

ECONOMICS AND ETHICS OF RESULTS-BASED FINANCING FOR FAMILY PLANNING:

Evidence and Policy Implications

Sadia Chowdhury, Petra Vergeer, Harald Schmidt, David Bishai, Scott Halpern, Helene Barroy, Rafael Cortez, Shreelata Rao Seshadri, and Suchi Bansal

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Health, Nutrition, and Population (HNP) Discussion Paper

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Abstract: This paper was developed for World Bank task team leaders (TTLs) and teams designing results-based financing (RBF) programs in family planning (FP). It explores the rationale for introducing such incentives based on insights from classical and behavioral economics, to respond to supply- and demand-side barriers to using FP services. To help the reader understand why incentivizing FP requires specific attention in RBF, the evolution of incentives in vertical FP programs introduced from the 1950s to the early 1990s and the ethical concerns raised in these programs are described. RBF programs after the 1990s were also studied to understand the ways FP is currently incentivized. The paper also touches on the effects of the incentive programs for FP as described in the literature. Finally, it examines ethical concerns related to FP incentives that should be considered during the design, implementation, and evaluation of programs and provides a conceptual framework that can be of use for task teams in the decision-making process for FP in RBF programs. It should be noted that the paper is concerned exclusively with developing a framework that can help design ethical programs to address the unmet need for FP.

Keywords: Results-based financing, incentives, family planning, unmet need, ethical concerns, privacy and confidentiality.

Disclaimer: The findings, interpretations, and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

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PREFACE

This Discussion Paper is designed for task team leaders (TTLs) and teams working on RBF projects and FP programs to provide information and help foster discussions about the use of incentives for FP among the Bank colleagues, country counterparts, and other stakeholders. The aim is to help task teams that are considering FP incentives in RBF to identify issues to be analyzed during the design phase, the best way to monitor implementation to mitigate ethical problems, and to offer guidance on evaluations.

This paper was written in response to TTLs of RBF projects who asked for guidance about the use of incentives for family planning (FP), following partners' concerns at the country level in two countries; in one instance the issue was resolved with an agreement on an acceptable indicator, while in the other the Ministry of Health removed the FP indicator from the RBF scheme. The 2010 Reproductive Health Action Plan (RHAP) further committed the Bank to improving access to quality FP and other reproductive health (RH) services and recognized the potential of innovative approaches such as RBF to improve RH indicators. It also acknowledged that the use of FP incentives may affect decision making and warranted further attention.

SUMMARY

This discussion paper was developed to inform World Bank task team leaders (TTLs) and teams designing results-based financing (RBF) programs in the area of family planning (FP). A conceptual framework is proposed and issues are identified that need to be analyzed and justified during the design phase as well as monitored during RBF implementation. Eight key areas are highlighted to mitigate any ethical issues and unintended consequences. The paper also suggests areas of evaluation once incentives are introduced.

The Introduction discusses the FP process, which includes the decision-making process on whether to use or continue a particular method, based on informed choice. The focus is on addressing unmet FP needs, whether they are for couples, single women, or adolescents who do not want any (or more) children, or those who want to postpone or space childbirth but are not using FP. It also defines RBF and how it may address the status quo and can improve the use and provision of quality services, while recognizing risks and challenges in launching RBF for FP.

Chapter 1 describes the motivation to introduce incentives for FP from a classical economics perspective and provides information on supply- and demand-side barriers to utilization of FP services, which is at the core of decision making for FP in RBF. It explains how FP differs from curative medical care in that it is elective rather than a direct life-saving service; and while people want to treat or cure disease, women do not necessarily want to avoid pregnancy. Of those who do want to avoid pregnancies but do not use FP, their reasons are not necessarily economic or geographic or determined by information barriers. Based on data from 2006–11 demographic and health surveys (DHS), reasons include opposition to the principle of FP, fear of side effects and other negative health concerns, or infrequent sex. This highlights the need to assess FP barriers in a particular context. The chapter concludes that by combining insights from classical and behavioral economics, creative use of incentives can promote better communication with clients and improve their knowledge about FP to ensure their reasons for nonuse are based on an accurate perception of FP, which then leads to informed decision making.

Chapter 2 describes the evolution of incentives in vertical FP programs from the 1950s to early 1990s, noting the ethical concerns that were raised in such programs to help the reader understand why incentivizing FP requires specific attention in RBF, while also touching on the effects of the incentive programs described in the literature. Financial incentives were often given to providers and clients to facilitate decision making and increase utilization of FP, usually linked to long-term or permanent methods. The findings show an increase in FP use and — to a lesser degree — an increase in knowledge about methods as well as limited attention to the quality of services. The aggressive promotion of such programs (and their incentives) also raised ethical concerns about whether couples were offered appropriate choices to achieve their desired family size. This caused FP programs to stress informed choice, free from targets or quotas, and a move from a vertical FP program approach to one that is part of a comprehensive reproductive health program.

RBF programs after the 1990s were studied to understand the ways FP is currently incentivized. These RBF programs sought to mitigate some of the earlier effects, for example, FP is one of several incentive serviced and the amount of the incentive allocated to FP is relative to the other health services while with particular attention is paid to the quality of the services. Evidence from recent conditional cash transfers (CCTs) and voucher programs shows a significant increase in knowledge and use of FP, but less effect on the fertility rate. On the supply side, initial results are promising, but the evidence base of their effect is still limited. Results of impact evaluations for many World Bank–supported RBF programs are expected to become available in the coming years.

Chapter 3 examines ethical concerns related to FP incentives, which should be considered during the design, implementation, and evaluation of programs. The following eight issues are identified:

1. Intrusiveness and negative impacts on client autonomy: Though supply- or demand-side incentives may empower clients to make informed decisions, they may also intrude and negatively affect people’s choices or undermine autonomy. Incentives that alter the ways that risks and benefits of interventions are communicated or perceived need to be studied.
2. Decisions may not be fully informed and genuine: It cannot be assumed that the decisions are voluntary, and signatures on a consent form cannot guarantee that clients fully understand the information.
3. Provider and client values may not be respected: It is generally assumed that health care providers’ interests are linked to promoting awareness and use of FP methods. But providers may be biased or object to all or certain forms of FP for personal or religious reasons. Thus, providers may not offer full information or be biased, thus compromising the quality of the service. Clients may also struggle with conflicting values that require careful consideration.
4. A focus on the quantity of FP services may compromise quality: When incentives are used to increase the quantity of FP services, this may compromise their quality. Thus, appropriate standards must be ensured in any RBF program.
5. Possible negative effect on intrinsic motivation: Incentives may affect the motives of health care workers and clients. Some critics suggest that offering incentives for using FP services could subvert social values.
6. Differences in use due to structural biases: Equal access to services is highly desired and can be measured in relatively straightforward ways. Disparities in the use of services can be acceptable if they are the result of free choice and not an expression of structural conditions that work against specific groups, particularly when using RBF for FP.

7. Trust in the provider-client relationship may be affected: Both supply and demand incentives can change the trust placed in health workers, which is an essential element of the provider-client relationship. Thus, measures must be taken to ensure that negative impacts are minimized.

8. Privacy and confidentiality could be compromised: Planning, verifying, and evaluating FP in RBF programs can increase governments' involvement in peoples' lives, or be perceived as such. The sensitivity of FP-related data can make current and potential clients reluctant to share data that is intended to help design or implement the programs — this, in turn, affects their quality.

The last chapter ties together all previous chapters into a conceptual framework to help guide teams in the decision-making process for FP in RBF programs. It should be noted that we are concerned exclusively with developing a framework that can help design ethical programs to address the unmet need for FP. The framework is not prescriptive but rather supports self-assessments to identify if RBF for FP may be an appropriate strategy for a particular context and provides considerations for design, monitoring and evaluation of RBF for FP.

INTRODUCTION

BACKGROUND

In 2010, it was estimated that 287,000 women die annually worldwide from complications related to pregnancy and childbirth. A vast majority of these deaths could be prevented if women were provided with quality maternal health care and family planning (FP) services. Substantial evidence links FP with reducing maternal mortality by (a) reducing the risk of pregnancies, including those that are high risk; (b) promoting better spacing and timing of pregnancies; and (c) reducing the incidence of unsafe abortions.^{1,2} In addition, FP has also shown considerable benefits for child survival.

While most countries' fertility rates declined in recent decades, they remain high in several Sub-Saharan countries, where they are in excess of five children per woman and have shown little or no decline in the past five decades. The Guttmacher Institute estimates that across the developing world, 215 million women need FP services, the lack of which results in 53 million unintended pregnancies annually.³ According to a recent *Lancet* study, satisfying that unmet need could prevent more than 100,000 maternal deaths a year (a 29 percent reduction).⁴ The concept of unmet need adopted in this paper relates to couples, single women, or adolescents who do not want any (or more) children, or want to postpone or space childbirth but do not use any FP methods.⁵

Changing behavior in FP use

An investigation of FP programs in multiple settings and countries has shown that expanded provision of FP had an effect on fertility decline that ranges from 6 percent (in weak programs) to 32 percent (in strong programs) — typically showing a 10 to 25 percent net reduction in fertility.⁶ However, it is recognized that fertility decline and increases in FP use are not determined solely by access to quality FP services. Since the 1960s there have been extensive reviews and research looking into the determinants of fertility. Casterline (2010) discusses how the fertility decline in Latin American and Asian societies was largely due to the fulfillment of an existing demand for small families.⁷ However, the demand for children is high in most of the remaining high fertility countries (especially in Central and West Africa) as documented by the DHS data. FP use and fertility are also sensitive to changes in the following factors:

- *Mortality*: Improved child survival is perhaps the most powerful stimulant for fertility decline. In contrast, increased mortality due to the HIV pandemic is having minimal overall impact on rates of fertility and population growth.

- *Education*: Formal schooling is second only to mortality as a determinant of fertility.⁸ Research in developing countries shows an inverse relation between the amount of formal schooling and

1. J. DaVanzo et al. 2008.

2. J. T. Jensen, and L. Speroff 2000.

3. The Guttmacher Institute and the International Planned Parenthood Federation. 2010.

4. Saifuddin Ahmed et al. 2012

5. Cf: World Bank 2010..

6. Warren C. Robinson, and John A. Ross 2007.

7. J. B. Casterline 2010.

8. Luis Angeles, 2010.

fertility. In cross-sectional analyses, education indicators are often the strongest single correlates of fertility, both at the macro and micro levels.⁹

- *Income*: By contrast, income is a relatively weak predictor of fertility decline, net of mortality and education. Poor economic performance is not in itself an obstacle to fertility decline or decreased use in FP.

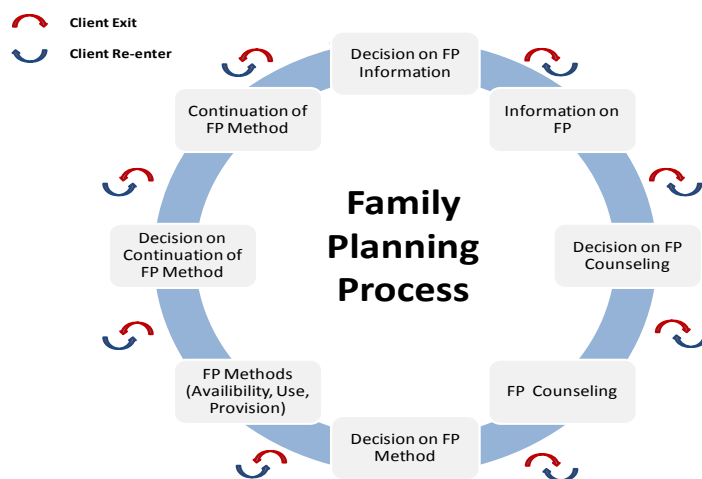
- *Age at first union*: In most high-fertility societies, the age of first union is young (less than age 20 on average). Several years' delay would have health and socioeconomic benefits and would contribute to fertility decline.

Change in these factors is not easily accomplished. Over the years a range of policy options for promoting fertility decline have been suggested, encompassing FP programs as well as human capital investment (health, schooling) and interventions that promote gender equity and empower women. This paper focuses mainly on FP programs and the possible use of incentives to address unmet need.

THE FP PROCESS AND UNMET NEEDS

FP programs involve interventions to expand information, counseling, availability, uptake, and continued use of all modern contraception.¹⁰ The FP process involves the following steps:

Figure 1. The Family Planning Process



Source: Authors

It is important to note that there are always two possible outcomes for each step of the process, since clients and providers choose whether or not to proceed with a given step. The desired

9. Susan H. Cochrane 1979; Teresa Castro Martín 1995; Shireen J. Jejeebhoy 1995.

10. Modern contraception includes temporary methods (condoms, vaginal applications, pills, and injections), long-lasting/semipermanent ones (implants and IUDs), and permanent ones (female and male sterilization).

outcome is the provision of quality FP services,¹¹ where clients' informed choice¹² is central. The ability to make informed choices increases people's control over their lives, encourages them to take more responsibility for their health, to have ownership of choices made, and can promote a trusting partnership between clients and providers.¹³

Demand and supply barriers can affect the FP process at any stage. They may be due to sociocultural, economic, gender-based, political and infrastructural obstacles, poor provision of services and supplies, and the quality of care. Often they are multidimensional and overlap (see annex 1, Table 1.A1 Barriers to FP).

Nonuse may have several causes that reflect different issues: (a) lack of knowledge and unformed opinions about FP methods; (b) barriers to FP such as cost, ease of access, including availability of FP method of choice, or false beliefs about health risks; and (c) cases where women have considered all relevant information about available FP methods and voluntarily decided against using any kind of FP method. The first two categories constitute unmet need, which may be addressed through RBF for FP on the supply and/or demand side, while the third one does not. As will be described in chapters 3 and 4, the key rationale of any supply- or demand-side RBF program should be to help clients decide for or against particular FP methods through noncoercive, free, and active choice.

FP IN RBF

Finding ways to address barriers and improve the provision and utilization of FP worldwide has been challenging. To this end, RBF has emerged as a promising strategy to strengthen use and provide quality health services, including FP. It is defined as “a cash payment or nonmonetary transfer made to a national or subnational government, manager, provider, payer, or consumer of health services after predefined results have been attained and verified. Payment is conditional on measurable actions being undertaken.”¹⁴ RBF programs reward the delivery and/or utilization of one or more health outputs or outcomes through financial incentives, when it is verified that the agreed results have occurred. These programs focus on health results (such as the number of couples receiving FP counseling or new users of modern methods), rather than inputs (such as the construction of health centers and training of staff); thus more tightly linking financing to results. This approach is supported in the Bank's 2007 Health, Nutrition, and Population (HNP) Strategy.

11. Quality FP service has six fundamental elements that clients see as critical for making informed choices. They are choice of methods, information given to users, technical competence, interpersonal relations, follow-up or continuity mechanisms, and an appropriate array of services.

12. “The process by which an individual arrives at a decision about health care” is an informed choice when it is “based upon access to, and full understanding of, all necessary information from the client's perspective,” according to one definition by EngenderHealth.

13. Population Reports 2001.

14. www.rbhealth.org.

CHAPTER 1: ECONOMICS OF FP INCENTIVES

SUMMARY

The basic economics of FP incentive payments is based on the belief that most individuals do what is best for their households most of the time and that they generally have complete authority over their goals. Despite consumers' knowledge of their personal situation, many women still do not use FP in circumstances when they wish to avoid pregnancy. The most common reasons for nonuse among these women are reasons related to opposition, fear of side effects, health concerns, or infrequent sex.

Based on insights from classical and behavioral economics, creative use of incentives could help promote better communication with clients to ensure their reasons for not using FP rest on accurate perceptions of what is involved in the different FP methods. Where reasons for nonuse are lack of access to or high costs of FP or that women are not fully informed about FP methods or sources, demand-side vouchers or supply-side subsidies may bring the cost of FP services and products to below the market price. Demand-side incentives for information sessions on the use of FP methods can help determine if opposition based on health concerns or side effects is genuine, rather than the result of poor information or communications. There is also empirical evidence demonstrating that demand-side incentives can assist in compliance with follow-up activities. Supply-side incentives can ensure that providers are offering a wider range and higher quality of both information and products.

The use of FP incentives has been promoted, given the success stories of RBF for health care in areas other than FP. However, caution is crucial because FP services differ from other health services: those who are ill always want to be cured, but fertile people do not always want to use FP. Thus, incentives designed to reduce disease are not generally viewed as being against clients' self-interest, but, in some cases, FP incentives might be seen in this way.

In this chapter a simple economic model shows how both supply and demand incentive payments can increase FP use (see p. 22). Incentives can be used to make the methods and information about them more available or incentives can focus on the actual quantity of FP services provided. This chapter compares the rationale for incentives in FP programs to those accepted in other areas of health care; while similarities exist, there are also important contrasts. We begin by exploring the perspective of classical economics, and later consider behavioral economics.

A classical economic perspective states that policy makers' motives to lower the price of FP services are based on the belief that market prices are not optimal for social well-being. Although the public might want lower prices in many areas, FP services merit publicly financed price reductions for various reasons: Unintentional pregnancies often stem from a planning failure to properly access and use FP services, and although families affected by unintended pregnancies bear most of the costs and potential negative health effects, there are effects on others as well. Outsiders may have altruistic concerns for the reproductive rights, health, and financial future of such families and may launch policies to reduce unintended pregnancies. They may also want to

reduce such pregnancies if they believe that population growth may harm the economy, environment, or international security.¹⁵

However, simply because it is possible to reduce FP prices below the market price — which may lead to increased use and reduced unintended pregnancies — it is not a sufficient reason for public funds to be earmarked for these subsidies. (Indeed, many worthy causes compete for limited public subsidies.) Thus, it is critical to demonstrate that the gains to public well-being from FP investments exceed what could be achieved from other useful expenditures.

Such health gains are easiest to identify in the form of preventing unintentional births. Assuming a maternal mortality ratio of 250 per 100,000 live births,¹⁶ preventing 400 unintended pregnancies in low- and middle-income countries could save one woman from a maternal-related death. Further, the monetary savings to the health sector from reducing the routine medical costs of unintended pregnancies and births, as well as maternal medical complications, have been shown to offset the costs of FP programs in models designed for India¹⁷ and Mexico.¹⁸ Such savings would accrue to whomever or whichever entity pays for the medical treatment of pregnancy and birth; in some cases patients pay out-of-pocket fees, while elsewhere the costs are assumed by the government or an insurance group.

These models indicate that reducing the unmet FP need has saved women's lives and money, even when FP programs' likely impact on saving infants and newborns by improving birth spacing is not included in the equation.¹⁹ A limitation of the cost-effectiveness models is that estimates of the cost of achieving an increase in FP use by currently unreached women assumes that scaling-up occurs by building and staffing more facilities; this assumption may not be relevant to incentive-based strategies. The efficiency with which incentive programs translate into increased use of FP services and reductions in unintended pregnancies will vary because their impact is heavily influenced by how well the programs target couples most at risk for unintended pregnancies.

One reason to intervene with incentives is as a response to a woman who says, "I do not want to be pregnant this year, and I am not using modern methods of family planning." We begin by likening this statement to one in which a woman says, "I do want my sickness cured, and I am not using modern methods of medical care." Both may reflect problems of information, but motives for not wanting to be pregnant and not using FP are far more complex than those for not wanting illness or not using medicine.

15. Because population growth's effect on the economy and the environment will affect everyone including those having children, these impacts are also internalized by families. Writers like Hardin and Ehrlich led a generation of thinkers to view population growth as a tragedy of the commons, Hardin's well-known essay likened families having babies to farmers grazing their sheep on public pastures called "commons." Writers from the 1960s missed a point that is now obvious to many — families prefer smaller size because they themselves would have to bear the health and financial burdens of large families. The commons will not take all the burdens away from parents. Fertility declines have been led by declines in how many children families themselves want. Declines in desired fertility are observed in both the absence and presence of coordinated and effective FP programs — which can and do accelerate the ability of families to achieve their goals.

16. M. C. Hogan et al. 2010.

17. S. J. Goldie et al. 2010.

18. D. Hu et al. 2007.

19 J. DaVanzo et al. 2008.

SIMILARITIES BETWEEN CURATIVE MEDICAL CARE AND FP

Medical and FP services are part of a process that combines drugs, supplies, and health professionals. The term “information asymmetry” describes situations where clients don’t have the information they need to determine which drugs and supplies are best for them and how to use them. While markets are widely held to be the best way to efficiently move products from suppliers to consumers, they perform poorly when there is information asymmetry.²⁰ Misinformed or uninformed consumers do not demand products as their fully informed counterparts do. Moreover, poorly motivated health workers will supply a mix of services that may only partly serve their clients, as they may be influenced by other concerns.

