planning users served by the MHS (3). The most appropriate distribution of MOH services found in these LAC analyses is in El Salvador, where the two poorest quintiles account for 52% of family planning users served by the *Ministerio de Salud Pública y Asistencia Social* (Ministry of Public Health and Social Welfare) (4). Similarly, in most countries, beneficiaries of social security programs must obtain family planning commodities and services through other types of providers, primarily the MOH, generally because the social security programs are not able to meet their beneficiaries' family planning commodity and services needs. For example, in Honduras only 17% of the beneficiaries of the *Instituto Hondureño de Seguridad Social* (Honduran Social Security Institute) use Social Security services for family planning; 20% of beneficiaries rely on the *Secretaría de Salud* (Secretariat of Health); and 47% utilize the private sector (3). Again, El Salvador has the most appropriate distribution, with 51% of the beneficiaries of the *Instituto Salvadoreño del Seguro Social* (Salvadoran Institute of Social Security, or SISS) obtaining contraceptives from SISS programs; however, 26% of family planning commodities and services used by SISS beneficiaries are provided by the Ministry of Public Health and Social Welfare (3, 4).

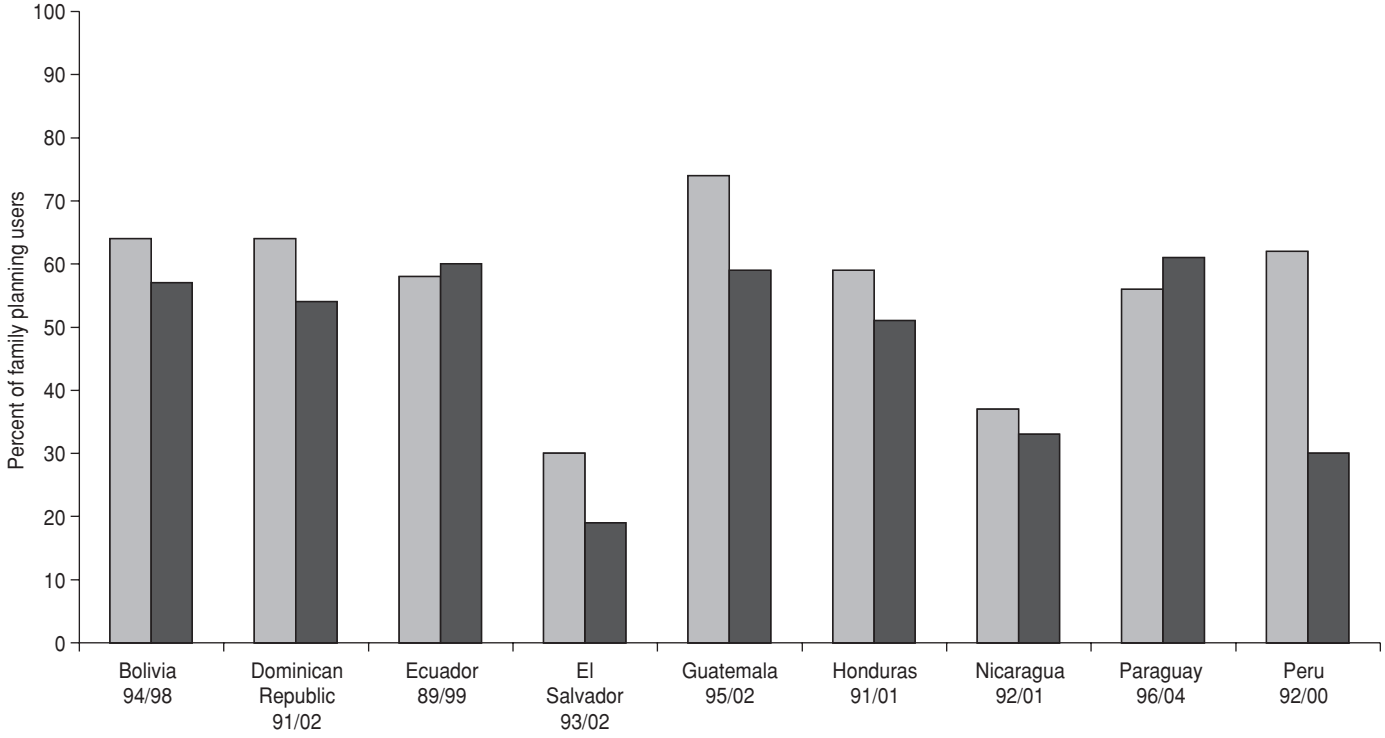
## Rationale for private sector mobilization in Latin America and the Caribbean

