# What is the recent experience of programs that distribute contraceptives free of charge versus for a price?

## *A Review of the Literature*

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# Inspiration for this Presentation: Kinshasa, DRC

Modern contraceptive prevalence is low (20.4%)

Unmet need is high (31.3%)

Contraceptive are available in over 400 health facilities

Yet uptake is very low, until…

….the campaign (or training day) when they are given free…

# What have we learned from the literature on paid versus free contraception?

Overview of presentation:

- Historical perspective
- Arguments for requiring clients to pay – at least something
- Arguments for distributing contraceptives free of charge
- Current solution: total market approach (TMA)
- But what is the question we SHOULD be asking?

“

*It was the subject of a huge debate but one that was largely unencumbered with facts.*

-- Dr. Duff Gillespie, former director of the Office of Population at USAID

# Arguments that contraceptives should NOT be free (government/donor Perspective)

Sustainability:

- Growing number of women needing and wanting contraception
- Donors cannot meet global needs for contraception[6]

Cost recovery reduces burden on government

- Subsidizes contraception for those who cannot afford it

Fees provide stronger likelihood of use and minimal wastage

Private sector incentivized to carry contraceptives[7]

# Arguments that Contraceptives Should NOT be Free (Consumer Perspective)

Convenient, but higher priced commodities may be less "costly" than the time and money spent accessing free services[8]

People value what they pay for

- Price is associated with quality
- Many societies distrust free services, including in Africa[9]

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# Free Contraceptives may "Crowd Out" the Commercial Sector

Rural Brazil (1979): Free CBD program did not increase use of orals in 3 years but decreased commercial market share by 39%[6]

Free commodities may result in "leaked brands" that compete with commercial brands[6]

Charging in the public sector is associated with higher use in the commercial sector[6]

# Arguments that Contraceptives Should be Free

Demand increases initially among both poor and wealthier women when contraceptives are free

Where high fertility represents a cost to society, government subsidies are warranted (notion that FP is a public good)

People are unwilling to pay for what they feel should be free

Requiring payment discriminates against the poor[4]

Payment toward curative health care tends to take priority over preventative health care[5]

Men are reluctant to spend money on their wives' health care[4]

# Contraceptives may be Over-Subsidized

In all 56 countries with relevant DHS data (in 2004), fewer than 3% of women who have discontinued contraceptive use cited price as the reason[10]

Several studies have found that there is little difference in demand between free and moderately priced products[9]

# Contraceptives may be Over-Subsidized

Sri Lanka and Jamaica:

- Price increases for condoms and oral contraceptives initially decreased demand
- After a few months demand returned to original levels
- Original levels were exceeded in Jamaica[6]

Malawi:

- Women felt that the long term value of contraceptives (child rearing) outweighed the initial cost and that contraceptives were affordable[5]

Bangladesh:

- Within a year of increasing prices:
    - Number of urban users who paid for contraceptives increased from 42% to 57%[11]
    - Those who refused to pay decreased from 33% to 23%[11]
    - Those unable to pay remained at 25%[11]

# Willingness to Pay (WTP) Studies

Overall trend: context-dependent user fees are acceptable and will result in limited impact on demand, even in resource poor countries

- Egypt (1994): 45% of women were willing to pay for injectable contraceptives[12]
- Ethiopia (2013): 68% of women who expressed interest in using injectable contraceptives were willing to pay[12]

WTP is dependent on the perceived quality of services

- May be enhanced by introducing quality improvements

CAVEAT: willingness to pay and ability to pay are not the same thing[11]

- Willingness: influenced by perceived need and value
- Ability: influenced by available resources

# Improving Quality as a Strategy for Introducing/Increasing Cost of Contraceptives

Cost recovery allows for:

- Increasing the number of outlets and improving the quality of services, workers salaries and customer satisfaction[8]

Clinics that can retain at least some revenue has incentive to ensure return clientele

Clients should have greater rights and the ability to demand higher quality  if he or she is the 'payer' or 'partial payer'[4]

Quality improvements can offset the demand-reducing effects of price increases, even among poor clients

# Total Market Approach (TMA)

Encouraging commercial sector participation in reproductive health could ease the burden on government subsidies and donor support

TMA may involve high administration costs in determining eligibility and may be inaccurate in determining ability to pay[5]

- Income based measures alone may be unreliable due to dependence on informal work and unemployment rates in the poorest communities[5]

# Expansion of the Commercial Sector is Feasible: minimum conditions needed already in place

Presence of women who are able to pay

- World Bank: estimates of GDP and income distribution shows large numbers can afford to pay commercial prices[6]

Presence of commercial brands already on the market[6]

- DHS data on brand usage shows that commercial outlets do carry low and moderately priced commercial OC brands[6]