DIFFERENCES BETWEEN CURATIVE MEDICAL CARE AND FP

Curative medical care is often complicated and requires extensive information along with complex medical judgments to determine a diagnosis and to select and implement an appropriate treatment plan. In contrast, FP information can often be provided in a less costly setting, through counseling sessions staffed by well-trained health workers rather than by medical specialists. Another difference is that, as mentioned earlier, those who are ill want to become well, while not everyone wants to avoid pregnancies. Even for those who do, and do not use FP, their reasons differ from the reasons connected to nonuse of medical care, which often involve economic and geographical barriers or lack of information. Instead, they offer religious or personal reasons; married women’s decisions are often influenced by their spouses or extended families. It is unclear that incentive payments, price reductions, or encouragements (also called “nudges”) will be able to alter deeply held beliefs or powerful social forces driving the FP decisions. The extent to which incentive payments work will depend on the strength of these principled objections, which will vary contextually.

AN ECONOMIC MODEL OF INCENTIVES IN FP

Incentive payments to consumers and suppliers are generally blunt instruments to correct information deficits. The payments convey very little information about the value of the health outcomes derived from the medical care being sought. In economics, the optimal amount of health services a consumer ought to buy is individually specific and defined by the standard of what perfectly informed consumers would buy if they faced the true cost of products. In the traditional economic model, incentives may be used to try to reach the optimal target by subsidizing the cost of products and anticipating that the reaction of uninformed or misinformed consumers to the new lower prices will approximate the optimum.

Figure 2 illustrates how, in theory, incentive payments may solve information problems. It shows a consumer whose “true” perfectly informed demand is the upper dotted line labeled Demand_{True}, while the solid line labeled Demand_{Effective} represents the lower demand due to the consumer’s misinformation. Consumers may overestimate how compliant or successful they will be in using FP methods that require partners’ cooperation or proper timing. Or they may not

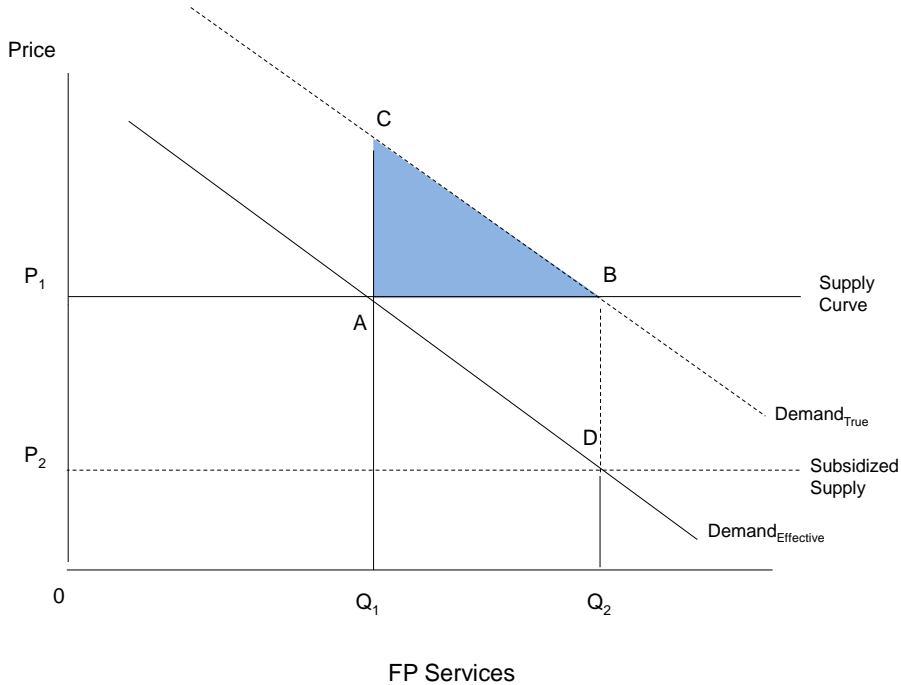
20. K. J. Arrow 1963.

realize they need more FP services (such as more counseling or more effective methods) to obtain the results they desire.

The upper, solid line showing the supply curve is drawn horizontally and reflects the unit cost to produce one episode of FP care. Having the supply curves slope upwards does not change the basic operation of this simple model, but adds unnecessary complexity. For now, we do not assume that suppliers suffer structural obstacles, which make their prices artificially high. Rather, we assume that the S_1 curve offering price P_1 is the best the suppliers can do in a free market. The supply curve intersects effective demand at point A, where the consumer demands quantity Q_1 . If the information problem were solved, the patient's true $Demand_{True}$ would intersect the supply curve at point B, and the patient would demand Q_2 . The best and cheapest way to spur consumers to want and pay for quantity Q_2 would be to somehow (magically) transport the patient onto her true demand curve. A second best solution is a subsidy that drops the price from P_1 to P_2 , so the patient observes the lower subsidized supply curve shown by the dotted line. In this case, the $Demand_{Effective}$ line would intersect supply at point D, thus achieving the optimal quantity demanded at point Q_2 . The reduced price will cost the public an amount equal to $(P_1 - P_2) \times Q_2$ and is likely to mean a greater expenditure than needed — offering discounted FP to women who would have purchased the product at the higher price, P_1 . Thus, Q_1 of these FP products would be unnecessarily discounted. Further, current users will receive a windfall of lower prices for products they would have bought anyway. However, careful targeting of incentive payments to those who would otherwise not buy them can help limit this risk. But, such targeting can be a costly operation, and the best approach depends on the local context.

Policy makers have supply-side and demand-side options to reduce the price to the lower one (P_2). Supply-side programs can lower the wholesale price of FP commodities by donating them or negotiating bulk purchases. At a more local level, retailers can be given price supports, or suppliers can be compensated for producing an output at a price below production costs. On the demand side, consumers can be offered a voucher or an instant rebate $(P_1 - P_2)$ for each unit purchased.

Figure 2. Simple Model of How Reducing the Price from P_1 to P_2 Can Bring Consumers from a Suboptimal Low Level of Demand (Q_1) to the Level They Would Display If They Were Fully Informed and Motivated



Source: Authors

Price subsidies that are used as incentives must be set at the right level. If the subsidy is too low, consumers buy too little; if it is too high, consumers buy too much. If subsidies are offered in locations where demand is already high, the price reductions are enjoyed mostly by current users.

Thus far, this model assumes that all consumers are identical. But, because they are not, it implies that even if an optimal subsidy were arranged for consumers that were exactly average, we would be offering too many incentives to consumers with above-average demand or offering too little to those with below-average demand. A solution — where average consumers move to Q_2 while many are induced to over- or underconsume the product — is not better than the original situation. Thus, proper targeting of reduced prices to market segments requires attention in design and calls for ongoing evaluations during and after implementation to see who is responding and by how much.

THE GAP BETWEEN EFFECTIVE AND TRUE DEMAND

Policy makers with the “magic” to move consumers to Demand_{True} at a social cost less than $(P_1 - P_2) \times Q_2$ could save taxpayers and donors money. The magic is more likely to work if it is targeted to the informational, emotional, and quasi-rational reasons that consumers give for not demanding their true amount in the first place. With an approach known as behavioral economics (which assumes people face cognitive and other challenges in rational decision making that are overlooked by classical economics), we could include encouragements to help consumers reconsider their “true” demand. Incentive projects include efforts to spur consumers to think about their FP choices (for example, rewarding attendance at a counseling session regardless of whether FP is adopted). However, it is important to note there is a big distinction between encouraging consumers to *use* FP or to merely *reconsider* the issue. Encouragements often lead to nonrational decision-making shortcuts that are part of human nature — such as copying the behavior of the crowd — but may produce decisions that differ from those in rational choice criteria. In a rational choice, one must assess how the benefits and costs of a choice apply to one’s own situation. Commercial marketers who deploy nudges are sometimes accused of manipulating consumers to gain profits, if their goal is to promote those products without having to satisfy a fundamental value. When one nudges a potential FP user to become informed about FP use, the appeal must be to their present or future informed and rational judgment.

Social marketing and demand-creation programs can be seen as attempts to supply neutral information, which helps consumers get on the demand curve that — if they were informed — they would want to be on. Under such conditions, this can be very cost-effective. However, in practice, social marketing has to deal with distinctions between informing, persuading, and, in the most extreme cases, deceiving: Informed consumers unambiguously move from a false and uninformed demand curve to one that fits their best interests; uninformed, yet “persuaded” consumers may not do what is best for them. Patients who are uninformed about medical options will still know facts about their personal situations that, their “persuader” may in fact not know; or, it is possible that the persuader considered all the facts, but whether the patient is better off for having been persuaded is ambiguous. The right balance between information and persuasion in social marketing depends on the social and cultural context. Information is generally safer than persuasion, but information alone may be sterile and insufficient to remedy irrational decision making.

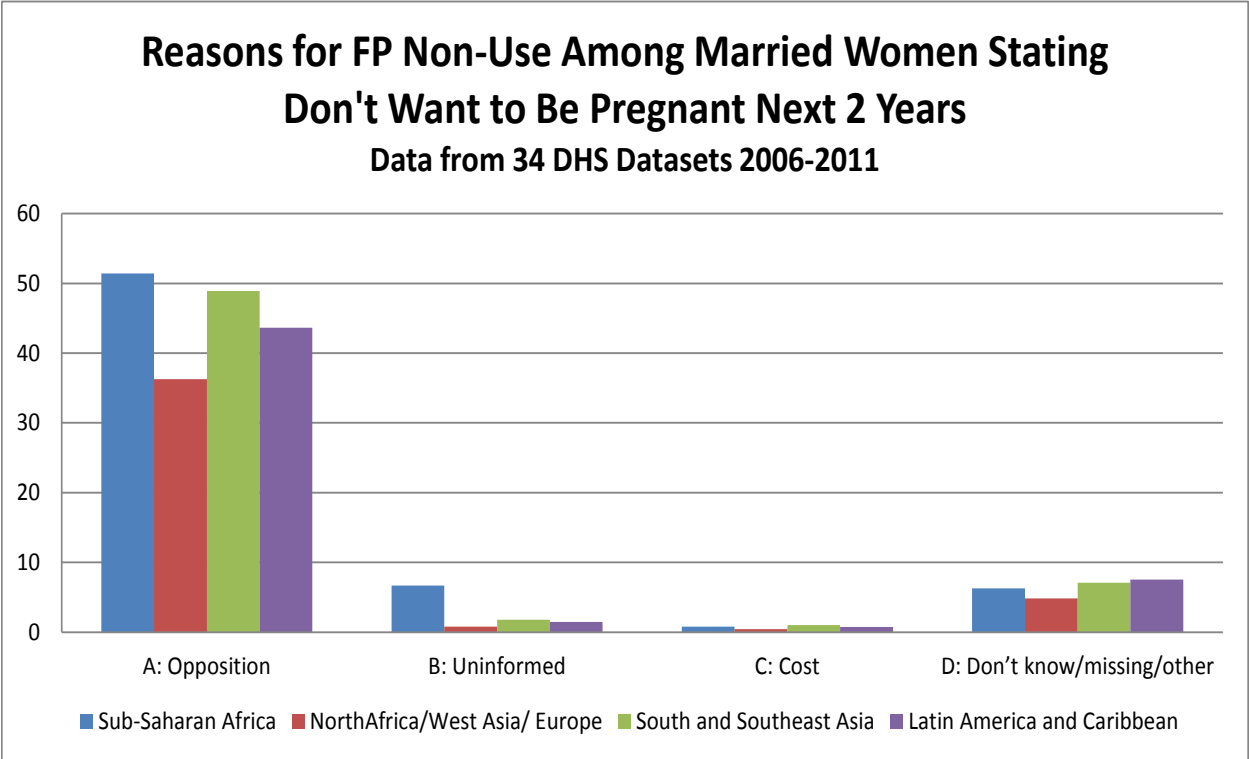
To determine why women’s effective demand is not aligned with their true demand, it is useful to ask those with unmet FP needs why they are not using such FP methods and products. Figure 2 summarizes data from 34 countries’ demographic and health surveys (DHS) from 2006 to 11 for reasons women cite for not using FP. With only 34 countries to study, it is impossible to represent any particular region. However, the surveys are nationally representative samples²¹ of women from 15 to 45 years of age that ask about women’s fertility intentions and whether they use modern FP methods. If they do not, but say they do not want to be pregnant in the next 24 months, they are asked to choose as many of the following reasons as apply:

21. The overall response rate in the 34 countries studied averaged 93 percent, and each survey was weighted to adjust for nonresponse.

Grouping of Reasons for FP Non-Use						
A	Opposition	Infrequent sex		B	Uninformed	Knows no method
		Respondent opposed			Knows no source	
		Spouse opposed		C	Cost	Lack of access
		Others opposed			Cost too much	
		Religious prohibition		D	Other	Other fertility related reasons
		Other opposition to use				Other method related
		Health concerns				Other
		Fear of side effects				DK
		Inconvenient to use				Missing
		Interfere with body				

Reasons for nonuse were grouped in the above categories to simplify the many disaggregated ones obtained by each country. Figure 4 provides a breakdown of category A, while the detailed list for each country is presented in annex 2.

Figure 3. Classification of Main Reasons for Not Using FP Methods in 34 Demographic and Health Surveys, from 2006 to 2012



Source: Demographic and Health Surveys for Sub-Saharan Africa: Benin 2006, DR Congo 2007, Ghana 2008, Kenya 2009, Liberia 2007, Madagascar 2009, Mali 2006, Namibia 2007, Niger 2006, Nigeria 2008, Rwanda 2008, Sao Tome and Principe 2009, Sierra Leone 2008, Uganda 2006, Zambia 2007.

For North Africa/West Asia/Europe: Albania 2009, Azerbaijan 2006, Egypt 2008, Jordan 2007 and 2009, Ukraine 2007.

For South and Southeast Asia: Bangladesh 2007, India 2006, Indonesia 2007, Maldives 2009, Nepal 2006, Pakistan 2007, Philippines 2008, Timor-Leste 2010.

For Latin America and the Caribbean: Bolivia 2008, Colombia 2010, Dominican Republic 2007, Guyana 2009, Haiti 2006.

The decision to include the category of “infrequent sex” as a type of opposition to FP was somewhat arbitrary. Nonuse because of infrequent sex does not necessarily mean a woman is opposed to FP. In some cases, infrequent sex is really abstinence, and nonuse of FP would be reasonable as there is no unmet need. However, the situation could change, and some women may not know they could become pregnant even with low coital frequency; these women would thus be more correctly listed as “uninformed.” We have done the analysis both ways, and note that infrequent sex was cited for not using FP about 6.7 percent of the time across the countries sampled, with a maximum of 14.4 percent in Rwanda and a minimum of 0.7 percent in Liberia.

Figure 4. Breakdown of Category A by Four Regions

	Infrequent sex	Health concerns	Fear of side effects	Inconvenient to use	Interfere with body	Respondent opposed	Spouse opposed	Others opposed	Religious prohibition	Other opposition to use
Sub-saharan Africa	6.0	7.3	12.7	0.8	2.6	11.4	6.0	0.3	4.1	0.0
North Africa/West Asia/Europe	8.1	10.5	7.0	0.6	0.6	5.6	2.9	0.2	0.9	0.0
South & Southeast Asia	7.6	8.7	8.1	0.6	1.2	13.5	5.1	0.2	3.1	0.9
Latin America & Caribbean	5.7	10.3	12.0	1.7	2.8	7.0	1.8	0.1	2.2	0.0

Source: Authors using DHS 2006-11

Category C included two reasons: “lack of access” and “costs too much.” This means that women who responded this would benefit from supply- or demand-side incentives. However, it is striking that not even in one of the thirty-four countries, did over 3 percent of respondents cite category C as the reason for nonuse. However, this is not a new finding: Guttmacher Institute researchers studying DHS surveys in the six years before the period under examination also documented relatively low frequencies of women citing cost and access constraints.²² Still, it is important to note that since 2000, the question has been worded in a way that allows respondents to select multiple reasons for nonuse.²³ Earlier investigators noted a trend toward increased though infrequent mention of the cost barrier between DHS surveys in the late 1980s and those in the early 2000s. At the same time, the data do not indicate whether many women who face cost and access barriers are the same women who have social and health reasons for not using FP. And, it may have never occurred to these women that they faced cost and access barriers because they never bothered to find out. The degree of overlap between lack of interest and lack of information about barriers is an important question for future research.

22. G. Sedgh et al. 2007.

23. The DHS question is fielded as open ended: “You have said that you do not want any (more) children, but you are not using any method to avoid pregnancy. Can you tell me why? ... Any other reason?” The field worker is instructed to interpret and check the code that corresponds to the response. Multiple responses are allowed since the year 2000.

With regard to category B, it is clear that being uninformed about FP methods can mean that no methods are available — in this case, demand-side incentives would be pointless — while supply-side ones may be effective. However, ignorance of methods may also be the reason given in cases where methods are, in fact, available, but women are unaware of them. As annex 2 shows, conditions vary across countries, with more than 10 percent of women in Liberia, Niger, and Sierra Leone citing lack of knowledge as a reason for nonuse, but only between 0 and 1 percent cite this reason in 17 other countries. As for category A, where health concerns, fear of side effects, ease of use, and interference with the body are the main reasons, it is important to determine if respondents had received thorough clinical information about FP methods and products. In some cases, health concerns (blood clots, migraines) could be valid reasons for nonuse. But they could also reflect a lack of accurate information. The best approach to women who say they have “health concerns” about FP is to offer excellent, unbiased information about the products’ effects and ensure that the information is understood.

Demand-side incentives may have a crucial role in this regard, and RBF programs could aim to inform clients about FP health issues and find metrics to establish that clients have indeed become informed about FP methods. Figure 3 also shows that “respondent opposition” frequently ranks in the top two reasons. The data are silent on the strength of the opposition, but incentives might lead some to reexamine their negative positions. The key point about category A reasons is that they can be independent of financial barriers; other issues must be addressed to move respondents to the point on the demand curve they would find appropriate if they were fully informed.

While the current price-reducing policies appear to have lowered the cost barrier, there are still many women who do not use FP although they do not want to get pregnant. Thus, much could be done to address women’s health concerns — both by personalized counseling and through a better mix of methods attuned to, for example, the personal or religious reasons that restrain them. Indeed, the real reasons for nonuse must be assessed and addressed in each given context. Incentive payments and subsidies targeting the prices of products alone will not be sufficient, but must be part of a more comprehensive strategy that considers both local and individual concerns.

As long as supply and demand factors keep the market from realizing the optimal quantity, Q_2 that would occur on the true demand curve (see figure 1), there is a problem to be solved. Women have personal and other concerns, which might make effective demand less than true demand. Lack of information is a classical reason for failure to optimize, but recent challenges to classical economics — through behavioral economics — hold that an agent’s capacity for rational behavior is often overestimated. Thus, the availability of information is a necessary but insufficient condition for people’s use of FP methods: People do not always use information that is in their interest for personal or social reasons — as is apparent in the DHS reports of nonuse — because of others’ opposition (although the classical economic view assumes that people are self-interested, rational agents who generally can identify the means needed to achieve their goals and act accordingly).

By contrast, behavioral economics suggests that other mechanisms are involved in people’s decision making. A series of empirical studies found that people often focus on tangible rewards in the present or near future at the expense of those that are less certain or likely to materialize

later. These observations have led to the concept of present preference bias and can explain different kinds of decision fatigue, inertia, and procrastination.^{24,25} Behavioral economics researchers have begun to design studies that incorporate the underlying mechanisms — by providing immediate feedback and rewards for behavior change — using incentives including fixed sum discounts, cash rewards, or lotteries in areas such as following medication regimes, stopping smoking, losing weight, and managing substance abuse.^{26,27,28,29,30,31,32,33} In the present context, procrastination, awkwardness around the topic of reproductive health, or conservative social conventions may restrain women who would like to know more about FP from seeking and using such information (whether available through their health care providers or elsewhere).