Strengthening public-private partnerships and expanding the private sector will help make up for the limited public resources available to meet high, growing needs for family planning commodity and service (5–8). The private sector in LAC represents a relatively large share of the contraceptives market in comparison to other regions of the world because of the high overall prevalence of modern family planning methods in the LAC countries. (Modern contraceptive methods include oral contraceptives, injectables, intrauterine devices, condoms, and female and male sterilization.) For example, in Colombia and the Dominican Republic the commercial sector is responsible for providing over 40% of family planning commodities and services (9). In other countries, such as Guatemala and Haiti, the NGO sector has a large share of the family planning market, but the NGOs often rely on donors for commodities and other assistance. However, as indicated in Figure 1, in many of the LAC countries, private sector participation has declined since the 1990s. In spite of the active participation of the private sector in some LAC nations, various factors indicate the need for the private sector to increase its market share (9).

**Declining donor support.** In recent years, the United States Agency for International Development, the United Kingdom Department for International Development, and the United Nations Population Fund have been gradually phasing out contraceptive commodity donations as well as some types of technical and management support to LAC countries. The phase-out process has not been uniform, but eventually all of the LAC countries will graduate from donor support, and so they must prepare to finance, procure, and manage their own contraceptive commodities (3). In preparing for the transition, nations must take into account that the number of women of reproductive age is increasing, as is the trend toward higher prevalence of modern contraceptive methods. Thus, the cost for purchasing commodities and delivering services in a given country is likely only to increase over time.

**Insufficient public sector investment in commodities**. Most of the MOHs in the LAC countries have relied on donations to meet their contraceptive commodity requirements. As recently as 2003 the *Ministerio de Salud Pública y Bienestar Social* (Ministry of Public Health and Social Welfare) of Paraguay and the Ministry of Health and Sports of Bolivia relied 95% and 100%, respectively, on donated contraceptives (3). Most of the MOHs in the LAC countries have begun to increase government funding to address the immi-

**FIGURE 1. Changes over time in the percentage of use of the private sector for family planning commodities[a] and services among women of reproductive age in countries of Latin America and the Caribbean**




***Source:*** Taylor et al. (3).
[a] "Family planning commodities" includes only modern methods of family planning.

nent gap between donor support and/or government funding and the expected cost of family planning commodities and services. For example, the Ministry of Public Health and Social Welfare of El Salvador expects to cover 100% of its needs for 2005, through an investment of US$ 1.25 million (3). However, for the most part, budgetary allocations by the public sector are not large enough, and the rate of increase is not sufficient to cover the widening funding gap. In addition, the lack of commitment to family planning, due to ideological issues, on the part of many government officials contributes to instability in the public sector financing of commodities.

**Increasing dependence on limited public sector resources.** With the exception of Ecuador and Paraguay, most LAC countries have seen significant increases in the public sector's family planning market share over the past 15 years. In El Salvador, Nicaragua, and Peru, the government share of the contraceptive market exceeds 50%—a market share that is simply not sustainable in the future (3). Accompanying this increasing government role has been a decline in private sector market share, as free or heavily subsidized contraceptive products render private sector prices uncompetitive (9, 10). As governments have taken on the primary responsibility for providing contraceptives, they have focused on the short term, without much thought about long-term sustainability and funding needs. Thus, the dependence on the public sector for contraceptive funding has come with an emphasis on increasing the prevalence of modern methods, but without sufficient attention to market segmentation trends.

**Services not reaching vulnerable populations**. Between 1990 and 2003 the prevalence rate for modern contraceptive methods for women of reproductive age increased between 10 and 26 percentage points in seven LAC countries: Bolivia, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, and Peru (3). Despite these overall increases, modern methods use continues to be low among certain groups of women. Priority populations for reducing unmet need (i.e., women of reproductive age who want to space or limit births but are not currently using any family planning method) in the LAC countries include rural, low-income, and less educated women; adolescents (ages 15–19); and certain ethnic groups (3). Addressing the needs of these groups frequently requires identifying and overcoming operational policy barriers, such as by increasing family planning providers' cultural sensitivity to local customs and by increasing the range of the categories of health care workers able to provide certain modern family planning commodities and services. Making these changes requires additional commitment and resources from the public sector and/or the private sector (11).