# But is the experience from the rest of the developing world relevant to the poorest countries in Sub-Saharan Africa?

## 25 lowest ranking Sub-Saharan countries: HDI[3] and % Living on <$1.25/day[2]

| Human development index (HDI) | HDI Rank | 2013 HDI Value |
|---|---|---|
| Senegal | 163 | 0.485 |
| Uganda | 164 | 0.484 |
| Benin | 165 | 0.476 |
| Togo | 166 | 0.473 |
| Sudan | 166 | 0.473 |
| Djibouti | 170 | 0.467 |
| Cote d'Ivoire | 171 | 0.452 |
| The Gambia | 172 | 0.441 |
| Ethiopia | 173 | 0.435 |
| Malawi | 174 | 0.414 |
| Liberia | 175 | 0.412 |
| Mali | 176 | 0.407 |
| Guinea-Bissau | 177 | 0.396 |
| Mozambique | 178 | 0.393 |
| Guinea | 179 | 0.392 |
| Burundi | 180 | 0.389 |
| Burkina Faso | 181 | 0.388 |
| Eritrea | 182 | 0.381 |
| Sierra Leon | 183 | 0.374 |
| Chad | 184 | 0.372 |
| Central African Republic | 185 | 0.341 |
| Congo (DR) | 186 | 0.338 |
| Niger | 187 | 0.337 |

| % living on < $1.25/day | % Living on < $1.25 |
|---|---|
| Chad | 36.50 |
| Uganda | 38.01 |
| Swaziland | 40.63 |
| Guinea | 43.34 |
| Kenya | 43.37 |
| Lesotho | 43.41 |
| Niger | 43.62 |
| Burkina Faso | 44.60 |
| Benin | 47.33 |
| Guinea-Bissau | 48.90 |
| Mali | 50.43 |
| Sierra Leon | 51.71 |
| Congo-Brazzaville | 54.10 |
| Mozambique | 59.58 |
| Malawi | 61.64 |
| Rwanda | 63.17 |
| Tanzania | 67.87 |
| Nigeria | 67.98 |
| Zambia | 74.45 |
| Madagascar | 81.29 |
| Burundi | 81.32 |
| Liberia | 83.76 |
| Congo (DR) | 87.72 |

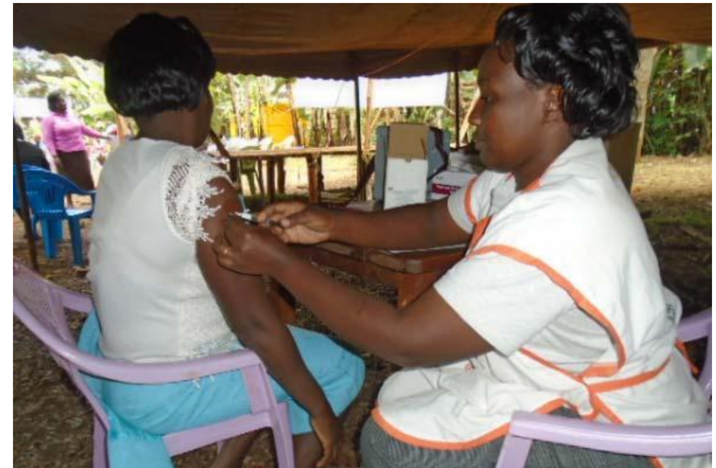
# Sub-Saharan Africa: GDP Per Capita (US$ 2014)[1] and mCPR

| Country | GDP | mCPR |
|---|---|---|
| Equatorial Guinea | 17,430.10 | 10 |
| Seychelles | 15,359.20 | n/a |
| Gabon | 10,208.40 | 19 |
| Mauritius | 10,005.60 | 39 |
| Botswana | 7,123.30 | 51 |
| South Africa | 6,477.90 | 60 |
| Namibia | 5,589.00 | 55 |
| Angola | 5,423.60 | 12 |
| Cape Verde | 3,641.10 | 57 |
| Nigeria | 3,203.30 | 10 |
| Congo-Brazzaville | 3,137.80 | 20 |
| Swaziland | 2,679.40 | 66 |
| Sudan | 1,875.90 | 12 |
| Djibouti | 1,805.00 | 18 |
| Sao Tome-Principe | 1,797.20 | 33 |
| Zambia | 1,721.60 | 45 |
| Cote d'Ivoire | 1,545.90 | 13 |
| Ghana | 1,442.80 | 22 |
| Cameroon | 1,429.30 | 14 |
| Kenya | 1,358.30 | 53 |
| Mauritania | 1,275.00 | 10 |
| Senegal | 1,061.80 | 20 |
| Chad | 1,024.70 | 2 |
| Tanzania | 998.10 | 26 |

| Country | GDP | mCPR |
|---|---|---|
| Lesotho | 990.00 | 60 |
| Zimbabwe | 896.20 | 67 |
| Comoros | 841.20 | 14 |
| Benin | 825.30 | 13 |
| Sierra Leon | 774.60 | 16 |
| Eritrea | 754.90 | 7 |
| Burkina Faso | 713.10 | 18 |
| Mali | 706.70 | 10 |
| Uganda | 696.40 | 26 |
| Rwanda | 695.70 | 48 |
| Togo | 635.00 | 17 |
| Mozambique | 602.10 | 11 |
| Guinea-Bissau | 567.80 | 14 |
| Ethiopia | 565.20 | 40 |
| Guinea | 539.60 | 5 |
| Liberia | 461.00 | 19 |
| Madagascar | 449.40 | 33 |
| Congo (DR) | 440.20 | 8 |
| Niger | 427.40 | 12 |
| The Gambia | 418.60 | 8 |
| CAR | 371.10 | 9 |
| Burundi | 286.00 | 18 |
| Malawi | 255.00 | 57 |
| Somalia | n/a | 1 |

# Where demand is fragile and poverty extreme, do the lessons of the past serve us well (if the international community is serious about increasing MCPR)?

- Need for an updated systematic analysis of existing payment mechanisms for contraception in least developing countries:
  - Free (through public sector or NGOs)
  - Partially subsidized
    - Government insurance
    - Social marketing
    - Taxes
  - Cost recovery
  - For profit



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