Demand-side incentives for using information or attending individual or group counseling sessions are no magic bullet but may energize some women who would otherwise not use available information.

Incentives may also be effective for following through with FP checkups (as required for IUDs or injectables), another area where procrastination and decision fatigue has been documented, demonstrating the difference between the approaches of classical economics and behavioral economics. For classical economists, women who have voluntarily decided to use IUDs are rational agents who typically know that follow-up visits are useful and necessary. Yet, not all women behave in their own best interest, confirming the core assumption underlying behavioral economics. Incentives can bring future benefits into the present, as demonstrated by a study conducted in India, which showed higher rates of follow-up visits for IUDs among women who received incentives to make a follow-up visit.³⁴ Another study in Egypt found supply-side incentives increased the likelihood of providers asking clients about a follow-up FP visit.³⁵ Similar arguments can also be made for offering incentives for other FP methods, where clients may prefer them but are not sufficiently motivated to obtain them.

SUPPLY-SIDE FACTORS

The analysis of the reasons given for nonuse of FP helps explain what may keep effective demand from being as high as true demand, but does not address whether there are structural impediments to the supply of FP services. If the latter is true, incentive payments can address issues that restrict supply. If the private market price (P_1 in figure 2) is thought to be too high, it

24. D. Laibson 1997.

25. S. Frederick, G. Loewenstein, and T. O'Donoghue 2002.

26. K. G. Volpp and L. K. John et al 2008.

27. K. G. Volpp and G. Loewenstein et al. 2008.

28. K. G. Volpp et al. 2006.

29. K. G. Volpp et al. 2009

30. J. P. Lussier et al. 2006.

31. A. Giuffrida, and D. J. Torgerson 1997.

32. M. L. Burr et al. 2007.

33. V. Paul-Ebhohimhen, and A. Avenell 2008.

34. J. R. Stevens, and C. M. Stevens 1992.

35. D. Huntington et al. 2009.

is necessary to examine which scarce input factors are raising the price — that is, FP services are produced with labor and supplies that have other potential uses and have an opportunity cost that must be recovered. And, it is possible that scarce human resources and the need to import scarce FP commodities may impede the entry of suppliers into this market. Other barriers include the need for health workers to acquire training to insert IUDs, perform surgical sterilizations, and provide some of the long-acting hormonal methods. It is unclear that incentive payments to consumers and suppliers of services are the obvious solution to scarcity when the human resource obstacles could be addressed through training and human resources policies. Clearing bottlenecks in the supply of human resources and commodities used for FP can be done to help both the public and private sector. Examples exist where a subsidized government FP service affected the private market for family planning.³⁶

36. M. Lewis, and G. Kinney 1988.

CHAPTER 2: EXPERIENCES OF COUNTRIES WITH FP AND INCENTIVES

SUMMARY

In the pre-1990s, policy makers in developing countries concerned with high birth rates and population growth, implemented target-based, vertical FP programs. The programs included incentives for providing FP in line with the targets and for adoption of FP as well as disincentives for having large families. The evidence shows an increase in FP use and, to a lesser extent, increase in knowledge about FP methods. There was limited attention to the quality of services or the availability of a wide range of FP methods; instead, the emphasis was on long-term (IUDs) and permanent (male/female sterilization) methods. Supply-side incentives were mostly financial, while those on the demand side were financial or in-kind. Some of the incentives were considered unethical in their approach, and faced strong opposition from human rights and women's health advocates as well as from proponents of voluntary FP. The International Conference on Population and Development (ICPD) in Cairo, which followed soon after in 1994, called on countries to enforce a voluntary FP program, free from targets or quotas, focusing on informed choice and a client-centered approach.

FP in most current RBF programs is part of a range of incentivized health services whereby the size of incentives for these services is provided with the aim of preventing unintended consequences. The RBF programs intend to increase the use of services (including FP) and address the conditions that hamper or promote quality services. They also aim to foster choice by ensuring the continuous availability of a wide range of FP methods (including temporary, long term, and hormonal ones). CCT and voucher programs since the 1990s show a significant increase in knowledge and use of FP methods, which may have positively affected birth spacing but not necessarily led to fertility decline. This could mean that clients made informed choices about not using FP, but this conclusion needs to be substantiated through further study. On the supply side, early results on FP use are promising, but the evidence base of the effect is still limited. Impact evaluation results for many Bank-implemented RBF programs will be available in the coming years and should offer more information about these results. Further research is also needed on users' views and preferences when FP incentives are applied.

In the 1950s and 1960s, policy makers in many developing countries were concerned that high birth rates and continued population growth would impede economic development, threaten food supplies, and deplete natural resources — problems that would also negatively affect women's and children's health and increase poverty.^{37,38} Based on this demographic rationale, vertical FP programs driven by targets were implemented to help lower fertility rates and population growth.³⁹ Despite these significant investments, the programs did not attract many users, and changes in fertility were limited. The programs were poorly designed, with inadequate attention to quality and ineffective implementation.⁴⁰ Targets were given to providers to attract new FP

37. N. Birdsall et al. 2001.

38. United Nations Population Policies 2007.

39. International Family Planning Programs 2010.

40. J. Bongaarts, and D. Sinding. 2009

users, as well as cash or in-kind incentives to both providers and clients based on the notion that financial incentives could change FP decisions.

Various disincentives were also created, such as rationing government accommodations or promotions for public sector employees with large families. The incentives and disincentives were to address what the countries considered "...the perceived lack of demand for smaller families."⁴¹ Human rights groups and women's health advocates criticized the emphasis on targets and demographic goals and were concerned that incentives would unduly interfere with women's right to autonomy on decisions about child bearing and contraception.⁴² Such policies were considered shortcuts to population control and seen as violating human rights. Development partners were also criticized for their aggressive promotion of FP in the 1980s, and accused of pushing the Western agenda of limiting population rather than addressing the needs of local women.⁴³

As a result, countries and development partners became sensitive to the issues, resulting in several changes in FP policies and programs. The landmark International Conference on Population and Development (1994) in Cairo endorsed a broader concept of reproductive health (RH), which included FP as part of a wider package of services. It also called on countries to promote a voluntary FP program free from targets or quotas with a client-centered approach. Most major international donors developed policies that involved voluntary approaches and incentives that could lead to the acceptance of FP (see annex 3, International Action on Family Planning and Choice); the US government created the Tiahrt Amendment in 1998. After the 1994 ICPD, programs moved from targets linked to reduced fertility rates to those integrating FP as part of broader RH and reproductive rights concerns.

This chapter describes the progression of incentives linked to FP, including ethical concerns as well as the effect of the incentives on program results as evidenced in the literature.

METHODOLOGY

To better understand the evolution of the use of incentives in FP programs over time, the following methods were adopted.

First, pre-1990s published and grey literature on FP programs in low-income countries was reviewed to identify the types of incentives used and the rationale behind them, and any ethical concerns that they may engender. Studies on users' views and preferences about incentives were also reviewed, but are limited. Most of the studies focused on user views regarding permanent FP methods (see table 3.A4 in annex 4). The strength of this evidence is debatable for various methodological reasons including the quality of design and analysis, and the veracity of clients' answers.

Second, post-1990 RBF programs were examined to understand the ways FP is incentivized in current programs. In particular, the review focused on different RBF recipients, the indicators

41. Ibid.

42. International Family Planning Programs: Criticisms and Responses 2010.

43. S. Rozario 1999.

used for offering the FP incentives, their integration in a wider health service package, and existing quality assurance mechanisms. (See annex 6 for specific country examples). The methodology used was not systematic, but opportunistic, aiming to highlight the various incentive approaches being supported.

Last, a systematic literature review was conducted to gather evidence on the effects of FP incentives on outputs and health outcomes at the microlevel.⁴⁴ The search included the following words in the title and abstract: (incentive, bonus, reward, payment, transfer) + (family planning) + (low- and middle-income countries).⁴⁵ Each of the three concepts was tested with different medical subject headings (MeSH) terms and words.⁴⁶ Peer-reviewed journal articles published from January 1960 to March 2012 were searched through PubMed, Medline, Cochrane Collaboration, and Embase databases. Additional searches in the grey literature and journals also offered relevant studies. The screening process resulted in 68 documents.

A second screening was performed, based on two criteria (i) accurate assessment of effectiveness, efficacy, or impact and strength of the evidence; and, (ii) strength of study design, whereby only case-control type of studies and quasi-experimental studies were selected. This resulted in removing descriptive studies and weak study designs. Thus, 21 studies were ultimately selected for the review: 16 were on demand-side incentives, 5 covered provider payments, 9 were on FP and incentive programs started before 1990, and 12 were RBF programs launched after the 1990s. The review focused on the outputs (the effects on contraceptive use and/or increase in knowledge) and outcomes (the impact on health, fertility, or demography). The study designs ranged from case/control to quasi-experimental or experimental and before/after analysis with or without control groups. See annex 4 for details on the study results.

INCENTIVES IN FP PROGRAMS (PRE-1990)

On the supply side, incentives in FP programs before 1990 were often financial payments; on the demand side, they were in the form of food (in Ghana, powdered milk to females who accepted FP services), clothing (in Bangladesh, *saris* and *lungis* for males and females who agreed to be sterilized), or jobs (in India). Decisions on the details (who would receive them, how much, when, and under which payment schemes) were largely based on local conjecture and opportunistic choice, rarely following a diagnosis of health care supply/demand and local barriers.⁴⁷

Supply-side programs were initiated in Bangladesh, India, Korea, Nepal, Pakistan, Philippines, Sri Lanka, and Taiwan whereby providers were paid for female and male sterilizations as well as for providing IUDs.⁴⁸ In Peru and Egypt, incentives were also offered to IUD providers and

44. At macrolevel there is a general consensus between demographers and social scientists that family planning and socioeconomic factors have joint interactions on fertility decline, though no study specifically assesses incentive-based policies.

45. A preliminary search indicated that adding effects-related search terms was ineffective.

46. For the first one, a generic MeSH term “motivation” was used to gather the largest number of studies. For family planning, the MeSH term Family Planning Services was used. Low- and middle-income countries (LMICs) were assessed using the Developing Countries MeSH term.

47. Henry P. David 1982.

48. Payment for IUD provision was not included in the Sri Lanka and India programs.

those who distributed oral contraceptives.⁴⁹ Further, those who referred clients were given financial payments when accompanying or referring clients to the FP clinic. Four studies were identified (Indonesia, Ghana, Philippines, Taiwan) about such programs in which the evidence showed an increase in acceptance and use of FP.

On the demand side, many governments provided client incentives to increase demand for specific types of FP (for male and female sterilizations in India, Sri Lanka, Pakistan, Bangladesh, Korea, and Nepal; and also for women using IUDs in Bangladesh and India). The payments were often given as compensation for transportation costs or loss of time from work so the poor could access these services (Pakistan and Kenya).⁵⁰ In the 1960s in Taiwan and Korea, women were given vouchers to obtain IUDs for free or at a 50 percent discount price.⁵¹ Thailand piloted a program, which provided better access to agricultural loans for villagers with continued FP use.⁵² In other types of schemes, incentives were delayed or provided over a longer period of time, like the pilot in India in the 1970s by tea-plantation employers: the tea estates deposited a certain number of rupees for each month a woman was not pregnant into a savings account, which could be accessed upon retirement. Results showed a downward trend in birth rates and an increase in FP practice.⁵³ The Chinese “one-child policy” also provided payments or benefits (related to maternity leave, housing allowances, school subsidies, future pensions) to couples who adhered to the policy.

Four studies were identified in which financial (in Thailand, Taiwan, India) or in-kind incentives (in Ghana) were provided to those who accepted specific long-term or permanent FP methods. All studies found increased use of FP methods (two studies showed reduced birth rates) while two showed clients also had greater knowledge about FP methods.

In the 1980s and 1990s, a few pilot schemes sought to mitigate ethical concerns about payments for permanent FP methods by providing incentives to rural women for using the FP method of their choice or for attending FP information sessions. An example is the Ammanpettai Family Welfare Program (in Tamil Nadu, India), which gave women a small payment to attend such sessions in the clinic and then a monthly incentive when accepting and continuing the use of FP methods of their choice (including temporary methods) from a field-based motivator. The program attracted up to 70 percent of eligible women in the area who agreed to try the method of their choice. There was an increase in use of temporary FP methods from 3.2 percent at baseline to 24.0 percent in the treatment villages. Control villages showed use rates of 5 percent and 6 percent, respectively. The percentage increase in male sterilization was 24 percent in the control villages and 27 percent in the program villages, while female sterilization percentage increase was 13 percent and 23 percent, respectively, in the control and program villages. The program was later expanded to other Indian districts and cities.⁵⁴

49. John A. Ross, and Stephen L. Isaacs 1988.

50. USAID 2010.

51. G. Cernada, and L. P. Chow 1969.

52. A village loan fund was used to provide access to agricultural loans to villagers who accepted FP on a graduated scale. The fund grew in size with the increase in contraceptive prevalence rate. The dividends from this program were also paid to those agreeing to use FP on a sliding scale based on the effectiveness of the FP method determined by the CPR (Weeden, et al. 1986)

53. R. G. Ridker 1980.

54. J. R. Stevens, and C. M. Stevens 1992.

Many interventions combined both demand- and supply-side incentives. The vast majority of sterilization programs in Asia offered both client and provider payments. The Bangladesh sterilization program and Indian vasectomy program in Kerala and Tamil Nadu gave incentives to health personnel, those accepting the procedures, and community recruiters (called “canvassers”).⁵⁵ One study found that the contraceptive prevalence rate (CPR) in Bangladesh exceeded 54 percent in the mid-1990s due to this program while a study in Tamil Nadu, India, found that 55 to 63 percent of married women were sterilized and that female sterilization was the method of choice among those accepting FP. In Ghana, clients were given powdered milk for accepting various FP methods, and providers were also given the same incentive for every woman referred to the clinic. Acceptance rose overall and the addition of the provider incentive was associated with a five-fold increase.

ETHICAL CONCERNS WITH INCENTIVES IN FP BEFORE 1990

The aggressive promotion of FP in developing countries in the 1970s and 1980s, as described above, raised concerns about whether the incentives reduced a couple’s ability to exercise choice in achieving their desired family size.⁵⁶ Moreover, the studies summarized here represent only some of the programs that have, in fact, been implemented. It is therefore also necessary to draw on what we know about the effects of programs that have been implemented on a more ad hoc basis.

In Bangladesh, human rights abuses were identified in the implementation of target-driven FP programs — where food aid was withheld from poor women unless they were sterilized. A pamphlet by Hartmann and Standing in 1989, “Food, Saris and Sterilization: Population Control in Bangladesh,” created considerable debate on the ethics of such incentives for FP. This pressured the government to be more restrained in its sterilization drive. In addition, several countries withdrew support from the country’s National Population Program and entered into separate agreements with the government in which they supported maternal and child health (MCH) activities, particularly through the private nonprofit sector, but refrained from further support for sterilizations.⁵⁷

The Indonesian program also set targets for IUD and pills uptake for all levels of workers and held community groups responsible for ensuring the targets were met.⁵⁸ The military directly supported the government’s FP program; so if targets were not met, they pressured the communities. As one FP fieldworker noted, “If the target is still high and has not yet been reached, and the people are difficult to reach, the army makes them a little bit afraid so that they are willing to come together for a family planning session.”⁵⁹ Such targets were not accompanied by a financial incentive. However, since little was invested in training health workers and for monitoring and supervision, the targets negatively affected the quality of services (for example, lack of counseling and follow-up) and the full range of choices was often not made available to clients.

55. J. Cleland, and P. W. Mauldin 1991.

56. S. Rozario 1999.

57. B. Hartman, and H. Standing 1989.

58 T. Hull, and V. Hull 1997.

59. Quoted in Hull and Hull 1997, p. 395.

In the late 1960s in India, the rapid pace of population growth led to draconian targets being set for population control — to reduce the birth rate from 41 per 1,000 to 20 to 25 per 1,000 by the mid-1970s.⁶⁰ Targets for the number of new contraceptive acceptors by method (sterilization, IUD, condoms) were calculated and allocated to all districts in the country. Field workers and recruiters as well as the facility-based service providers were responsible for achieving these targets, which were contraceptive-specific and provider-specific quotas. Financial incentives were offered to clients who agreed to be sterilized. Cases of government-enforced sterilization began to surface, resulting in a huge backlash against the FP program and a government change, which subsequently caused the government to revise its approach.⁶¹

Although the central government in India removed these targets, several state governments persisted with this approach. For example, the state of Andhra Pradesh set quotas for the number of sterilizations and used incentives to persuade women to agree. In one district, women were offered gold chains, steel pans, and other goods when the sterilization numbers fell short of the quota.^{62,63} Most of the women were poor and illiterate. Those who were sterilized after having their first or second child moved to the front of the line for loans, housing, and other government assistance. By the mid-1990s, the number of women who were sterilized rose from 500,000 to 800,000 over a period of five years. Not surprisingly, the state's population growth fell faster than any other's. A 2002 study found that one-fourth of those accepting the procedure would not have done so without incentives: About 83 percent of the acceptors reported that higher incentives should be given to couples who adopt the methods with only one or two daughters; 10 percent said they adopted the methods because they feared losing government benefits.⁶⁴

China has the second highest sterilization rate and the highest rate of IUD users; about 90 percent of those using contraceptives depended on these two methods in 1988. The one-child policy, which forbids couples in both rural and urban areas⁶⁵ from having more than one child was introduced in China in 1979 in response to government's fears of escalating population growth. Parents with multiple children were denied certain benefits, including bonuses at their workplace. Many studies documented the impact of this policy on fertility decline, enhanced socioeconomic development, and fertility change in China.⁶⁶ However, the policy has been controversial both within and outside China because of concerns about negative social consequences and the manner in which it has been implemented: Couples with more than one child faced heavy "social compensation fees" — up to ten times the annual household income in China. Other penalties included loss of employment or some health care coverage and educational opportunities for their children, imprisonment, forced abortion, and legally mandated

60. P. J. Donaldson 2002.

61. US Library of Congress 2010.

62. *New York Times*, June 2001.

63. Jim Yardley 2010.

64. A three-district survey study in Andhra Pradesh during 2002 conducted by the Population Research Centre, Vishakhapatnam, and sponsored by the National Commission on Population, interviewed 683 acceptors of sterilization and asked whether they would have accepted sterilization in the absence of incentives.

65. Exemptions are given to ethnic minorities (such as the Uighurs and the Tibetans) or in cases in which the father is a disabled serviceman or when both parents are single children or to parents who have severely disabled or deceased children. Following the 2008 Sichuan earthquake, a new exception to the regulations was announced for parents who had lost children in the earthquake.

66. Q. Yang 1993.

sterilization. It should be noted that China has 56 percent of global female suicides, many of which have been attributed to the one-child policy.⁶⁷ The program is said to vary depending on the location⁶⁸ and has been criticized for pressuring women to use specific methods, mostly IUDs and sterilization, often without adequate counseling.⁶⁹ Other studies suggest that in China, when women have no strong preferences for a method and information services are lacking, it is mainly the provider who influences contraceptive choices.^{70,71}

Seven studies on user perspectives were reviewed, (see annex 5, Table on Users' Perspective), which assessed ethical issues through post-acceptance user surveys. The focus of their analysis was to assess whether users cited the financial benefit as the salient reason for using FP methods. Most of the studies reviewed focused on using demand-side incentives for permanent methods. The studies show mixed evidence between monetary compensation for FP and coercion, according to the users' perspectives. The strength of this evidence base is debatable for various methodological reasons —such as the quality of design and analysis and the veracity of client answers. Despite these limitations, evidence seems to indicate that financial compensation is not the main impetus in immediate decision making for permanent contraceptive methods.

THE USE OF FP INCENTIVES IN RBF PROJECTS SINCE 1990

Incentives have been incorporated into vertically implemented, standalone FP programs since the 1960s.⁷² Some programs still continue to pay only for FP interventions, as in India where payments are made to those accepting long-acting FP methods (for example, \$11 for tubal ligation and \$20 for a vasectomy in high focus states). By the end of the 1990s, the use of payments for specific FP methods shifted in many countries as a result of (a) a move to integrated service delivery packages; (b) ethical concerns raised in connection with earlier FP incentive programs; and (c) the creation of output-based programs in health care (so-called results based financing — RBF). (See the table of RBF programs in annex 6).