In general, targeting strategies are not well developed in the LAC countries. When effectively implemented, a targeting strategy helps segment the market appropriately so that there is an equitable distribution of available resources. In a well-segmented market, the poorest two quintiles receive free services from the MOH, the middle quintile group uses social marketing and NGO programs, and the two upper-income quintiles use the commercial sector, and those with insurance coverage utilize appropriate third-party services. (People with insurance coverage can belong to any economic quintile, though the vast majority belong to the middle and two highest quintiles.)

## PARAGUAY: PRIVATE SECTOR DOMINANCE, BUT WHAT ABOUT THE POOR?

Paraguay's family planning market illustrates a vibrant private sector in the absence of a deliberate targeting strategy. The result is limited access to family planning commodities and services for those who cannot afford private sector prices.

Unlike in most LAC countries, in Paraguay the Ministry of Public Health and Social Welfare (MPHSW) is not the dominant contraceptive provider for the country. Rather, the private sector serves roughly 60% of contraceptive users, with 43% of all contraceptive users utilizing pharmacies, which are distributed throughout the urban and rural areas of the country (12). This segmentation arose, in part, because the MPHSW has a history of frequent contraceptive stockouts and an inconsistent political climate supporting family planning. Thus, Paraguayans tend to consult the more-reliable private sector for their contraceptive needs.

An unfortunate result of the private sector dominance is that a high unmet need for modern family planning methods and services—27% among the two lowest quintiles—exists among the poorest women of Paraguay (12). The cost of contraceptives at the commercial pharmacies tends to be prohibitive for Paraguay's poor. In response, social pharmacies have evolved to provide lower-cost medicines and contraceptives to lower-income clients. However, there are relatively few of these facilities, and thus they make up only a small proportion of the pharmacies providing family planning commodities and services in the country.

The large proportion of services provided by the private sector in Paraguay offers the MPHSW a clear opening to focus its limited resources on those who are less able to pay, and to attempt to decrease unmet need among Paraguay's poorest citizens. By focusing its resources on the lower quintiles, the MPHSW can guarantee reliable, affordable contraceptive stocks to meet those clients' needs. In addition, by institutionalizing strategies that waive fees, the MPHSW could target free or highly subsidized family planning services to those most in need.

## PERU: PUBLIC POLICIES UNDERMINING PRIVATE SECTOR INVOLVEMENT

The mantra of "health for all the people of the world by the year 2000" was contained in the Declaration of

**TABLE 1. Percentage of women of reproductive age using different family planning methods, across standard of living index quintiles, Peru, 1996 and 2000**

| Family planning method used | Poorest | | Second | | Middle | | Fourth | | Wealthiest | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1996 (*n* = 4 714) | 2000 (*n* = 3 672) | 1996 (*n* = 7 937) | 2000 (*n* = 7 065) | 1996 (*n* = 5 880) | 2000 (*n* = 6 117) | 1996 (*n* = 5 716) | 2000 (*n* = 6 129) | 1996 (*n* = 4 706) | 2000 (*n* = 4 857) | 1996 (*n* = 28 953) | 2000 (*n* = 27 840) |
| Not using | 66.0 | 60.8 | 54.8 | 52.3 | 56.3 | 54.1 | 61.2 | 56.7 | 60.6 | 59.4 | 59.1 | 56.0 |
| Pill | 2.9 | 2.9 | 5.1 | 4.7 | 4.1 | 5.4 | 3.8 | 4.4 | 3.1 | 3.4 | 4.0 | 4.3 |
| IUD[a] | 3.8 | 2.3 | 7.4 | 3.6 | 9.1 | 5.9 | 8.6 | 8.4 | 8.5 | 8.3 | 7.6 | 5.8 |
| Injection | 6.8 | 12.0 | 7.1 | 12.8 | 4.1 | 9.4 | 2.9 | 6.6 | 3.3 | 4.5 | 5.0 | 9.1 |
| Condom | 0.6 | 1.0 | 2.4 | 2.5 | 3.9 | 4.2 | 4.5 | 5.8 | 4.0 | 5.7 | 3.1 | 4.0 |
| Female sterilization | 3.1 | 5.5 | 6.0 | 8.6 | 6.7 | 7.9 | 6.2 | 7.1 | 7.4 | 7.6 | 5.9 | 7.5 |
| Other modern | 0.4 | 1.7 | 0.8 | 1.1 | 1.1 | 1.6 | 0.8 | 1.0 | 0.9 | 0.9 | 0.8 | 1.2 |
| Traditional[b] | 16.5 | 13.8 | 16.5 | 14.3 | 14.7 | 11.4 | 12.1 | 10.0 | 12.1 | 10.2 | 14.5 | 12.0 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

***Source:*** Perú, Instituto Nacional de Estadística e Informática, and Macro International (16, 17).
[a] IUD = intrauterine device.
[b] Traditional methods include rhythm, withdrawal, periodic abstinence, and others.