On the demand-side, RBF programs may involve conditional cash transfers (CCTs) or vouchers. With CCTs, a monthly income transfer to poor households is made to alleviate poverty while the conditionality focuses on improving health and education.⁷³ Such programs have been implemented in many Latin American countries, where transfers to households may be conditioned on attending health education talks, which include information on FP. CCTs have generally led to substantial reductions in consumption poverty; particularly when transfers were large, they substantially increased the use of health and education services, especially among the poor households. In general, CCTs have had mixed success in improving final outcomes in education and health, due to the need to improve the supply of services, both in terms of physical access as well as quality.⁷⁴ Country studies (in Mexico, Brazil and Nicaragua) and one multicountry study (of Honduras, Mexico, and Nicaragua) on CCTs were identified that focused

67. A. D. Joseph 2004.

68. Joan Kaufman et al. 1989.

69. John Aird 1985.

70. Joan Kaufman et al. 1989.

71. Ibid.

72. K. B. Santhya 2003.

73. A. Fiszbein, and N. Schady 2009.

74. L. Rawlings. 2012.

on the effect on FP. The multicountry study showed mixed results on fertility and FP use; in Mexico and Nicaragua, contraceptive use increased, but there was no change in fertility; while in Honduras, fertility increased as did the numbers of those getting married (among recipients of the CCTs). Two studies in Mexico also showed an increase in FP use and clients' improved knowledge, while a third study showed a significant increase in FP use in the treatment area in the first two years and thereafter, very little difference between the treatment and control areas in FP use. A study in Nicaragua found an increase in birth spacing with a consequent decrease in risks during delivery. The size of the effects varied across the studies (see annex 4). The study on the Bolsa Familia Program in Brazil showed no effect on fertility.

Where vouchers are used, they are provided to clients at highly subsidized rates to obtain certain services with providers, often including private health facilities, which are paid for providing them. For example, in Pakistan and Kenya voucher holders receive free counseling and modern temporary and long-acting FP, while providers are reimbursed for the service rendered for each voucher presented at the clinic. In Pakistan, vouchers are provided to cover transportation costs to FP facilities. For quality assurance, providers must be accredited to enroll in the program and obtain satisfactory client reviews. No link exists between the amount paid and the (perceived) quality of services. A review by Bellows et al. (2011)⁷⁵ of such programs for reproductive health revealed that vouchers can increase the use of available services and reduce the burden of cost-sharing. Five studies (two in Kenya, two in Nicaragua, and one in Pakistan) explored the effect of vouchers on FP use. In Nicaragua both studies showed an increase in knowledge of FP methods and an increase in FP use, especially among sexually active girls who were neither pregnant nor married. The Pakistan study showed an increase in FP and reproductive health (RH) services: 79 percent of the voucher holders returned to the clinic for postnatal FP counseling — 25 percent chose not to adopt FP methods while the rest mainly chose long-acting methods and injectables. Both Kenya studies showed high knowledge of FP methods while the use of FP services was lower than anticipated and much lower than the use of “safe motherhood” vouchers. However, those who had longer exposure to the program had a higher rate of FP use.⁷⁶ The main reasons offered for these results are poor marketing and distribution strategies, a limited mix of FP methods offered (female sterilization, IUD, and implants only),⁷⁷ fear of perceived side effects, and low quality of services including low quality of contraceptives. In Pakistan, where the mix of FP methods was larger and involved well-performing private services, the evaluation showed higher adherence (79 percent of voucher users attended postpartum counseling, with 75 percent of them deciding to adopt FP methods,⁷⁸), although the clients were responsible for meeting some out-of-pocket fees.

In RBF supply-side programs, providers (either NGOs or public/private health facilities) are contracted and paid based on the number of services provided or the coverage rate — including FP. For example in Afghanistan, the government contracts NGOs to run all health facilities in a province and provide health services, including FP. Incentives are given to both the NGO and each facility based on indicator performance. Of the NGO's performance payment, 20 percent (which is up to 10 percent of the total contract value) is earmarked for CPR, and 33 percent is

75. N. M. Bellows, et al. 2011.

76. Half receivers did not take benefit/use FP vouchers.

77. The scheme was limited to female sterilization, IUDs, and implants.

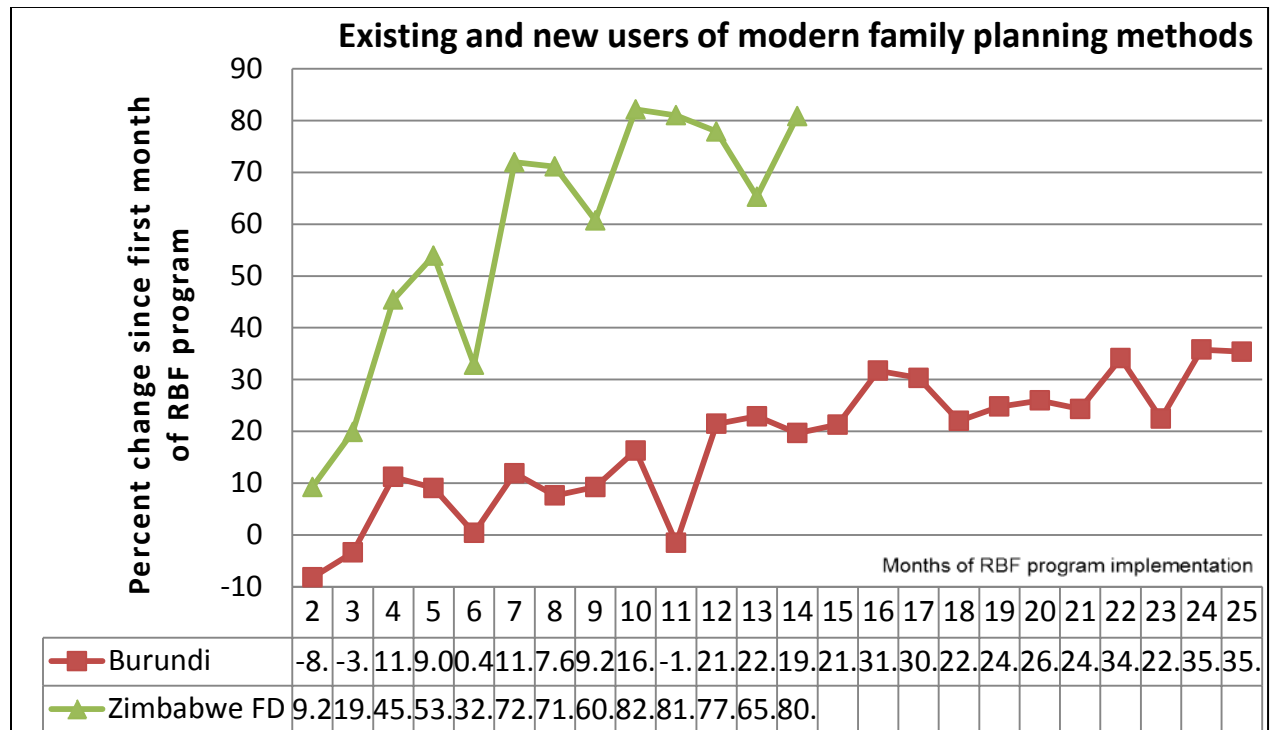
78 H. Bashir et al. 2010.

paid for each percentage point increase a year. Their facilities are also paid based on the FP coverage attained, with their performance payments discounted by the quality of care. The latter is scored using a National Monitoring Checklist, which includes the availability of FP supplies, such as condoms, oral and injectable contraceptives, and IUDs in the facility throughout the last month.

In many Performance-Based Financing (PBF) schemes in Sub-Saharan Africa, public and private health facilities and health authorities are “contracted,”⁷⁹ based on their performance; subsequently, they allot part of these performance payments to their health workers. Performance payments to the facilities are determined by the “quantity” (based on a predetermined unit fee) for a range of health indicators (between 9 to 24), often with adjustments involving equity considerations. The indicators include FP at health center level, such as new or existing users of temporary and long-acting FP methods, tubal ligations, and vasectomies at hospital level. A weighting exercise determines how much subsidy to pay for each service. This is often linked to a signal of importance of the service and the effort made rather than its actual cost. In addition, the “quantity” payment is often linked to “quality” of care, which includes FP aspects such as (a) privacy in the FP counseling room; (b) consultations with qualified personnel; (c) availability of FP methods; (d) availability of wall posters or images to demonstrate FP methods; (e) a review of ten FP records to justify the FP method recommended, used, and prescribed compared to methods indicated on the basis of questioning, history, and physical exams; and (f) monitoring the scheduled follow-up appointment. This quality payment can work as a “stick,” whereby the total paid to a facility is discounted based on the score obtained, or it can be a “carrot” whereby a facility can earn 25 to 50 percent more of its earnings based on the score. If the score is considered too low (for example, between 50 to 70 percent), there may be no bonus at all; and a score below, say, 50 percent may cause the facility to lose part of its earnings. All these steps attempt to improve both the quantity and quality of services. Figure 4 below shows the monthly increase in the number of people accessing modern FP methods (excluding condoms) based on performance payment data of health facilities participating in RBF programs in Burundi and Zimbabwe. Burundi’s nationwide RBF program has been operational since April 2010, and the Zimbabwean districts of Marondera and Zvishavane have used RBF since July 2011. Since the first month when the programs began, there was a 35 percent and 81 percent increase in the number of existing and new users of modern FP methods in Burundi and Zimbabwe, respectively.

79. It is recognized that within different levels of government “contracting” is not legally correct terminology, and this will take the form of an agreement or memorandum of understanding.

Figure 5 Monthly Increase in the Number of People Accessing Modern FP Methods (Excluding Condoms) Based on Performance Payment Data of Health Facilities Participating in the Burundi and Zimbabwe RBF Programs



Source: World Bank, analysis from RBF country performance payment data

Egypt launched a similar scheme with large-scale bonuses for health workers based on their performance linked to provision of FP services.⁸⁰ The payments were based on performance measured against a set of standard indicators, which included both curative and preventive services, along with quality of care-related indicators, such as completeness of medical records and patient satisfaction and waiting time. Provider fees were calculated based on a multiple-variable system including attributes of health workers’ profile. A study of this scheme showed an increase in the use of FP methods and improved quality of service.

RBF programs can focus on different levels within the health system. As in Rwanda and India, where community health workers (CHWs) are given incentives to either directly provide FP methods or refer clients for FP services. In Rwanda, this is linked to performance on a range of indicators; while in India, CHWs can keep the revenues from the sale of temporary FP methods (provided by the government) and thus increase earnings when more FP supplies are sold.

Some RBF programs, mostly in Latin America, focus on results-based fiscal transfers from the national to decentralized level. In Argentina, provinces receive a subsidy based on the number of eligible recipients enrolled in an insurance program with the aim of ensuring that women and children have access to health services. Part of the capitation payment for each enrolled client

80. D. Huntington et al. 2010.

(40 percent) is based on the performance of the province with respect to ten indicators, which include FP. This Plan Nacer consists of a “percent of eligible postpartum clients who received sexual and reproductive health consultation within 45 days after delivery;” while in the new Plan Sumar program, it is the “percent of eligible adolescents between 14 to 19 and women under 25 who received sexual and reproductive health consultations,” which reflects the enhanced targeting in the new program. The provinces, responsible for paying for health care services in Argentina’s federal system, pay providers on a fee-for-service basis, which includes FP services.

Lastly, donor funding to countries can also be conditional on performance related to policy, coverage, and quality indicators, including those for FP results. For example, in Salud Mesoamerica 2015, Central American governments are partly reimbursed (50 percent) for their contribution to the Salud Mesoamerica initiative when they achieve 80 percent of the negotiated 9 to 12 health indicators (including FP indicators) linked to health facilities without stock-outs of modern temporary and long-acting FP methods; the unmet need for FP and use of any modern contraceptive methods among women in need of contraceptives; and the FP discontinuation rate.⁸¹

SOME OBSERVATIONS ON THE DESCRIBED RBF PROGRAMS SINCE 1990

The FP incentives attached to current RBF programs are mostly monetary and may target RBF recipients on both the supply and demand side. The former may involve different levels of the health system, such as (a) CHWs rewarded for FP referrals, (b) health facilities that subsequently reward health workers for providing FP services, and (c) provinces or district health authorities rewarded by the national government for FP services or for verifying RBF program results. On the demand side, incentives reward clients for utilizing FP services such as attending information and counseling sessions on FP. Each RBF program is designed to address the need and availability of health services in the country. For example, some RBF programs provide incentives for all types of health facilities (public, private, faith-based, and NGOs), while others reward only public and private facilities, and some operate only in the public sector. Also, some donors may offer incentives to governments based on performance linked to indicators that include stocking FP materials, dealing with unmet FP needs, and improving discontinuation rates for FP.

Current RBF programs often offer incentives for a mix of health outputs and processes related to maternal and child health indicators, which include FP. When this occurs, it increases the programs’ effectiveness as clients can more easily access various services in the same visit, maximizing the impact of health investments by increasing the number of health workers that can address the clients’ multiple needs. These programs have significantly increased the use of a range of health services; for example, in Burundi (where RBF is also an approach to implement the free health care policy for pregnant women and children), the number of institutional births increased by 25 percent compared to data for the first quarter of the nationwide performance-based financing (PBF) program with that of a year later.⁸² Similarly, prenatal care visits rose by 20.4 percent, child immunizations rose by 10.2 percent, and FP use increased by 26.9 percent.

81. E-mail correspondence with Inter-American Development Bank (IADB) in July–August 2012.

82. PBF data of April–June 2010 (the first quarter of the nationwide RBF program) was compared with April–June 2011 data.

Also, the average quality score in health facilities improved by 52 percent according to program data.⁸³

All current RBF programs provide incentives for indicators related to quantity of FP services, such as the number of new and continued users of modern FP methods. Voucher programs use only accredited health facilities to ensure that facilities provide quality care. In other schemes, payments to providers are now often linked to quality, such as with most PBF programs in Sub-Saharan Africa, which pay an additional bonus (carrot) or present a sanction (stick) to health facilities based on their score with respect to a quality assessment index. The index includes indicators for FP as measured through (a) client satisfaction surveys, (b) a review of medical records, and (c) direct observation of the delivery of FP services or (conditions to provide care). The aim is to focus on both improving the quantity and quality of care. Other RBF programs do not use accreditation or link payments to the quality of care but may use training and regular monitoring or supervision to assure quality in FP when providing demand-side incentives or incentives at other levels of the health system.

The amount of the FP incentive varies for each RBF program and can be larger, smaller, or equal to the amount paid for other essential health services. For most programs, it is smaller than that given for institutional deliveries and larger than for outpatient care. The FP payment usually does not reflect the actual cost of the service provided, but rather is a subsidy; it is larger in hospitals, reflecting the added complexity of the service (for example, performing a tubal ligation as opposed to providing contraceptive methods).

83. Burundi, Ministry of Public Health and Fight against HIV/AIDS, Performance-Based Financing National Technical Cell. 2010

CHAPTER 3: ETHICAL CONSIDERATIONS FOR SUPPLY OR DEMAND RBF FOR FP

SUMMARY

Given past experiences with incentives for FP, it is important to consider ethical issues when designing and implementing RBF for FP programs. The ethical issues include possible intrusiveness and negative impacts on clients' autonomy, the degree to which clients are informed and values respected, unequal access due to structural biases, changes in the trust between providers and clients, and privacy or confidentiality issues. In addition, the importance of ensuring quality of services is highlighted, as is the effect, which FP incentives may have on intrinsic motivation.

Some argue that RBF for FP should not be pursued due to possible unintended consequences and ethical issues. However, this would imply acceptance of the status quo, which often entails low awareness of the availability or safety of FP methods and materials, or high levels of unintended pregnancies and the ensuing maternal and child mortality. Thus, the risks of using RBF for FP must always be weighed against those of other approaches or inaction. In other words, continuing the status quo may mean losing the opportunity offered by incentive programs to overcome barriers and address the unmet need for FP.

This chapter explores ethical issues related to RBF for FP so as to maximize its potential, while minimizing unintended consequences. Eight problem areas are discussed in which key ethical values are at stake.

INTRUSIVENESS AND NEGATIVE IMPACTS ON CLIENT AUTONOMY

In the best case, supply- or demand-side incentives empower clients to make informed decisions and exercise them. But they may also be intrusive, negatively affect clients' choices, or undermine autonomy. Particular concerns are that incentives can alter the ways in which the risks and benefits of interventions are communicated or perceived.

For example, this can occur in a supply-side RBF program where health facilities receive a substantial bonus if a certain percent of women in the catchment area receive FP services, (if the quota is not met, the clinic receives nothing). This may lead providers to behave in ways that maximize participation, say, in incompletely informing clients of certain risks, which could increase clients' participation in using certain services, but could also undermine the principle of genuine consent.

Some argue therefore that RBF should instead be tied in a fee-for-service model to individual services, since the desire to meet quotas and the uncertainty of meeting the required thresholds could cause facilities to pursue particularly aggressive enrolment approaches. Nevertheless, both quotas and fee-for-service may influence patients' abilities to make informed choices, and the challenge is therefore to minimize providers' possible conflicts of interests while addressing the unmet need for FP in the target population. Adequate consent procedures are thus extremely important.

With respect to demand side RBF, the main concern is that incentives may lead clients to accept risks they would otherwise not. Figure 6 presents the forces that can influence individual decision making. Accordingly, ethical concerns increase when incentive programs are (a) mandatory rather than voluntary, and (b) use penalties (or sticks) rather than rewards (or carrots). The most extreme examples of this point would be the following: Most people would be comfortable with a policy that provided financial incentives to women who voluntarily attended an information session on FP (the upper-left cell of figure 6); however, they might oppose a policy where couples who have a third child lose all social welfare assistance (lower-right cell). The size of the reward or penalty would intensify such reactions.

Figure 6 Gradient of Ethical Concerns with Demand-Side Incentive Programs

Nature of program		Nature of Incentive	
		<i>Reward (carrot)</i>	<i>Penalty (stick)</i>
<u>Voluntary</u>			
-target output		Fewest arguments against	---
-target outcome		---	---
<u>Mandatory</u>			
-target output		---	---
-target outcome		---	Most arguments against

Source: Authors

Opposition to demand-side incentives often centers on the argument that payments (or noncash incentives) may be coercive. However, in linguistic terms it is not straightforward to consider all forms of incentives as coercive⁸⁴ or as undermining autonomy,⁸⁵ since coercion typically entails a “credible and direct threat of harm” to a person who chooses not to do something. Sticks in the form of large penalties or the withholding of social assistance may be perceived as harmful, or may in fact have this effect. “Carrots”, on the other hand, are different and typically not viewed negatively. Thus, it is not useful to suggest that all forms of incentives are coercive.

Carrots may be provided in different ways, for example, as a cash sum at the end of every year that a woman did not give birth. But, drawing on the principle of loss aversion, which means that losses typically loom larger than gains, the incentive can also be framed by providing steady net-benefits, which may need to be forgone in the case of childbirth. For example, on tea plantations in some Indian states, companies would deposit a nonbirth bonus to female workers. The tea estates would pay into a savings account a certain amount of rupees for each month a woman was not pregnant; and women could not remove the money until their childbearing years were over, roughly the same age as retirement (around 45). Each time a woman became pregnant, payments were stopped for 12 months. Moreover, after the birth of a third child and any subsequent children, the payment would be stopped for a year and an amount (besides the

84. A. Wertheimer, and F. G. Miller 2008.

85. R. Ashcroft 2011.

cessation of payments during the pregnancy) would be deducted from the account. In one sense, the program can be seen as a reward for avoiding childbirth, as it confers a net benefit to the women who comply with it: they end up financially better-off than before introduction of the program. However, women who fail to comply with the policy may feel penalized in missing the pension contribution their complying coworkers receive (even if, in comparison to the baseline condition, they are not made worse off). As this example shows, it is important to determine whether a carrot is indeed a true carrot rather than a stick.

Distinctions between voluntary and mandatory programs may be blurred. Voluntary ones are those whereby people may freely leave (regardless of incentives or disincentives to do so), while mandatory ones are those where participation is required. The great majority of RBF programs are developed to be voluntary; however, caution is needed to prevent the technically voluntary ones from evolving so that they are so difficult to discontinue that — while not quite mandatory — they are not truly voluntary either. For example, a village loan fund in Thailand, which grew in size as the contraceptive prevalence rate (CPR) increased, was made available to couples for income-generating activities (mostly agricultural). However, couples who practiced FP obtained larger loans than those who did not, and dividends from the profits were paid to individuals on a sliding scale, according to the effectiveness of the FP method they used.