Alma-Ata, which was produced by the 1978 International Conference on Primary Health Care. That call for action encouraged governments in Latin America and the Caribbean to extend universal primary health care and family planning coverage in the 1980s and 1990s (13). Securing universal access to primary health care, including family planning commodities and services, appeared to be a feasible objective when donors provided contraceptive commodities and technical and management assistance. However, given diminishing donor support and the economic crises affecting many LAC countries, the LAC public sector has become financially overextended and can no longer afford to support such a strategy.

In Peru, for example, between 1995 and 2000 the Government of President Alberto Fujimori increased funding for family planning and mandated the provision of free family planning services for all. The policy legally guaranteed the provision of contraceptive services and methods, including surgical methods, at no charge in Government health facilities. Prior to 1995, most of the *Ministerio de Salud* (Ministry of Health, or MOH) facilities in urban areas charged fees for family planning commodities and services, while in rural areas, where most of the poor live, commodities and services were provided free. Since 1995, donor and Government resources alone have not been sufficient to serve the growing demand for family planning. Furthermore, the high level of poverty is also a significant challenge (14).

Between 1995 and 2000 the proportion of all women of reproductive age who were using modern contraceptive methods increased from 26% to 32% (Table 1). According to a market segmentation analysis of the country, the proportion of users of modern family planning methods who obtained their family planning commodities and services from the MOH grew from 59% in 1996 to 69% in 2000 (Table 2) (15–17). Further, the proportion of those users

**TABLE 2. Percentage of family planning users by source of family planning commodities and services, across standard of living index quintiles, Peru, 1996 and 2000[a]**

| Source of family planning commodities and services | Poorest | | Second | | Middle | | Fourth | | Wealthiest | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1996 (*n* = 824) | 2000 (*n* = 903) | 1996 (*n* = 2 279) | 2000 (*n* = 2 318) | 1996 (*n* = 1 704) | 2000 (*n* = 2 079) | 1996 (*n* = 1 530) | 2000 (*n* = 2 018) | 1996 (*n* = 1 284) | 2000 (*n* = 1 468) | 1996 (*n* = 7 621) | 2000 (*n* = 8 786) |
| Ministry of Health | 88.2 | 95.6 | 74.0 | 85.6 | 53.8 | 70.9 | 41.0 | 52.6 | 41.1 | 44.5 | 58.9 | 68.7 |
| Social Security | 4.0 | 1.1 | 6.0 | 5.7 | 12.2 | 12.1 | 13.8 | 14.2 | 18.4 | 18.1 | 10.8 | 10.8 |
| Private clinics/ hospitals | 3.4 | 1.9 | 5.4 | 3.4 | 9.9 | 6.3 | 15.8 | 14.8 | 13.2 | 15.3 | 9.6 | 8.5 |
| Commercial pharmacies | 2.2 | 0.6 | 10.8 | 3.1 | 17.4 | 7.2 | 22.6 | 13.4 | 21.7 | 15.9 | 15.6 | 8.3 |
| NGOs[b] | 1.3 | 0.6 | 2.4 | 1.2 | 4.0 | 2.0 | 5.1 | 3.3 | 3.0 | 4.0 | 3.3 | 2.3 |
| Other | 0.8 | 0.3 | 1.4 | 1.1 | 2.6 | 1.4 | 1.7 | 1.8 | 2.6 | 2.3 | 1.9 | 1.5 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |

***Source:*** Perú, Instituto Nacional de Estadística e Informática, and Macro International (16, 17).
[a] "Family planning commodities" includes only modern family planning methods.
[b] NGOs = nongovernmental organizations.

whose needs were met by the commercial sector (private clinics, private hospitals, and commercial pharmacies) declined from 25% to 17% as higher-income clients shifted to the MOH. The decline in commercial sector involvement was especially noticeable for pharmacies, whose user share fell from 16% in 1996 to 8% in 2000.