While it can be argued the availability of a loan is better than no loans, there could be social pressure to use FP and thus increase the village CPR, making the choice less voluntary. Nevertheless, it should be noted that in this case, there was little evidence that villagers accepted FP under duress; rather, the loan fund officials were seen as effective FP motivators who disseminated credible FP information.⁸⁶ While functionally mandatory programs may not necessarily be unjustified, their restrictions on autonomy and individual choice raise important issues.

Another factor that may undermine autonomy is that some FP methods, such as sterilizations, are irreversible. Since preferences for the timing and number of children are generally not static, interventions that impose permanent rather than temporary effects on fertility will generally be more difficult to justify. In theory, people could make known the number or timing of children they wish to have, but their circumstances can change — say, a child dies or a partnership ends. More generally, evidence from behavioral economics suggests that people may be unable to predict accurately their future preferences for childbearing, a limitation of human decision making referred to as affective forecasting errors.⁸⁷ Thus, incentive programs that only promote permanent FP methods are more difficult to justify than those temporarily blocking fertility, since permanent treatments limit women's or couples' future decisions in ways that may not be avoided by simply assessing present choices.

As seen, incentives may become undue inducements. In fact, even incentives described as genuine carrots may bias risk perception in ways that people no longer evaluate them as they would if payments were not provided. Moreover, undue inducement could become more severe if higher levels should lead to more risk-blinding. However, to a significant degree, to ask to what extent undue inducements occur is an empirical question: Several studies suggest that

86. D. Weeden et al. 1986.

87. P. W. Eastwick et al. 2007.

financial (or other) gain may also lead people to examine risks more closely, as well as to decide whether they want to engage in the activity for which incentives are being offered.^{88,89,90,91}

Some may be concerned that incentive programs imply that people make unwise decisions and that health professionals or society somehow knows better about what constitutes their best interests. As noted above, such reasoning presumes that existing levels of FP use reflect the results of well-informed decisions by couples to use them or refrain from doing so. However, it is also possible that people have not made the decision for various reasons. If the incentive programs are voluntary or described as rewards (or both), they can promote informed decisions without limiting choices. For example, an incentive to attend a counseling session on FP methods can be viewed as helping people make *active* choices: the incentive is not provided to use a method, but to reflect on whether or not it is attractive, regardless of the final decision. Thus, it would be difficult to argue that incentives of this kind infringe upon autonomy.^{92,93} On the contrary, incentives may promote autonomy where a woman has already made an informed judgment to avoid a pregnancy at a particular time, but (for reasons of procrastination, decision fatigue, or preferring current benefits over future ones) required encouragement to act and decide which FP services she prefers.

DECISION MAKING THAT IS NOT FULLY INFORMED AND GENUINE

Our description of the earlier FP programs (chapter 2) showed that the concept of voluntary participation in FP was sometimes compromised. This issue was widely discussed after 1990, and it was concluded that, without exception, where informed individuals⁹⁴ refused consent to participate, it is considered unethical to proceed with promoting the use of a FP method.

The principle of consent is often ambiguous and not achieved merely by having participants sign a consent form. While a signature may protect providers from legal action, it is often questionable whether that alone signifies that individuals are truly informed and have provided their consent freely. This is particularly relevant where clients' reading and comprehension skills may be limited. Thus, it is crucial that the information be conveyed in ways that are understandable to the target population.⁹⁵

A second challenge regarding consent concerns the individual providing it. In some areas it is customary that senior family members, heads of households, or community leaders make important decisions on behalf of women and minors, or greatly influence the decision making. Where such third parties are not involved, proceeding may be considered disrespectful, negatively affect the role of health care workers, and may also jeopardize acceptance of FP

88. S. D. Halpern et al. 2004.

89. S. D. Halpern 2011.

90. C. E. Cryder et al. 2010.

91. Ibid.

92. R. Ashcroft 2011.

93. S. D. Halpern et al. 2009.

94. It is recognized that FP methods can be used for people lacking capacity or for psychiatric patients, whereby a legal proxy would need to make an informed decision.

95. This includes refraining from using unnecessarily technical or legal language, or medical concepts that are hard to understand for communities used to more traditional forms of knowledge. Instead, context-specific adaptations are required to ensure that the goals of consent, as stated above, are met.

methods in the long term. Tension in the consent process might be lessened through appropriately tailored information campaigns that are directed at the wider parties involved in the decision-making process. Such a broadening of efforts would recognize that it is shortsighted to see the consent process merely as a transaction between the clients concerned and the health care team. Depending on the circumstances, and just as for information campaigns aimed at clients using FP services, it may be appropriate to incentivize uptake of such broader measures. Evaluations of pilots should pay particular attention to whether incentivizing use of information campaigns by the wider parties involved in the decision-making process improves the decisions by the clients concerned. While these and other measures may well be effective in improving understanding and reducing conflicts and worries, they must not detract from the fact that community consent can never replace individual consent.

PROVIDER AND CLIENT VALUES MAY NOT BE RESPECTED

In general, it is thought that health care providers want to promote awareness about FP; however, this cannot be assumed either for institutions or for individuals, since they may have religious or other objections to all or certain forms of FP or to the introduction of supply- or demand-side RBF for FP programs. This can have undesirable consequences. Providers may not fully inform clients about FP methods; they may decline the supply-side-incentives or block demand-side ones if they do not want to offer a certain form of FP — which can affect the process of informed decision making and possibly FP uptake. In extreme cases, provider reluctance may also block the provision of any kind of FP services. Where institutions' finances are contingent on providing FP services that the providers oppose, they may seek different work or relocate their practice (if opposition is at the institutional level), which may reduce the overall capacity to serve clients.

Problems may also arise among clients. As noted in chapter 1, 10 to 25 percent of women did not use FP because of personal reasons (religious values, concerns about convenience, interference with their body concept, or spousal or family opposition). Choices about FP methods and eventual uptake are often complex and may require women to address conflicting values. For example, a woman may wish to use FP, but may also wish not to violate religious norms that oppose particular methods. In some cases, women using certain FP methods may fear social stigma and avoid them. Providers who ignore these and other constraints can be seen as lacking respect for clients' positions; equally important, disregarding client wishes and fears does not promote sustainable FP use. Thus, it is critical that clients' values be respected. This does not mean that providers must accept any decision without questioning it, but rather should ensure that decisions are appropriately informed and genuine. As noted, incentives may be helpful in this regard, and invite a consideration of the robustness of opposing values.

A FOCUS ON QUANTITY MAY COMPROMISE QUALITY

Using incentives to increase the quantity of FP services may compromise the quality of the services. Thus, it is crucial to both supply- and demand-side RBF programs for FP that the quality of care is of appropriate standard, regardless of whether incentives are involved. But because incentives seek to maximize use and can entail opportunity costs, the issue of quality is especially important.

As described in chapter 2, several supply-side RBF schemes (particularly the Performance-Based Financing schemes in Sub-Saharan Africa) use a quality score (based on a checklist) by which providers can earn an additional quality bonus (carrot) or face a reduction (stick) in the amount earned based on the quantity of services provided. This quality-linked payment and scorecard help ensure the quality of services, or at least the conditions needed to provide them. Other RBF programs may use accreditation of health facilities as the norm by which to ensure the quality of care provided by participating health facilities when incentives are provided based on the quantity of FP services.

POTENTIAL NEGATIVE EFFECT ON INTRINSIC MOTIVES

It has been suggested that RBF may undermine the motives of health care workers and clients: some say that offering incentives for behavior that people ought to adopt anyway, such as providing or using FP services, promotes monetary values and subverts social ones.⁹⁶ This concern has two components.

First, external incentives may “crowd out” intrinsic motivations to improve health.⁹⁷ In the case of supply-side RBF, this may mean that providers pay far less, or possibly even no attention, to offering other services. On the demand-side, the result could be that users stop using services once the incentives are removed — thereby undermining longer-term health outcomes — such as when women are incentivized to go for check-ups for FP use but cease to do so when incentives are removed. This issue reflects the efficacy of incentives, though not the ethics. Such concern about the effectiveness of the incentive programs underscores the need for careful research to measure the long-term effects and default rates before policies are designed or changed. However, the concern does not render incentives unethical.

Second, because incentives emphasize the value of money, the programs may unintentionally de-emphasize the positive aspect of FP. Although the incentives could have such effects, the hypothetical risks must be weighed against unwanted pregnancies and the importance of child spacing.

96. J. Shaw 2007.

97. J. Heyman, and D. Ariely 2004.

DIFFERENCES IN USE DUE TO PROVIDER/CLIENT STRUCTURAL BIASES

While equal access to services is important and can be measured, unequal use can be ethically acceptable only when it is due to free choice and not because of structural conditions that disadvantage specific groups, particularly when using RBF for FP.

Where providers respond positively to supply-side incentives — whether to FP or other health services — they may try to create efficiencies to prioritize those services that carry incentives, in which case it would be a net win situation. However, if they cannot identify or create efficiencies, or find it necessary to explore them, they may simply pay less attention or disregard other needed services, and thereby promote substitution of services. Evaluations from large pay-for-performance programs have shown that such consequences^{98,99} occur and must be addressed.

Another unintended consequence may be adverse selection — sometimes called “cherry picking” — where providers target *easy* clients (like those most likely to comply and achieve FP indicators) — who may be women or couples who already have several children and have achieved their desired family size. As a result, those most needing FP services receive less or no attention, such as younger women who need to delay their first pregnancy or couples with one child who need to space their pregnancies for the mother’s or child’s well-being. A further example is that providers may focus on couples who already use the health facility (for delivery or child nutrition and immunization services) and are readily available for FP services, and ignore other clients with an unmet FP need who are not attending the health facility. Or, those who would benefit from FP services might live far from the facility and require more effort and time to motivate them to come to the facility or for providers to visit them through outreach activities. Similarly, providers may focus less on clients who need more time to make informed decisions or on those less likely to adhere to continued use in cases where the FP method requires this. As noted in chapter 2, several RBF programs have used strategies to prevent such adverse selection, such as paying for new and continued FP use. Also, some RBF programs even include provisions to ensure equity, such as in Burundi, Benin, and Nigeria, where facilities receive an additional bonus for providing services in remote areas and to indigent populations. It will be important to carefully monitor and evaluate the effects of such strategies.

Regarding demand-side interventions, it should be noted that not all women or couples understand or are able to adopt behaviors to space children and avoid pregnancies. Different economic conditions and regional differences in access to services, relationships with partners, level of education, and social supports are all involved. Thus, it is too facile to assume that simply because a group of eligible women does not use available FP services, they could have done so just as readily as those who use FP services.

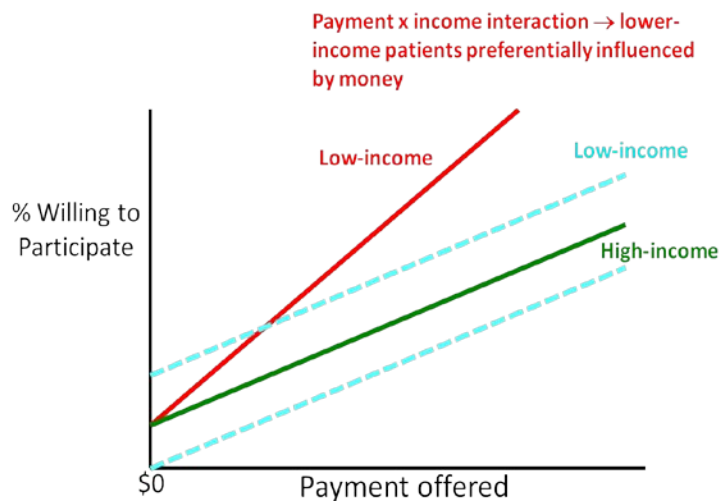
Socioeconomic differences also matter when incentives are used. Rewards can be unfair if it is disproportionately more difficult for some to achieve the activity than others; penalties typically exacerbate such disparities. For example, while most clients can attend a FP information session, outcomes — such as avoiding another pregnancy — are not always under the clients’ control, and access to the incentives may thus be unequal.

98. T. Doran et al. 2011.

99. H. E. Lester et al. 2011.

Demand-side inequities are also relevant when incentives may affect the perception of risk and become undue inducements for particular subpopulations. For example, the same incentive amount may influence the notion of risk more strongly among lower-income groups than among higher ones, whereby the former may accept risks they would normally not accept; in which case the incentives would be unfair inducements. Thus, an empirical question arises: Will varying rates of FP use among different income groups be magnified or mitigated by offering incentives? Suppose that in the absence of incentives, wealthier and poorer people used similar levels of FP services. If the introduction of incentives were to lead more lower-income mothers to use FP than those with higher incomes, this would suggest that payments could be unfair inducements (see figure 7).

Figure 7 Conceptual Representation of Unjust Inducements



Source: Authors

Although it appears reasonable to think such unfairness would be inherent in any incentive scheme, such effects should not be assumed since studies of incentives for research participants¹⁰⁰ and kidney donors¹⁰¹ have failed to reveal such biases. A study in Bangladesh on sterilization incentives showed that while money may be a contributing factor, only a small minority (6 percent) said it was the main one.¹⁰² Still, the extent to which this may occur when incentivizing FP should be monitored carefully in the implementation phase, and be included in the final evaluations. Consideration should also be given to whether poorer women were underutilizing a service relative to wealthier women before incentives were introduced, since increased use (among the poor) would not necessarily reflect unfair aspects, but rather might represent appropriate targeting of those with unmet needs.

100. S. D. Halpern et al. 2004.

101. S. D. Halpern et al. 2010.

102. J. Cleland and P. W. Mauldin 1991, p. 1–18.

PROVIDER-CLIENT TRUST

Incentives for both supply and demand side typically involve cash transactions to either health care workers or to users, which can negatively affect the health care professionals and the trust held by users of health care.

Clients are typically unaware of the details of supply-side payment structures in the health care system. When they do learn that providers receive additional payments for promoting FP methods, their trust in these professionals may change, which is crucial, since it is an essential part of the provider-client relationship. Thus, clients who learn their physicians' payments depend to some extent on the number of FP-related consultations or procedures that they perform may feel less certain that their well-being is central. This is more likely where there is a real or perceived element of population control driving RBF for a FP program. Especially when incentives are provided in areas where governments have historically sought to impose rigid top-down control measures (see chapter 2), RBF may be seen as a disguised form of these previous policies with potentially severe consequences on acceptability and uptake.

On the demand side, incentives in RBF for FP may pose a different challenge when clients have either not sought to achieve the indicator, or tried but failed, and still ask their health care providers to certify they have met required targets. For example, if a RBF program offers cash incentives to individuals to attend four information sessions on the use of different FP methods, some participants might miss one — perhaps because of work and family commitments. But to make up for this, they ask friends who did attend the sessions to tell them about what they learned. A provider who organized the talks might then be asked by women who missed a session to document that they did, in fact, attend. Such a scenario can place the health care professionals in an uncomfortable policing situation.¹⁰³ They then face two choices: Either they implement the rules strictly and deny the women their benefits — even if they made reasonable efforts to achieve the goals of the education program — or they lie on behalf of their clients, since the benefits may be important to the women's livelihood, and the clients' behavior may lead to near identical outcomes. Cases where health workers comply with clients' requests out of concern for their financial wellbeing — even where the latter have made limited or no effort to achieve the programs' targets (as occurred in Brazil's Bolsa Familia Programs)^{104,105} — can moreover corrupt data and complicate the effectiveness evaluations of programs.

PRIVACY AND CONFIDENTIALITY

Planning, verifying, and evaluating RBF for FP programs can increase governments' involvement in peoples' private lives, or be perceived as doing so. Such initiatives may be opposed, as people generally feel strongly about privacy regarding their sexual and reproductive practices.

Failing to recognize the sensitivity of FP-related data can alienate target populations, cause anxiety among actual and potential clients, and negatively affect the program design and

103. H. Schmidt 2012.

104. L. De Pasquale et al. 2008.

105. F. Bastagli 2009.

evaluation in cases where respondents are reluctant to share data, and this information is intended to improve the design and implementation of RBF for FP.

CHAPTER 4: CONCEPTUAL FRAMEWORK TO GUIDE FP IN RBF

SUMMARY

This chapter provides a conceptual framework, summarized in box 1.1, that teams can use when designing, implementing, monitoring and evaluating a RBF for FP programs. The framework is to help teams ensure that no unintended or unethical consequences occur when FP incentives are offered. The framework does not use a prescriptive yes/no approach as contexts differ, and there are various forms and options for RBF for FP, which prevent a one-size-fits-all approach. Moreover, ensuring programs are appropriate and ethical is not just a matter of following a simple rule, but requires teams (both Bank staff and country counterparts) to identify each of the areas and explicitly justify the design of the program. Several ethical issues are highlighted that require monitoring to limit unintended consequences and work toward best practices. The framework seeks to identify areas of particular importance and can be useful to policy makers, implementers, and investigators involved in monitoring or evaluating RBF programs in deciding which aspects need to be studied and monitored. As the World Bank is supporting more than 15 countries to implement RBF programs that are accompanied by rigorous impact evaluations, these initiatives provide opportunities to learn about ethical issues linked to RBF for FP. The framework can provide guidance on which areas should be covered during the evaluation to further broaden the evidence base.

This chapter proposes a conceptual framework of key issues related to RBF for FP, which should be actively considered during design, implementation, and evaluation. The framework has two stages. In the first, the key question is whether supply- or demand-side incentives should be explored at all. This involves determining the extent of unmet FP needs (as defined in the Introduction) and assessing the reasons. Also, it requires examining the risks of using and not using supply- or demand-side incentives, and comparing them to other policy options. If it appears that incentive programs may improve the status quo, the second stage is concerned with how to maximize this potential, while minimizing any unintended consequences. Following the structure presented in chapter 3, we describe eight areas where ethical values are addressed.

At the planning stage, addressing these areas may lead to several outcomes. At best, the process may identify RBF programs that are likely to achieve the desired goals and minimize ethical tensions. Alternatively, the framework may identify a number of unanticipated issues that require the program be redesigned but still help create one that can be implemented with minimal ethical objections. However, the analysis may also uncover ethical issues that cannot be resolved and cause policy makers to reconsider whether the status quo should be acceptable, or if there may be more suitable non-RBF methods to improve current conditions.

The framework should not be used only in the planning, but also in the implementation and monitoring phases to ensure that incentives do not lead to unintended or unethical consequences. Thus, redesign may be necessary, or at worst, programs may need to be stopped, where ethical issues emerge. As such, the framework can also help point to the areas to be covered in the evaluation, to broaden the evidence base on the effectiveness and acceptability of supply- and

demand-side incentives. Evaluations¹⁰⁶ are important to establish the extent to which programs work and also to identify the ethical issues — as incentives often involve offering monetary amounts that could otherwise be used for other health purposes. Thus, it is necessary to demonstrate they are worth their opportunity costs.

The framework does not provide a descriptive recipe for a successful RBF for FP. As the preceding chapters explain, programs can be implemented in a wide range of formats: monetary or nonmonetary incentives use penalties or rewards provided to individuals, groups of women, or couples. Also, they may incentivize a wide range of FP activities, including permanent and nonpermanent FP methods. These and other factors present a highly complex set of options for RBF for FP. Each may involve distinct ethical issues, and it is challenging to make all-encompassing prescriptions. Also, significant country-specific differences in religious, cultural, and political backgrounds prevent a one-size-fits-all approach. Last, acting morally consists not merely in following rules or guidelines; thus, a highly prescriptive approach is of limited use.¹⁰⁷ In other words, the best approach entails providing explicit justification for actions in particular contexts, and addressing local as well as international values.

Given the wide range of factors determining the effectiveness and acceptability of RBF for FP, and because moral behavior requires sound reasons for our actions and policies, we describe the areas that require special attention and justification, whether informal or formal, by internal and external stakeholders.^{108,109,110}

STAGE 1: EXPLORING THE UNMET NEED AND POSSIBLE USE OF RBF FOR FP

First, it is important to determine the level of unmet need for and barriers to FP. Second, the rationale for addressing the unmet need as well as the rationale for incentives must be explored.

a. Determining the unmet need

As a first step, the extent of unmet need must be assessed.¹¹¹ Such information is often found in a country's DHS or other household studies. However, the concept of unmet need as described in this paper (see p. 15) may be broader than that in the DHS and may require further exploration, particularly in regard to adolescents' unmet need for FP. It is vital to identify national levels of unmet need as well as possible regional or population differences.

106. Both impact evaluations of a more quantitative nature as well as more qualitative assessments and evaluations have an important role to play here.

107. Note that pleas for rigid guidance have also been made in the context of policy on research involving human subjects. For example, the World Medical Association which developed the Declaration of Helsinki, which is widely regarded as one of the preeminent guidance documents on the ethical conduct of research, has been asked to be more detailed and prescriptive.

108. A. Rid, and H. Schmidt 2010.

109. J. Le Grand, and D. Srivastava 2009.

110. H. Schmidt 2008.

111. As defined earlier, this relates to couples, single women, or adolescents who do not want any (or more) children, or want to postpone or space childbirth but are not using any FP, and thus is broader than the definition sometimes used, which only focuses on married women.

b. Determining FP barriers and how supply/demand RBF for FP can overcome them

Assessing barriers to informed decision making and barriers to FP use is particularly important with regard to building hypotheses as to whether supply- or demand-side incentives can improve the status quo. Barriers are likely to be highly specific to particular cultures, countries, and often, regions within them.

As noted in chapter 1, only 2 percent of all respondents in 34 demographic surveys cited cost of methods or transportation as major barriers. Equally, only 2 percent cited lack of knowledge of methods or sources in three of the four regions, although in Sub-Saharan Africa rates were three times higher (actual figures may be even higher, as respondents may be reluctant to admit a lack of knowledge). Health concerns and fears of side effects ranked between 7 to 12 percent in the four geographic regions (see figures 3 and 4). While a focus on percentages helps facilitate comparisons, in populous countries such as India or Indonesia, even relatively small percentage values can account for a large number of women. Supply-side incentives may play a role in ensuring that the full array of FP methods is available for clients to use so they have different FP options in the case of side effects with one particular method. Equally important, demand-side incentives that remove cost barriers can clearly benefit those who would like to use FP but cannot due to the financial burden.

Regarding knowledge, it must be noted that this varies across countries. While the mean in the four regions was about 6 percent, in some countries, much higher levels exist: For example, in a study completed in 2008,¹¹² 45 percent of married women in Chad cited lack of knowledge as a reason. Supply-side incentives could thus be used to motivate providers to make information available in the first place. Demand-side incentives could help ensure that available information is in fact used, and, ideally, correctly understood, which can be achieved by offering incentives for using evidence-based decision aids (health concerns and fear of side effects were important issues in the surveys summarized on p. 25). However, since the risks of modern FP methods are generally low, it would be erroneous to take such data as reflections of truly informed views.

In all cases, policy makers must initially assess whether supply and demand incentives are likely to bring better outcomes than alternative approaches, considering also the relative costs. Oftentimes, there will be no certainty about the possible magnitude of any benefits. Expecting or demanding full certainty is unrealistic and may stifle innovative approaches. Instead, the possibility of uncertainty points to the importance of adequate monitoring and evaluation of interventions.

c. Justifying the use or nonuse of RBF for FP

A comparison of possible benefits and risks should be made for continuing the status quo versus the likely benefits and risks associated with incentives. The focus must be on justifying whether RBF for FP should be explored over the current status quo. Indeed, it may not automatically be

112. Cf. World Bank 2010. "Unmet Need for Contraception." Note, however, that the concept adopted here is broader than in this note, which focuses exclusively on the unmet need of married women.

assumed that the status quo is better as measured against the possible risks. Nor should the use of RBF for FP be automatically approved. Rather, both must be justified; there is no neutral default.

Consideration must be given to the reasons for introducing RBF for FP. The shift to RBF occurs in many countries where existing approaches are deemed unsatisfactory with regard to maternal and child health outcomes, including child spacing.¹¹³ Although higher levels of FP use may have a positive effect on population control, we do not advocate supporting this reason through the use of RBF. Instead, the framework seeks to help design ethical programs aimed at addressing unmet need.

To summarize, as a first step in considering RBF for FP, the level of unmet need must be determined — recognizing that it would be naïve to assume that levels of nonuse reflect informed decision making where different FP options were provided. Furthermore, it is necessary to state the main reasons for RBF for FP and communicate them clearly (for both supply- and demand-side incentives) in terms of fairness, acceptability, and effectiveness, especially in countries where FP methods have been introduced in ways that created opposition (see chapter 2). Thus, policy makers should describe why current levels of use of FP are considered too low, and whether their concern is with addressing unmet need or whether their concerns involve issues of population control. This framework is solely concerned with addressing unmet need.

STAGE 2: DESIGNING, IMPLEMENTING, MONITORING AND EVALUATING RBF FOR FP

Once it is determined that incentives have the potential to overcome some of the identified barriers, various questions must be considered in the planning, implementation, and evaluation phases.

a. To what extent are programs intrusive or empowering?

The aim of any FP program is for women and couples to be empowered to make informed decisions. When supply-side RBF for FP are used, it is vital that clients are not given biased information; also, that incentives — be they quota or fee-for-service-based — do not lead providers to understate risks or otherwise sacrifice the goal of genuinely informed client decision making in favor of securing a material benefit. The focus must be on ensuring that providers act professionally, which would entail appropriate training and monitoring of their behavior.

The type of FP interventions that are incentivized is very important, since conditions can change in people's lives. Hence, incentivizing FP interventions that cause permanent infertility are more difficult to justify than those that are promoting temporary methods. To minimize negative consequences, the full range of modern FP methods (both temporary and permanent) must be made available, and incentives should not favor irreversible methods over others.

Also, the size of the incentives matters. Higher incentive levels could bias the provider. Possible conflicts of interests can be minimized by structuring incentives in a way that they positively

113. As described in chapter 2, there has been a clear evolution globally in the rationale for FP programs since the ICPD.

affect behavior, but do not jeopardize clients' informed decision making. Thus, less intrusive FP methods and those that allow clients to be well informed should be the ones that providers focus on. The use of appropriate consent procedures is also critical.

On the demand side, incentives may sway clients to agree to use FP methods they would otherwise resist. Such incentives are less prone to ethical concerns when they are (a) voluntary (rather than mandatory or difficult to opt out of), and (b) use rewards (carrots) rather than penalties (sticks); also, the size of the incentives matters. Programs that cause some clients to be worse off after the program begins implementation will generally be more difficult to justify. This is not to say that functionally mandatory programs cannot be considered, but their restrictions on autonomy and individual choice require significant justification to show how their effects truly benefit the participants. They also require increased monitoring and evaluation of their potential effects.

As with supply-side incentives, a full choice of FP methods should be made available, favoring those that offer incentives for temporary FP methods. The size of the incentives also matters, since incentives may become undue inducements that bias people's perception of risk. As noted in the next section, communication about benefits and risks is essential to reduce that possibility. It can be useful to monitor FP users' understanding to determine if information procedures need alteration.

b. Informed decision making and consent¹¹⁴

At present, consent chiefly seeks to ensure that clients are clear about the risks and benefits associated with particular FP methods, and that the decision to accept a method is not forced or manipulated.

For consent to be genuine, health care workers must focus on detecting lack of consent and not simply assume that all relevant information has been understood.¹¹⁵ This means that a consent form in writing will typically not be sufficient. Instead, thought should be given to more appropriate formats; these could include using illustrations (which may be particularly helpful when clients are illiterate) or other approaches that allow clients to ask questions on any aspects that are unclear. In practical terms, ensuring that consent is genuine can make higher-than-expected demands on resources, be they financial or workforce related (whether skills or human capital). These skills can be both technical and interpersonal. Loevinsohn and Harding (2005)¹¹⁶ suggest that providers may be unsuccessful in responding to performance incentives when success requires changing patient behavior (which requires skills beyond clinical ability). For example, in the Rwandan program, providers were unsuccessful in increasing contraception use and in persuading patients to complete the contracted sequence of four prenatal care visits partly because of local patient preferences (superstitions about acknowledging pregnancies at an early

114. "The process by which an individual arrives at a decision about health care" is an informed choice when it is "based upon access to, and full understanding of, all necessary information from the client's perspective," according to one definition by EngenderHealth.

115. Nuffield Council on Bioethics 2002.

116. B. Loevinsohn, and A. Harding 2005.

stage).^{117,118} Given the crucial importance of genuine consent, resources should be prioritized accordingly.

Another challenge with regard to consent relates to the notion of voluntariness in certain cultures. While it may be thought appropriate and sometimes necessary to involve community leaders or senior family members in FP options, and while we noted above the potential usefulness of education campaigns targeted at the wider community, individuals ultimately need to make their own decisions for consent to be genuine: community consent must never replace individual consent.

c. Conflicts with personal values

Health care workers usually have good intentions when caring for their clients. However, some health care workers or their institutions may oppose the use of FP (or certain forms) based on religious or other beliefs. They may also simply disagree with the use of incentives in supply- or demand-side RBF for FP programs.

Early outreach can often help identify providers' concerns, and adjustments may be possible; for example, by providing a selection of FP methods, tailoring indicators, or allowing providers to find other solutions. One example of this occurred in Rwanda, where faith-based organizations enrolled in RBF but then subcontracted others to provide FP services to clients, since their religious beliefs prevented them from doing so. While some might argue that such double standards should not be acceptable, the case shows that FP approaches can vary. Here, the provider organization ensured their clients had access to FP services when desired, ultimately valuing the well-being of mothers and children higher than upholding the most rigorous religious standards.

Conflicting personal values may also exist on the demand side, which raises the question of how health professionals should respond. Respect for personal values may mean accepting clients' preferences without questioning their assumptions; but, it may also mean identifying their true preferences and providing assistance where it appears the client finds it difficult to reconcile competing interests and values. While the former approach is often the easiest, the latter requires sensitivity and tact. It also requires health professionals to communicate in detail all the risks and benefits. While respect for deeply held religious and cultural views is healthy and should be practiced, it should not be assumed that all members of a certain group share the same opinions about the use of a wide range of FP methods. Indeed, a hands-off approach may do more harm than good.

By contrast, information about how to reconcile values and beliefs could be included in the various decision aids or other suitable materials. For example, many women who use different forms of FP have found ways to reconcile their beliefs with FP needs.^{119,120} Brief vignettes or narrative stories of such cases can be used in one-on-one or group counseling sessions on FP.

117. P. Basinga 2010.

118. P. Gertler, and C. Vermeersch 2012.

119. D. Huber, N. Saedi, and K. A. Samadi 2010.

120. Pathfinder International; http://www2.pathfinder.org/site/DocServer/FBO_final_reference.pdf?docID=6901.

Without urging couples to use specific FP methods, such examples can help them make genuinely informed decisions and overcome feelings of isolation, and also provide them with arguments to justify their decisions to others.

Early outreach to understand clients' and providers' views and values is therefore critical. It can be a crucial tool for identifying acceptable interventions and also for developing consent procedures that are compatible with cultural practices or at least raise the fewest objections. Engagement can help elicit facts as well as values, contribute to the legitimacy and acceptability of programs, and increase general awareness of initiatives (See annex 5, table 4.A5 on user perceptions). Early engagement can also help assess the acceptability of incentives in-kind or of financial incentives of particular cash value.

d. The Trade-off between quantity and quality

The previous chapter discussed the problem of FP incentives for quantity (of services) possibly compromising their quality. Thus, it is crucial to ensure this does not occur. One helpful framework presented by Judith Bruce (1990) about 20 years ago proposes a focus on six aspects for FP: choice of methods, information given to clients, providers' technical competence, interpersonal relations, follow-up and continuity mechanisms, and an appropriate mix of services.¹²¹ The framework involves the following:

- Choice of methods: A range of FP measures should be available since their usefulness will vary at discrete stages of people's lives. Also, possible side effects must be communicated, such as those associated with hormonal contraceptives or devices like IUDs. Both supply- and demand-side programs may fail if they do not offer the full range of methods and only focus on promoting a single method that may or may not be consistent with patients' preferences. Also, programmatic FP goals could be undermined if patients are not engaged and their preferences are not considered. Ideally, satisfactory choices will be offered to women and couples who want to space childbirth or do not want any or more children.
- Information given to clients: As outlined earlier, information that is provided in ways that help the target populations and their understanding is essential to foster free and informed decisions. Oral consultations or counseling, written or illustrated materials, or other forms of decision aids can all be tailored to the needs of certain target populations. For content, the information must include facts about the range of available methods; risks such as side effects; and contraindications, practical advantages, and disadvantages (including implications for sexual practices); any follow-up that may be required; and what support providers will offer in the long term.
- Technical competence: Providers can differ in training, skills, expertise, and adherence to best practice guidelines. Facilities in developing countries often face challenges to ensure that surgical equipment and methods — such as IUDs — are kept aseptic. The term technical competence refers to adherence to the minimum service standards.

121. J. Bruce 1990.

- Interpersonal relations: The vision and mission of programs can affect how care is experienced, as does the style of management and organizational features such as the ratio of staff to clients.
- Follow-up and continuity: Some FP methods may require nothing but a single consultation, but many will benefit from or require longer-term support to ensure safety and efficacy. Formal or informal support can involve scheduled follow-up visits with professionals or community workers.
- Appropriate constellation of services: FP services should be provided in ways that are convenient and acceptable — through facilities or settings that are easy to reach and use, and are compatible with cultural concepts or norms about health and well-being.

The elements of this framework are interrelated, and the extent to which quality of care in each area can be optimized will often depend on contextual factors. Yet, each part provides crucial orientation in assuring the adequacy of practical and medical considerations, and in identifying ways to improve the programs. The quality framework can help identify which components matter the most and determine quality indicators for RBF payments or serve as benchmarks for monitoring to determine if RBF improves quality (or has negative effects).

The use of a quality scorecard linked to incentives, either as an additional bonus (carrot) or a reduction (stick) to the amount earned based on the quantity of services provided, may be a positive approach in several RBF programs (see chapter 2). It is vital to ensure that the aspects in the above framework are incorporated as quality indicators and are monitored proactively in RBF programs.

e. Effects on motivation of health providers and clients

Some argue that RBF incentives may undermine the basic motivation of health care workers and clients. However, this hypothesis has not been tested extensively and thus requires more study. Recent research on demand-side incentives certainly suggests that incentives do not undermine intrinsic motivations in areas such as weight loss, adherence to medication regimens, and exercise.¹²² Still, it is important to recognize that this has to do with the effectiveness of incentives and not their ethics. The same applies to the need to study whether users stop using services if demand-side incentives are removed. While further research is needed, these potential risks may also need to be weighed against preventing unwanted pregnancies and promoting child spacing. Any RBF for FP program should carefully monitor any changes in providers' and clients' motivations.

In addition, it can be useful to explore and evaluate the effects of different types of incentives. For example, the certainty of a financial incentive after each check-up for FP is completed could be replaced with the chance of a lottery win. In both cases, there is a benefit beyond the health gains, but the lottery may delink one from the other more than the guaranteed fix-sum incentive.

122. Aditi Sen. 2013 [forthcoming].

f. Differences in use across target populations

Supply-side RBF could lead providers to pay less attention to other needed services. In the case of FP, the possibility of substituting services suggests it is preferable to offer incentives for the full range of FP methods rather than specific ones, and ensure there is no imbalance with regard to incentives for other services that are considered important. Moreover, the amount of the FP incentive must be addressed to achieve a balance both in the sum paid for temporary and permanent methods as well as for other health services. Monitoring arrangements can provide empirical evidence to determine if incentives interfere unduly with the delivery of services to which they are not attached. Adjustments can be made such as informing providers about their obligation to provide services to all or to impose some sanctions if they do not.

The previous chapter noted that providers may focus on the “easiest” clients, such as those living near the health facility, those already using FP, or those who have already fulfilled their desired family size. Careful monitoring and evaluation is needed, including the effect of strategies used by several supply-side RBF programs (see chapter 2) to address these issues. These include paying for new and continued FP use. And, some RBF programs even include provisions for ensuring equity such as in Burundi, Benin, and Nigeria, where health facilities receive an additional bonus for providing services in remote areas and to the poor (see annex 6).

The results need to be studied to determine if poor women were underutilizing a service relative to wealthier women before incentives were introduced. If this is the case, the increase among the poor would not be caused by undue inducement but may mean the incentives are appropriately targeting those with unmet needs. Indeed, unequal use can be acceptable as long as it is due to free choice. This reveals the need for a well-designed assessment of underlying factors for FP use when introducing RBF for FP.

On the demand side, women and couples may not have the same abilities or knowledge about child spacing or preventing pregnancies. Varying economic conditions, regional differences in access to services, relationships with partners, level of education, and social supports all play a role. These and added structural factors are important for planning, implementing, and evaluating RBF for FP programs. The same level of incentives may cause lower-income groups to be less risk-averse than higher-income groups, and thus could become unfair inducements. Monitoring and assessing changes from the baseline are again vital to determine if such cases constitute undue inducement or appropriate targeting of those who lacked access.

Incentives can also become unfair if the activities related to them are more difficult for some to achieve than others. Attending a FP information session can be achieved by practically anyone, time and access permitting; while an outcome, such as (temporarily) avoiding another pregnancy, is not always under the client’s full control and could lead to fairness issues. Thus, it is important to review whether clients have a reasonable chance of achieving outputs and outcomes indicators¹²³ that hinge on incentives.

123. H. Schmidt, D. Ash, and S. Halpern 2012.

g. What is the effect on the relationship between clients and providers

RBF for FP can negatively affect health care professionals and the trust clients may have in their providers when they receive incentives for providing FP services. This raises both practical and ethical issues that need to be considered at the initial planning phase and onwards.

Seeking to hide the existence of supply-side RBF strategies would be inappropriate since this is likely to undermine trust, once uncovered. Thus, it is critical to be aware of possible tensions and transparency issues about payment mechanisms; the target population must be given details of the program that are appropriate for their understanding, to address potential negative impacts on clients and their relationship with health workers.

On the demand side, incentives for FP could place health care workers in a difficult position if they are asked to verify clients' compliance. Such undesirable consequences need to be considered in light of country-specific circumstances, problems need to be anticipated and adjustments made. These include more flexibility in the choice of indicators and could involve professionals other than those providing health services to state that the indicators were achieved. The RBF institutional design is vital to prevent conflict of interest. Thus, it is important to sufficiently separate and unbundle functions, particularly between the provider and those verifying the clients' use of services.

h. Privacy and confidentiality arrangements

The involvement of government or other parties in people's sexual and reproductive health practices could be seen to compromise clients' privacy and confidentiality arrangements. In all stages of the process, including (a) preliminary surveys to assess sexual practices and needs for FP methods, (b) individual or group counseling sessions to inform RBF design, (c) verification and monitoring of FP in RBF programs, and (d) evaluations after programs have ended, attention must be paid to the sensitive nature of the information. Thus, it is crucial to convey to clients which parts of the data remain anonymous and private (and will not be shared in ways that could identify respondents) and which parts are treated confidentially (and shared with a limited number of others, such as health professionals) in ways that do not enable those using the data to link them to specific individuals.

SUMMARY

This discussion paper described the economics of RBF for FP, the experiences with incentives that led to unintended consequences or possibly unethical situations and raised ethical issues, which must be considered when designing, implementing, monitoring and evaluating such programs. It was designed to offer World Bank task teams and country counterparts considerations during design and implementation of RBF projects with focus on FP. It can also provide general guidance for monitoring and evaluation.

Box 1.1 Areas in Which Informal or Formal Justification Regarding the Planning, Monitoring and Evaluation of RBF Programs Should Be Provided to Stakeholders

The proper justification of incentive programs includes, but is not limited to, the following two stages:

Stage 1: Assessing if RBF for FP should be explored

- Determine the level of unmet need for FP
- Determine the barriers to using FP and in what way supply- or demand-side incentives might overcome them
- Compare benefits and risks of continuing with the status quo against the likely benefits and risks associated with FP incentives

Stage 2: Designing, implementing, monitoring and evaluating RBF for FP

- To what extent do programs intrude or empower?
- What are the provisions for informed decision making and consent?
- Are there conflicts with personal values?
- What is the best trade-off between quantity and quality?
- What is the effect on motivation of health providers and clients?
- Are there differences in use across target populations?
- What is the effect on the relationship between client and provider?
- What are the privacy and confidentiality arrangements?