The 1995 policy decision had the undesirable effect of shifting more middle- and upper-income clients to the MOH for their family planning commodities and services. Women in the two wealthiest quintiles accounted for 29% of the MOH's family planning clientele in 2000, compared to 26% in 1996. The proportion of the MOH's clientele who were in the two lowest quintiles fell from 54% in 1996 to 47% in 2000, while the proportion in the middle quintile (who might have been able to afford social marketing prices) rose from 20% to 24% over that period. This shift in the MOH client distribution indicated growing inefficiency in the use of limited public resources, with subsidies rising for persons able to pay for family planning commodities and services. Overall, the 1995 policy, which sought to increase family planning coverage, had the effect of restricting access for the poor and leaving the MOH unable to pay for the growing need for family planning commodities and services.

Another group seeking free family planning commodities and services through the MOH are persons who have health care coverage through Peru's Social Security system; 85% of those persons belong to the middle quintile or the upper two quintiles. As many as 45% of the Social Security clients rely on the MOH for contraceptives, constituting 17% of the MOH's family planning clientele. For their family planning commodities and services, these clients should rely on the Social Security clinics or on the private provider network contracted by the Social Security system. Currently, however, there is no mechanism for the MOH to seek reimbursement from the Social Security system for family planning commodities services that the MOH provides to the Social Security beneficiaries. That is in spite of the fact that the Social Security system receives money from contributors to cover beneficiaries for health care, including family planning commodities and services.

Donors stopped providing contraceptive commodities to Peru in 2004, though some technical and management assistance is still being given. Since then the market shares have begun to change. That is because the public sector funds available to the MOH are not sufficient to cover the demand that its donor-supported national family planning program had created. Analysis of Peru's most recent Demographic and Health Survey, in 2004, found that between 2000 and 2004, the MOH's market share of family planning decreased from 69% to 54% (17, 18). The commercial sector has increased its market share from 17% to 26%. The prevalence of modern contraceptive methods (such as oral contraceptive pills and injectables) has declined, particularly in rural areas. Use of traditional methods (such as rhythm and withdrawal) has increased in all economic quintiles, and especially in the lowest two quintiles. Overall, these changes suggest that the MOH's decreased market share has affected the poorest women's ability to access modern methods. It is probable that, in the face of limited MOH contraceptive commodities, the upper quintiles are much more likely to seek private sector supplies and pay for them out of pocket.

## POLICY OPTIONS TO STIMULATE PRIVATE SECTOR PARTICIPATION IN LATIN AMERICA AND THE CARIBBEAN

In the LAC countries, ensuring continued national contraceptive security and rational use of available resources in the absence of donor support requires a multisectoral approach. The public sector needs to consider how to decrease inefficiency in the family planning market, enhance the public sector's capacity to provide the poor with family planning commodities and services, and take a stewardship role in ensuring consistent and continued supplies of family planning commodities and services. A first step is for governments to open communication channels with private sector providers and to recognize the complementary role that the private sector can play.

While governments cannot mandate private sector involvement, they do need to actively create a favorable policy environment that supports and encourages the private sector in meeting the growing need for contraceptives (10, 19). The public sector can take three steps to encourage private sector expansion: (1) involve the private sector in planning, decision-making, and resource allocation; (2) develop nonmonetary incentives to attract participation; and (3) eliminate or reduce legal and regulatory barriers that inhibit private sector growth, such as taxes on imported commodities and policies that mandate contraceptive procurement from expensive local sources (10).

It is important for policymakers to understand the relationships between the public sector family planning markets and the private sector family planning markets. Study results from LAC countries and elsewhere show that free or low-cost public sector prices for contraceptives can induce wealthier clients using commercial and NGO sources to switch to the public sector (9, 20, 21). When that happens, contraceptive prices in the commercial and NGO sectors will be high and distribution limited, due to insufficient economies of scale. When private sector family planning markets are small, there are few incentives for contraceptive manufacturers and distributors to compete by lowering their prices. Thus, the fixed costs of manufacturing, distribution, and sales must be passed on to fewer pharmacies, NGOs, and private providers, who in turn increase contraceptive commodity prices to their consumers. When both the family planning market and profit margins are small, the private sector is also less likely to promote low-cost, generic products and/or to

invest in expanding distribution of family planning commodities and services. Thus, by decreasing its market share in family planning, the public sector can promote the expansion of the private sector in family planning, which can eventually offer more competitive prices for the middle and highest two quintiles.