Source: Authors

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ANNEX 1: TABLE 1.A1 BARRIERS TO FP

Type of Barrier	Description	Where is it Manifested in the FP Processes	Barrier to whom/which
Sociocultural	Religious or cultural restrictions on acceptance of contraceptives	Supply side: at every step of the FP process Demand side: Prior to making the decision to get information on FP; even prior to making a choice on accepting method; also affects continuation of use.	Acceptor both male and female; can affect provider behavior
Quality of care	Lack of “quality” ¹²⁴ in provision of FP services	Supply side: at every step of the FP process Demand side: making a choice on attending FP counseling as well as prior to making a choice on accepting method; also affects continuation of use.	Acceptor both male and female; affects provider behavior and ability to offer FP services
Gender-based	Gendered view of women’s role; lack of decision-making power for women	Supply side: at every step of the FP process Demand side: prior to making the decision to get information on FP or even; prior to making a choice on accepting method; also affects continuation of use.	Acceptor both male and female; can affect provider behavior
Political	Policies that restrict or limit use of FP	Supply side: affects the overall provision of FP services Demand side: prior to making the decision to get information on FP; even prior to making a choice on accepting method; also affects continuation of use.	Acceptor both male and female; affects provider behavior and ability to offer FP services
Infrastructural	Geographic distance to FP services	Supply side: at every step of the FP process Demand side: prior to making the decision to get information on FP; even prior to making a choice on accepting method; also affects continuation of use.	Acceptor both male and female; affects provider behavior and ability to offer FP services
Economic	Price of FP method and opportunity cost of utilizing FP services; cost of setting up FP services in countries and funds available for FP	Supply side: at every step of the FP process Demand side: prior to making a decision to get information on FP; even prior to making a choice on accepting method; also affects continuation of use.	Acceptor both male and female; affects ability of governments and providers to offer FP services

124. Quality FP service is described as having six key elements that clients perceive to be critical for making an informed choice. These are choice of method, information given to users, technical competence, interpersonal relations, follow-up or continuity mechanisms, and appropriate constellation of services.

ANNEX 2: TABLE 2.A2 DHS DATA COMPILED

	Infrequent sex	Health concerns	Fear of side effects	Inconvenient to use	Interfere with body	Respondent opposed	Spouse opposed	Others opposed	Religious prohibition	Other opposition to use	Knows no method	Knows no source	Lack of access	Costs too much	Other fertility-related reasons	Other method related	Other	Do not know	Missing
Sub-Saharan Africa																			
Benin 2006 ⁽¹⁾	7.5	7.1	14.5	0.5	1.9	13.1	3.2	0.2	3.8	0.0	3.7	2.4	0.1	1.3	0.0	0.0	0.8	2.4	0.4
Congo Democratic Republic 2007	5.9	2.7	6.2	1.8	1.5	10.1	4.8	0.2	5.6	0.0	8.7	2.3	0.6	0.3	0.0	0.0	1.7	2.2	0.2
Ghana 2008	4.5	8.1	26.0	2.4	3.7	16.4	2.6	0.7	2.8	0.0	2.0	1.5	0.3	0.7	0.0	0.0	0.9	1.7	0.0
Kenya 2008–09	6.7	14.9	15.8	0.6	5.9	7.9	6.0	0.1	9.0	0.0	2.3	1.9	0.8	0.4	0.0	0.0	3.6	0.6	0.3
Liberia 2007	0.7	5.0	27.2	1.3	1.8	7.1	6.8	0.2	4.0	0.0	10.8	2.8	0.7	0.2	0.0	0.0	1.5	2.3	0.7
Madagascar 2008009 ⁽²⁾	3.9	10.2	17.5	1.2	1.9	9.7	4.2	0.8	1.2	0.0	3.8	1.6	0.6	0.2	0.0	0.0	0.2	1.9	0.1
Mali 2006	2.7	5.5	4.1	0.4	3.2	22.1	9.0	0.0	4.9	0.0	8.6	4.5	0.1	0.5	0.0	0.0	2.0	2.5	0.3
Namibia 2006–07	5.0	10.8	4.2	0.8	3.7	6.9	5.2	0.3	1.4	0.0	3.8	0.1	0.1	1.1	0.0	0.0	12.3	5.3	0.9
Niger 2006	4.8	3.0	2.4	0.8	2.7	15.9	6.4	0.3	6.3	0.0	11.7	4.5	0.5	0.4	0.0	0.0	3.9	2.8	0.3
Nigeria 2008	2.7	2.7	8.1	0.6	3.7	20.8	9.8	0.9	7.9	0.0	8.1	1.0	0.2	0.2	0.0	0.0	4.6	2.6	0.4
Rwanda 2007–08 ⁽³⁾	14.4	3.2	8.5	0.4	0.8	5.7	1.5	0.1	4.2	0.0	1.0	0.2	0.0	0.0	0.0	0.0	4.0	0.6	0.6
Sao Tome and Principe 2008–09	10.9	19.3	6.4	0.0	2.5	16.9	5.6	0.0	0.3	0.0	0.2	0.0	0.0	0.0	1.0	0.0	9.8	3.0	0.0
Sierra Leone 2008	1.4	3.4	10.8	0.5	1.3	13.5	14.4	0.2	9.3	0.0	11.3	0.7	0.3	1.3	0.0	0.0	3.1	2.0	0.2
Swaziland 2006–07	10.9	10.9	8.3	0.9	2.7	2.1	8.3	0.1	1.2	0.0	0.0	0.0	0.0	0.4	0.0	0.0	3.9	1.5	0.5
Uganda 2006	6.8	6.3	26	0.3	1.2	9.8	4.7	0.2	2.8	0.0	4.8	0.7	0.0	0.7	0.0	0.0	4.4	0.7	0.0

Zambia 2007	7.9	4.3	17.6	0.7	3.1	4.9	4.1	0.1	1.4	0.0	1.7	0.4	0.4	0.1	0.0	0.0	4.7	1.2	0.6
North Africa/West Asia/Europe																			
Albania 2008–09	4.2	9.0	18.9	0.7	0.9	17.8	6.6	0.6	0.2	0.0	0.7	2.2	0.7	0.5	0.0	0.0	0.3	1.0	0.0
Azerbaijan 2006	10.1	10.4	1.6	0.3	0.8	3.6	2.2	0.4	0.5	0.0	1.3	0.0	0.0	0.8	0.0	0.0	5.9	1.1	0.0
Egypt 2008 ⁽⁴⁾	7.3	9.7	7.1	0.4	0.6	2.1	2.4	0.0	1.5	0.0	0.1	0.1	0.0	0.1	2.6	0.0	0.8	0.2	1.1
Jordan 2009	8.4	10.1	7.3	1.2	0.5	4.2	2.4	0.0	0.9	0.0	0.0	0.0	0.0	0.1	0.0	0.0	8.7	0.4	0.0
Jordan 2007	8.8	16.3	6.0	0.8	0.3	3.1	2.1	0.0	0.4	0.0	0.3	0.0	0.0	0.5	10.4	0.0	3.3	0.7	0.0
Ukraine 2007	9.8	7.3	0.9	0.1	0.5	2.7	1.5	0.1	1.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.7	0.6	0.1
South and Southeast Asia																			
Bangladesh 2007 ⁽⁵⁾	10.4	2.6	3.5	0.2	1.8	5.3	3.0	0.0	3.8	0.0	0.3	0.3	0.1	0.0	0.0	0.0	4.7	0.2	0.1
India 2005–06	11.1	5.0	4.3	0.4	1.0	5.5	4.4	0.3	5.0	5.9	1.4	0.4	0.2	0.6	0.0	0.0	3.9	1.8	0.2
Indonesia 2007	8.2	10.1	12.3	1.5	0.6	1.2	3.1	0.1	0.4	0.0	0.8	0.5	0.4	2.5	0.0	8.1	4.1	3.1	0.4
Maldives 2009 ⁽⁶⁾	2.9	12.0	5.5	0.7	0.6	38.8	5.5	0.2	0.8	0.0	0.4	0.0	0.1	0.2	0.0	0.0	6.0	8.8	0.7
Nepal 2006	12.4	6.8	10.0	0.3	0.8	0.6	3.2	0.3	6.6	1.2	0.5	0.2	0.2	0.0	0.0	0.0	3.9	0.1	0.1
Pakistan 2006–07 ⁽⁷⁾	4.2	3.6	5.4	0.3	2.0	7.7	9.9	0.4	5.0	0.0	2.2	0.8	0.0	0.8	28.4	0.0	3.8	2.2	0.4
Philippines 2008	9.8	20.9	13.9	1.2	0.6	2.8	3.2	0.1	2.9	0.0	0.4	0.2	0.4	2.2	0.0	0.0	0.6	0.6	0.1
Timor Leste 2009–10	1.5	8.3	10.1	0.1	2.0	46.0	8.5	0.2	0.3	0.0	5.4	0.3	0.5	0.0	0.0	0.0	1.4	1.4	0.0
Latin America and Caribbean																			
Bolivia 2008	8.6	4.7	12.9	0.1	1.3	6.1	2.8	0.2	0.8	0.0	3.6	0.4	0.3	0.2	0.0	0.0	0.2	0.9	0.3
Colombia 2010 ⁽⁸⁾	3.6	4.9	2.4	0.0	0.0	3.6	0.9	0.0	0.4	0.0	0.2	0.1	0.2	0.8	11.6	0.0	4.7	0.6	0.0
Dominican Republic 2007	5.1	8.8	6.0	1.9	1.5	12.8	1.2	0.0	0.6	0.0	0.9	0.4	0.0	0.1	0.0	0.0	6.0	1.3	2.6
Guyana 2009	7.4	14.1	11.9	2.3	6.5	6.1	1.9	0.1	1.6	0.0	0.8	0.7	0.7	0.9	0.0	0.0	9.8	9.7	0.2
Haiti 2005–06	3.7	19	26.9	4.1	4.7	6.6	2.3	0.3	7.5	0.0	0.2	0.1	0.3	0.3	0.0	0.0	0.8	0.2	0.3

Source: DHS Data 2006-11

ANNEX 3: INTERNATIONAL ACTION ON FAMILY PLANNING AND CHOICE

The experiences from countries with vertical population control programs focused on attaining targets in family planning — with less attention to the rights of the couple to make an informed decision — influenced the discussions at the International Conference on Population and Development (ICPD) in Cairo in 1994. The ICPD declared that attaining the goals of sustainable, equitable development requires that individuals are able to exercise control over their sexual and reproductive lives. This includes the rights to the following:

- Reproductive and sexual health as a component of overall health, throughout the life cycle
- Reproductive decision making, including voluntary choice in marriage; family formation; and determination of the number, timing, and spacing of one's children; and the right to have access to the information and means needed to exercise voluntary choice
- Sexual and reproductive security, including freedom from sexual violence and coercion, and the right to privacy

Overall, there is strong support for promoting FP from the donor community; this is, however, tempered with an equally strong cautionary note that FP programs must be implemented within the framework of gender and human rights. There is a universal endorsement of the reproductive rights approach adopted during the ICPD; and while supporting incentives for enhancing health outcomes for women, it does not support any incentives that might infringe on the principle of voluntarism in uptake of FP services. Most major international donors have articulated a policy with regard to voluntarism and the issue of incentivizing family planning acceptance:

- The United Nations Population Fund (UNFPA) supports provision of reproductive health services within the framework of reproductive rights. This includes the “right to decide the number, timing and spacing of children, the right to voluntarily marry and establish a family, and the right to the highest attainable standard of health, among others.”¹²⁵ UNFPA also acknowledges the dangers of undue inducement. “UNFPA is committed to informed, voluntary choice in population and reproductive health programs, and supports training and management reforms to ensure this. The Fund only assists service delivery projects that rely on informed consent and offer quality care.”¹²⁶
- The government of Sweden, through the Swedish International Development Agency (SIDA), has been a long-term supporter of sexual and reproductive rights, and more recently has offered strong support to the achievement of the MDGs. Sweden has provided population assistance since the 1950s, initiating the funding of contraceptive supplies and services by a bilateral donor. Over the years, Sweden has backed many controversial policies, including combating unsafe abortion and violence against women, and also expanded coverage of family planning services to adolescents and unmarried women. The government has also actively supported human rights, gender equity, maternal and child health, abortion, and programs to reduce HIV/AIDS and sexually transmitted diseases (STDs). Its holistic approach preceded and was reinforced by ICPD. Funding has moved from project-specific to

125. UNFPA website, accessed April 27, 2011.

126. UNFPA. 1997. *State of the World's Population*. UNFPA: New York.

sector-wide approaches, and SIDA's emphasis is now on strengthening health systems to enhance reproductive health outcomes.¹²⁷

- Denmark is the world's most generous contributor to reproductive health programs relative to the size of its economy, through its bilateral assistance agency, Danida. It continues to be a major proponent of ICPD and a significant contributor to UNFPA. The Danish program emphasizes the importance of improved health in the context of poverty reduction and lays special emphasis on reproductive health and rights and improving the status of women. The program places considerable emphasis on integrating family planning and MCH services into primary health care, and focuses population assistance on improving information availability on sexuality and reproductive health among adolescents and more vulnerable women. It also funds research on new contraceptive technologies that can enhance client choice and satisfaction.¹²⁸
- The government of Norway is a signatory to the UN Committee on the Elimination of Discrimination against Women (CEDAW), which states that "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence."¹²⁹ Norwegian Agency for Development Cooperation (NORAD) supports sexual and reproductive health rights including better access to family planning methods.
- United Kingdom's Department for International Development's (DFID's) new focus on family planning recognizes that the international community has ignored the needs of women for access to safe reproductive health services, as a result of which the MDG on maternal health is lagging well behind targets. The heart of DFID's strategy is to increase the availability of family planning services.¹³⁰ DFID, along with NORAD, is a supporter of the Bank's RBF work, that is, in principle it is a supporter of demand- and supply-side incentives and has supported programs with incentives for improving maternal health outcomes.
- USAID has set the most explicit policy reflecting its values and principles with regard to voluntarism in family planning. The document "Guidance for implementing the 'Tiaht' requirements for voluntary family planning projects"¹³¹ specifically states:
 - "Service providers and referral agents cannot implement or be subject to quotas relating to numbers of births, FP acceptors, or acceptors of a particular FP method;
 - There be no incentives to individuals in exchange for becoming acceptors or to program personnel for achieving targets or quotas for numbers of births, acceptors, or acceptors of a particular FP method;

127. Sweden Profile;

http://209.68.15.158/Publications/Reports/Progress_and_Promises/Interactive/pandp/pdfs/Sweden_profile.pdf.

128. Denmark Profile;

http://209.68.15.158/Publications/Reports/Progress_and_Promises/Interactive/pandp/pdfs/Denmark_profile.pdf.

129. See government of Norway;

http://www.regjeringen.no/upload/UD/Vedlegg/Utvikling/Kvinner%20og%20likestilling/Handlingsplan_kvinner_Eng0510.pdf

130. <http://www.dfid.gov.uk/Media-Room/News-Stories/2010/Mitchell-New-focus-on-family-planning-to-reduce-deaths-in-pregnancy-and-childbirth/>.

131. http://www.usaid.gov/our_work/global_health/pop/tiahtqa.pdf, accessed on July 29, 2010.

- Rights or benefits not be withheld from persons who decide not to become acceptors;
- Acceptors get comprehensible information on health benefits and risks of the FP method chosen, including conditions that might make the selected method inadvisable as well as its known adverse side effects.”¹³²

This important amendment reflects the law of the United States with regard to voluntarism and family planning. The requirements apply to all USAID projects that deliver family planning services, whether funds, goods or services, and are strictly monitored. An example is the report on the assessment of whether the provisions of the Tiahrt Amendment were being followed in the Rwanda RBF project (conducted by USAID, 2005). The assessment, which included consultations with a wide range of stakeholders, found that the provisions of the Tiahrt Amendment were not currently being violated by the project, but did sound some cautionary notes: (i) subsidies for FP service outcomes should be carefully balanced vis-à-vis other desired health outcomes to prevent the aggressive pushing of FP services; (ii) any situation that led to the excessive promotion of FP services could detract from voluntarism — in short, it is a fine balance; and (iii) the government, donors, and other stakeholders should work together to refine the model and enhance oversight to ensure that voluntarism is protected.¹³³ The implications for an RBF program would be that any violation of the Tiahrt requirements by implementing governments would lead to the withdrawal of USAID support. However, USAID is overall favorable toward RBF concepts, and has developed guidance on how they can be designed within the overall Tiahrt framework.¹³⁴

132. Ibid.

133. USAID 2005.

134. R. Eichler and L. Morgan 2010.

ANNEX 4: TABLE 3.A4 LIST OF RELEVANT EVIDENCE OF EFFECTS OF FP INCENTIVES

Country	Incentive type: recipient; cash/kind; contraceptive methods	Effects	Study reference and design
SUPPLY-SIDE INCENTIVES			
Pre-1990			
Indonesia	Diffusers; Monetary incentives were provided to acceptors of IUD and oral pills.	Increase in use among acceptors (“doubled”).	E. Rogers. 1971. “Incentives in the Diffusion of Family Planning Innovations.” <i>Studies in Family Planning</i> 2 (12). Before/after analysis; no controls
Ghana	Potential clients given coupons for in-kind incentive (powder milk) for acceptance of various methods of FP in first few weeks of pilot and in last week in addition to free milk coupons, field workers also given in-kind incentive for every women referred and every women who came to clinic — the tins of milk increasing with increased number of clients.	Increase in acceptance from 11% during control week to 20% in week with incentive. The addition of the workers incentive was associated with a five-fold increase in acceptance of FP. The time between the referral and the acceptance also shortened.	Gordon W. Perkin 1970. “Nonmonetary Commodity Incentives in Family Planning Programs: A Preliminary Trial.” <i>Studies in Family Planning</i> 1 (57): 12–15; http://www.ncbi.nlm.nih.gov/pubmed/5538543 . Experimental design. Short-term (five-week) pilot.
Philippines	Financial incentive to motivators on (i) per-acceptor basis with no quota/target; (ii) individual quota/target + bonus for performance above the quota; (iii) group quota/target + bonus for performance above the quota. Control area motivators paid a flat rate. Methods — pills, condoms, IUDs, and rhythm method.	Motivators paid on per-acceptor basis with no quota performed best, followed by those with individual quotas and bonuses. Motivators in the individual bonus and per-acceptor–rate incentive plans produced twice as much protection per peso spent as the motivators in the control area.	James F. Phillips. “Aurora Silayan-Go and Aurora Pal-Montano; An Experiment with Payment, Quota, and Clinic Affiliation Schemes for Lay Motivators in the Philippines;” http://www.jstor.org/stable/1964698 . Case/control study
Taiwan	Financial incentive to field based motivators/field workers per FP method in addition to their salary — \$2.50 for each loop acceptor and \$0.50 for each acceptor of pills or condom. Control area — field workers/motivators only paid salary.	In area with incentive 6% of women accepted the loop compared with 2% in control area; in incentive area 14% of all women visited accepted a FP method compared with 7% in control area; new acceptors in incentive area were 20.7%, and 10.7% in control area; in four months the absolute increase in contraceptive use in incentive area was to 44% from 37.6%.	M. C. Chang, George P. Cernada, and T. H. Sun. “A Field-worker Incentive Experimental Study;” www.jstor.org/stable/1965248 Case /control study

Country	Incentive type: recipient; cash/kind; contraceptive methods	Effects	Study reference and design
Post 1990s			
Egypt	Incentive payments of a maximum of 275% times the total base salary of all personnel in Primary Health Care Unit for the provision of a package of services including FP, antenatal care, gynecological services, immunization and other services. FP and immunization given different weighting. Performance measured against set of standardized indicators (curative, preventive, and quality indicators) and rating criteria. Control area providers did not receive incentive.	Positive effect on performance of FP providers with significant difference observed with regard to better history taking, less laboratory investigations, more follow-up visits, and more information about the available FP methods. Clients reported increased involvement in decision making for FP method. Positive effects on quality of antenatal and child care.	Case-control Quasi-experimental study design with post-test only for comparison groups. Huntington D, Zaky HH, Shawky S, Fattah FA, El-Hadary E. "Impact of a Service Provider Incentive Payment Scheme on Quality of Reproductive and Child-Health Services in Egypt;" http://www.ncbi.nlm.nih.gov/pubmed/20635638 .
DEMAND- SIDE INCENTIVES			
Pre-1990s			
India	Women tea plantation workers in childbearing age were provided joint savings account. The tea estate paid Rs.5 /month into the account for every month that the woman remained nonpregnant. The woman would draw the amount when she completed her childbearing. The amount would also accumulate interest. There would be forfeiture after every birth following the second child — if the gap between the second and third child was greater than three years, then 50 Rupees would be forfeited from the amount, and 100 Rupees if the gap were less than three years, 250 Rupees for the fourth child, and the total amount after the fifth child. All FP methods were available for acceptor with a slight stress on sterilization.	Knowledge of and attitudes toward contraceptives, especially sterilization universally high and generally favorable. Birth and fertility rate decreased (from 5.0 to 2.8, approximately). Between 1971 and 1975 22% of eligible couples were sterilized compared to 12% sterilized prior to 1971	Ronald G. Ridker. 1980. "The No-Birth Bonus Scheme: The Use of Savings Accounts for Family Planning in South India." <i>Population and Development Review</i> 6 (1): 31–46; http://www.jstor.org/stable/1972656 . Experimental design. Assessment of results pre- and post-intervention. Sample survey; review of records; personal observations and interviews of acceptors.
India	Female acceptors were given same amount of financial incentive for first and subsequent monthly clinic visits for FP method; continuing the FP method and not becoming pregnant. After five months they received the FP method from field based contact person.	Increase in knowledge of FP methods; increase in use of temporary FP methods from 3.6% at baseline to 13% in cluster A and from 3.2% at baseline to 24% in cluster B. Control villages showed utilization rates 5% and 6%, respectively. Male sterilization increased by 24% and 27%, respectively, while female sterilization increased by 13 % and 23%, respectively.	Janice R. Stevens and Carl M. Stevens. 1992. "Introductory Small Cash Incentives to Promote Child Spacing in India." <i>Studies in Family Planning</i> 23 (3): 171–86; http://www.jstor.org/stable/1966726 . Case/matched controls.