It is important for both the public sector and the private sector to understand each quintile's ability to pay for family planning commodities and services when attempting to operationalize a more sustainable market structure for family planning. For example, it is logical for the commercial sector to initially respond to the demands of wealthier clients, especially in urban areas. Within the upper two quintiles, there are those who are able and willing to pay for the convenience, prestige, or perceived quality of branded contraceptives.[3]

Policymakers should consider that social marketing programs also have an important role to play in family planning markets, by increasing the accessibility and affordability of family planning products, particularly for those in the middle-income quintile. Socially marketed contraceptives are sold in commercial retail outlets or NGO health facilities at partially subsidized prices. (Though social marketing programs are generally managed by NGOs, Jamaica's Government has actively supported and managed a social marketing program (22)). Social marketing programs can also help create demand for brand names and a viable market for the commercial sector.

Further, for those who are unable to pay, especially persons in the lowest two quintiles, the public sector can focus on using its limited resources to ensure that those individuals have access to free family planning commodities and services. Even if the public sector begins to charge user fees for its family planning services, policymakers can institute targeting mechanisms that protect the poor's access to affordable family planning products and services (22). For example, mechanisms can be institutionalized to waive fees for those from the poorest two quintiles. In that way, limited public resources are channeled to those who cannot afford to pay for private sector services, and new market opportunities are created for the private sector among better-off clients.

Countries must also learn from the past, and think through the long-term consequences of policy changes. Given the experiences of Paraguay and Peru, governments must realize that there is an appropriate level of involvement for each sector in order to achieve contraceptive security. In Paraguay the Ministry of Public Health and Social Welfare has not taken a strong enough position, with the result that the very poor do not have access to affordable contraceptives. The private sector, however, has responded to the market demands of the upper two quintiles. In Peru the MOH is overextended and unable to meet everyone's needs, with the result being that the very poor have less access to the public sector.

Finding the right policy options to produce contraceptive security and appropriate market structures is an ongoing challenge in the LAC countries. While no single solution exists, the process of studying the existing market structure, identifying a more equitable structure, and putting in place policies that bring about needed change has begun. The situation did not arise overnight, nor will the problem be corrected that quickly. However, the first step to solving the problem is to recognize that the current market structure needs to change and to be open to new market structures and policies so that the future provision of family planning commodities and services remains sustainable for all women and men.

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**RESUMEN**

## La creación de opciones en materia de planificación familiar para el sector privado en América Latina

Los países de América Latina y el Caribe enfrentan el cese gradual del apoyo y de la ayuda técnica y administrativa brindados por donantes internacionales a los proveedores de productos anticonceptivos, por lo que dependen cada vez más de los limitados recursos del sector público y del papel menguante del sector privado para la provisión de anticonceptivos al público en general. Así las cosas, dichos países tendrán que crear estrategias multisectoriales para lograr la provisión segura de anticonceptivos. Deberán, asimismo, tener en cuenta la situación del mercado de los productos y servicios de planificación familiar a fin de poder definir y promover los papeles complementarios que han de desempeñar el sector público, el sector comercial y el sector de las organizaciones no gubernamentales, así como determinar con más exactitud a qué grupos de la población debe servir cada uno de estos sectores. Si bien es cierto que el sector público no puede exigirle al sector privado su participación, sí le es posible crear las condiciones propicias para que este asuma un papel más destacado en la satisfacción de las necesidades cada vez mayores de quienes usan métodos de planificación familiar. Tomar medidas para incrementar la participación del sector privado en el mercado es una estrategia esencial si se ha de lograr una distribución más equitativa de los recursos existentes, satisfacer necesidades insatisfechas y crear un futuro sustentable para los proveedores de productos y servicios de planificación familiar. En este trabajo también se examinan en detalle las experiencias de dos países, Paraguay y Perú. El mercado de servicios de planificación familiar en Paraguay es ejemplo de la vigorosa participación del sector privado, aunque el acceso a los servicios de planificación familiar es limitado para quienes no pueden afrontar los costos de dicho sector. En Perú tuvo lugar en 1995 un cambio de políticas orientado a aumentar la cobertura de los servicios de planificación familiar que redundó en un acceso restringido para los pobres y dejó al Ministerio de Salud sin poder sufragar la necesidad creciente de productos y servicios de planificación familiar.

**Palavras clave** Anticoncepción, prestación de atención de salud, servicios de planificación familiar, accesibilidad a los servicios de salud, comercialización de los servicios de salud, sector privado, mercadeo social, América Latina, Región del Caribe.