Country	Incentive type: recipient; cash/kind; contraceptive methods	Effects	Study reference and design
Thailand	Loans from a village fund were given to villagers for income-generation activity in agriculture. The villagers who accepted FP got larger loans than those who did not, and the loan fund grew in size as the village CPR increased. Dividends from the profits were paid to individuals depending on the effectiveness of the FP method.	Significant increase in use of reversible FP methods; CPR raised from 46% to 75%, while in control from 51% to 57%; pregnancy rate in program villages fell from 11% of women of reproductive age at the start of the program to 5%. In the control village the rates were 7% and 8%, respectively. Unmet need for FP declined faster in program villages.	Donald Weeden, Anthony Bennett, Donald Lauro, and Mechai Viravaidya. 1986. "An Incentives Program to Increase Contraceptive Prevalence in Rural Thailand." <i>International Family Planning Perspectives</i> 12 (1): 11–16; http://www.jstor.org/stable/2947624 . Case/control study.
Ghana (also under supply-side incentive above)	Potential clients given coupons for in-kind incentive (powder milk) for acceptance of various methods of FP in first few weeks of pilot and in last week in addition to free milk coupons, field workers also given in-kind incentive for every women referred and every women who came to clinic — the tins of milk increasing with increased number of clients.	Increase in acceptance from 11% during control week to 20% in week with incentive. The addition of the workers incentive was associated with a five-fold increase in acceptance of FP. The time between the referral and the acceptance also shortened.	Gordon W. Perkin ; Nonmonetary Commodity Incentives in Family Planning Programs: A Preliminary Trial ; Studies in Family Planning Vol. 1, No. 57 (Sep., 1970), pp. 12-15 http://www.ncbi.nlm.nih.gov/pubmed/5538543 Experimental design. Short-term (5 week) pilot.
Taiwan	Female users of FP were provided with vouchers for IUD use. 3,181 IUD acceptors over three years in Taiwan were matched with nonacceptor controls (by characteristics and fertility rates at time of insertion).	Fertility declined among IUD-users from 381/1,000 to 77/1,000 or 80%, while the matches declined from 376 to 195. The decline was 91% for women with six or more live births, decreasing to 50% for those with less than two. The net effectiveness was 99/1,000 or one birth a year averted per every ten insertions.	L. P. Chow, M. C. Chang, and T. H. Liu. 1969. "TAIWAN: Demographic Impact of an IUD Program." <i>Studies in Family Planning</i> 1 (45): 1–6; http://www.jstor.org/stable/1965002 Before/after analysis of cases matched with controls.
Post-1990s			
Mexico	Designated female household heads provided cash transfers equaling 20% of the household's monthly expenditure, based on several conditions including FP pregnancy-related care, and nutritional advice. The transfers were dependent on the providers certifying that the required health-related activities have been completed. Modern contraceptives — hormonal injections, IUDs, condoms, sterilization provided.	Significant increase in contraceptive use among acceptors in the treatment group in the first two-year period ("difference in log odds of 0.16, which was statistically significant"). There was no effect during second period of two years when both groups had similar probabilities of contraceptive use. The average birth intervals were similar for the treatment and control showing no effect. No impact on birth spacing.	Feldman BS, Zaslavsky AM, Ezzati M, Peterson KE, Mitchell M. "Contraceptive Use, Birth Spacing, and Autonomy: An Analysis of the Oportunidades Program in Rural Mexico;" http://www.ncbi.nlm.nih.gov/pubmed/19397185 Household and population based surveys. Treatment and control groups randomly selected.

Country	Incentive type: recipient; cash/kind; contraceptive methods	Effects	Study reference and design
Nicaragua	Adolescent girls from low-income urban areas provided vouchers for free SRH services in clinics. Oral pills, injectable+, IUDs, and condoms provided.	Increase in contraceptive use among sexually active girls who were neither pregnant nor mothers. The intended use of contraceptives doubled among the sexually active nonpregnant voucher redeemers— from 24% to 57% among those who were not yet mothers, and from 47% to 82% among those who were mothers; 69% of the sexually active girls left with a contraceptive method.	Meuwissen LE, Gorter AC, Segura Z, Kester AD, Knottnerus JA. 2006. “Uncovering and Responding to Needs for Sexual and Reproductive Health Care among Poor Urban Female Adolescents in Nicaragua.” <i>Trop Med Int Health</i> 11 (12): 1858-67; http://www.ncbi.nlm.nih.gov/pubmed/17176351 . Before/after analysis of medical files using descriptive statistical analysis, and multiple logistic regression analysis.
Nicaragua	Poor households were provided CCT to invest in children’s health, nutrition, and education on the basis of compliance with a set of health/nutrition and education indicators. Various contraceptive methods were provided.	Decrease in hazard of birth; increase in birth spacing (“reduction the odds of birth by 32%”).	Jessica E. Todd, Paul Winters, and Guy Stecklov. 2011. “Evaluating the Impact of Conditional Cash Transfer Programs on Fertility: the Case of the Red de Protección Social in Nicaragua.” <i>Journal of Population Economics</i> 25 (1): 267–90. Case/control study with strong Cox proportional hazard model.
Kenya	Vouchers used as a means to reduce maternal and child mortality. Subsidized vouchers are targeted to poor women, enabling increased access to a range of safe motherhood and family planning services. Accredited public and private health service providers are reimbursed for voucher-supported services provided.	The SM voucher was very popular. The FP vouchers accounted for roughly two-thirds of FP services provided at the clinics, the use of FP methods remained lower than anticipated.	Ben Bellows, Matthew Hamilton, and Francis Kundu. 2010. “Vouchers for Health: Increasing Utilization of Facility-based Family Planning and Safe Motherhood Services in Kenya.” USAID; http://www.healthsystems2020.org/content/resource/detail/2563/ . Process evaluation. No controls. Pre- and post-surveys.
Pakistan	Poor women provided vouchers at a highly subsidized price to access FP and RH services from private providers. They also received transportation costs. Providers are paid a fee for each service provided. FP services included oral pills, injectables, long-term methods and condoms.	Increase in use by voucher holders for both FP and RH services. 79% of voucher holders returned to facility for postnatal FP counseling — 25% chose no methods while the remaining chose long-term methods such as IUDs, followed by injectables, then condoms and ligation. Every voucher holder brought with her three to four pregnant women from her family for services — a spillover effect of the scheme.	Hamid Bashir, Sarfaraz Kazmi, Rena Eichler, Alix Beith, and Ellie Brown. 2010. “Pay for Performance: Improving Maternal Health Services in Pakistan.” USAID; http://www.healthsystems2020.org/content/resource/detail/2577/ . Process evaluation. No controls.

Country	Incentive type: recipient; cash/kind; contraceptive methods	Effects	Study reference and design
Honduras, Mexico, Nicaragua	Assessment of CCT programs in three Latin America countries to assess the potential, unintended impact of conditional cash transfers programs on childbearing.	Honduras: the program may inadvertently have been designed to create incentives to have children, and it showed increase in fertility by 2 to 4 percentage points, possibly due to increase in marriage rates; in Mexico and Nicaragua contraceptive use rose, but this might simply be to counteract the impact of reduced spousal separation — another possible unintentional impact of the poverty programs. There was no change in fertility in both countries.	Guy Stecklov, Paul Winters, Jessica Todd, and Ferdinando Regalia. <i>Demographic Externalities from Poverty Programs in Developing Countries: Experimental Evidence from Latin America</i> . American University, Department of Economics Working Papers 2006-01. http://w.american.edu/cas/economics/repec/amu/workingpapers/2006-01.pdf . Case/control trials.
Brazil	a monthly minimum income provided to families below the poverty line, additional benefit provided to each pregnant woman, child at low age or child at scholar age; Various contraceptive methods.	No impact on fertility of beneficiaries	B. Signorini, and B. Queiroz. 2011. "The Impact of Bolsa Familia on Beneficiaries' Fertility." Working Paper no. 439. Belo Horizonte: UFMG/Cedeplar; http://www.cedeplar.ufmg.br/pesquisas/td/TD%20439.pdf . Data from national household surveys; Experimental design.
Mexico	Cash transfers were made to poor women conditional to utilization of health services including FP. Various contraceptive methods.	Increase in knowledge of FP services; increase in use; no impact on fertility among users.	Prado B., Salomon Urquieta J, Villalobos MR, Figueroa JL: <i>Impacto de Oportunidades en la salud reproductiva de la poblacion beneficiaria</i> , National Institute of Public Health, Mexico, 2004. Experimental design.
Mexico	Poor female users; CCTs Education: Cash transfers conditional on keeping kids at school; health: package of services mainly for pregnant women and children under five years of age; health talks (Pláticas) to female heads of household; nutrition: supplements of vitamins.	The program has a large and positive impact on contraceptive use by the poorest; and it has a small impact on those near the threshold. Positive effect on contraceptive use ("size of effect: 0.049").	Hector Lamadrid Figueroa, Gustavo Angeles, Thomas Mroz, Jose Urquieta Salomon, Bernardo Hernandez Prado, Aurelio Cruz Valdez, Martha Maria Tellez Rojo Solis. 2010. "Heterogeneous Impact of the Social Programme Oportunidades on Use of Contraceptive Methods by Young Adult Women Living in Rural Areas." <i>Journal of Development Effectiveness</i> (2) 1: 74–86; http://www.3ieimpact.org/en/evidence/impact-evaluations/details/397 . Impact evaluation. Strong statistical analysis.

ANNEX 5: TABLE 4.A5 USERS' PERSPECTIVE

Source	Nature of FPI	Assessed risks	Comments
Hapugalle 1989	Small monetary incentives for sterilization in Sri Lanka	LOW	Regret: 14–17% No association between amount paid and regret No association with income No perceived pressure in decision making probably due to small amount paid
Srinivasan 1968	User incentive for vasectomy in India	HIGH	43% of acceptors: money is the sole motivator but 59–61% agree with incentive model
Population Research Council, Andhra Pradesh, 2002	Monetary incentives for sterilizations	MEDIUM	75% of acceptors: they would have accepted even without incentive. 25% where money has been the key driver
De Silva 1988	Incentives for vasectomy in Sri Lanka	LOW	5% of acceptors: cash is an important reason for choosing vasectomy
Barnett and Stein (cited in Seltzerland)	Incentives for one child policy in China	MEDIUM	Despite apparent coercive characteristics, acceptors see the policy as part as “societal norm”
Cleland 1991	Monetary incentives for users of sterilizations in Bangladesh	LOW	6%: money was the main reason. Where there is desire for limiting family size, money works as an “additional spur”
Thapa 1987	Incentive for vasectomy in Sri Lanka	LOW	3–8%: money is the main reason for acceptance.

ANNEX 6: TABLE 5.A6 RBF EXAMPLES SINCE 1990

RBF program example	Funding agency	RBF recipient	Indicators and FP-linked payment mechanism	Quality assurance mechanism, with a FP focus	FP payment compared to payment for other health services
Demand-side RBF programs					
Clients are rewarded for utilizing health services including attending FP sessions or the actual uptake of FP					
Conditional cash transfers (CCTs) in Latin America	Various governments (Brazil, Colombia, Ecuador, Honduras, Jamaica, Mexico, Nicaragua) and the World Bank	Poor households participating in the program	Monthly income transfers to poor households linked to a series of conditionalities (linked to education, health, social security) that include attendance at health education talks that include FP	Programs use different quality assurance mechanisms including interviews with program participants on several indicators including quality of health education talks and/or interviews with program providers on perceptions of quality of care. No direct link between quality and RBF payment.	Clients are rewarded for attending health education talks that include FP through monthly income transfers. Amount of income transfers vary for each program.
Clients are rewarded for uptake of long-acting and permanent FP methods*					
In India payments are made to acceptors of Intra Uterine Device (IUD) insertions and sterilization at public health facilities	Ministry of Health and Family Welfare, government of India	Acceptors of IUD and sterilization. In high-focus states: all men and women; In nonhigh focus states: poor households and scheduled caste/tribe rewarded the same as men and women in high-focus states but reduced incentive for non-poor households	Payments are made to acceptors of IUD insertions and sterilization at public health facilities. There are no other indicators, the program only focuses on acceptors of IUDs and sterilization.	No information on quality assurance could be identified.	High-focus states: US\$11 for tubal ligation and US\$20 for vasectomy. Same payment in nonhigh focus states when the service is provided to a scheduled caste/tribe and US\$5 for tubal ligation at public health facilities for non-poor households. US\$0.18 for IUD insertion at public facilities in all states and US\$1.38 in high-focus states. Clients are given cash compensation in case of death or disability from having undergone the procedure.
Demand- and supply-side RBF program					
Eligible clients, pregnant women, or poor are sold vouchers at subsidized rates to access FP services at public and/or private health facilities — whose providers are paid for providing FP services to voucher holders					
Sehat Voucher Program, Pakistan	Ministry of Health, Pakistan	Voucher holder (pregnant women) and FP service provider	Pregnant women are sold vouchers at a subsidized rate for antenatal and postnatal visits, institutional delivery and postdelivery FP counseling services. They get free access to FP counseling and modern temporary and long-acting methods as well as reimbursement for transportation costs. Providers receive payments for FP services provided including	Quality is assured through client interviews on quality of care and visits by health services department of the social franchise to the regional level and head office level to check the quality of services. No direct link between quality and RBF payment.	The woman pays US\$1.21 for the voucher booklet (with a total value of US\$50). Voucher holders receive free FP service and are reimbursed US\$0.60 in transportation costs; providers receive US\$1.05 for each FP service. In comparison, providers receive US\$26 for a normal delivery while voucher holders are reimbursed US\$2.60 in transportation costs for a normal delivery. No link in payment to

RBF program example	Funding agency	RBF recipient	Indicators and FP-linked payment mechanism	Quality assurance mechanism, with a FP focus	FP payment compared to payment for other health services
			FP counseling; provision of pills, injections or IUDs.		provider for "quality" of FP.
Maternal health and FP voucher program in Kenya	German Development Bank, EU; implemented through Voucher Management Agency (VMA)	Voucher holder and service providers (public, private, NGO, and FBO).	Eligible clients are identified, using a standardized Poverty Assessment Tool developed by MSI, who are sold vouchers at a subsidized rate. The voucher holders redeem these for modern long-acting and permanent FP methods. Service providers are paid a fee for providing FP services to voucher holders.	"Only accredited facilities (i.e., specified standard of care, infrastructure, staffing).	
Supply-side RBF programs					
NGOs are contracted for provision of different health services including reduced FP discontinuation, increased FP utilization, and, in some cases, improved quality of FP services					
Performance-based contracting of NGOs for service delivery in Afghanistan. Currently a RBF health facility approach implemented under this NGO contracting	Implementation of the Basic Package of Health Services (BPHS) through contracting is funded by three agencies: European Union, World Bank (with HRITF), and USAID.	NGOs contracted by the government to run and provide health services in a province and subsequently the health facilities contracted by the NGOs, with the performance payments benefitting the health facility staff.	Six health indicators paid for at the health center, including contraceptive prevalence rate (CPR). The NGO performance payment is based on increase in the CPR (proportion of married, nonpregnant women of reproductive age who or whose partner are currently using at least one family planning method) in the province, next to equity in service utilization (of the poor).	Quality at the health center level is measured by scoring using a National Monitoring Checklist. For FP, it includes the availability of FP supplies, namely condoms, oral contraceptive pills, DMPA, and injectable contraceptive, and IUDs throughout the last month. This is counter-verified by the Balanced Scorecard (which is also used to measure quality in the hospitals).	10% of the NGO total contract value is allocated for RBF, of which 20% is earmarked for CPR: One-third is paid for each 2 percentage point increase per year. Health centers receive bonuses linked to quantity of services (above the baseline), including FP, and are conditional on quality, which incorporates the FP availability index. Health facilities subsequently pay health workers part of the performance payment based on their performance.
Contracting RBF purchasing agent who contracts health facilities based on "quantity"/ number of services provided, including FP utilization					
Public, private, and nongovernment health facilities in DRC are contracted by a purchasing agent (an NGO), which implements the incentive program	HRITF and the World Bank	Public and private health facilities and health authorities paid based on performance with part of this RBF payment subsequently benefitting the health care workers.	RBF payments are provided to health centers based on the "quantity" (based on a predetermined unit fee) for ten health indicators, including a FP indicator per woman who uses a modern method of FP.	No quality indicators are included with a direct link to payment.	Health centers receive US\$3 for each woman who uses a modern method of FP compared to US\$0.35 for an outpatient visit and US\$3 for normal delivery. No link in payment to provider for "quality" of FP.

RBF program example	Funding agency	RBF recipient	Indicators and FP-linked payment mechanism	Quality assurance mechanism, with a FP focus	FP payment compared to payment for other health services
Public and private sector health facilities (in, e.g., Rwanda, Zambia, Benin, and Sierra Leone) are contracted based on performance. RBF payments are provided to health facilities based on quantity and conditional on quality of services (so-called <i>carrot and stick method</i>). Often it is implied, or in some cases it is a (pre)condition, that user fees are reduced or completely removed for the incentivized services					
National Performance-Based Financing (PBF) for Health Centre, Rwanda (using carrot and stick method)	Initially two donor-funded and NGO-implemented pilots in 2002; subsequently mainstreamed by the Rwanda Ministry of Health and partners from 2006 onwards	Public and private health facilities and health authorities paid based on performance with part of this RBF payment subsequently benefitting the health care workers.	RBF payments are provided to health facilities for "quantity" (based on a predetermined unit fee) for each of 22 health indicators, which include 2 FP indicators: New FP acceptors temporary and long-acting FP methods. Payment is conditional on "quality" scoring, i.e., a 70% quality score results in 70% of the amount based on the quantity of services provided. This method is called "carrot and stick."	Quality is ensured using a "carrot and stick" method, i.e., total payment made to facilities is discounted based on final score on quality assessment that includes availability of FP methods and an analysis of the records of ten FP cases to assess the justification of methods recommended, used, and prescribed compared to methods indicated on the basis of questioning, history, and physical examination; as well as verification and monitoring of the scheduled appointment. The FP indicators in the quantitative quality checklist account for 11.4% of all points that facilities can earn for quality.	Health facilities receive US\$1.83 for each new FP user; US\$0.18 for one-month of contraceptive resupply compared to US\$0.18 for outpatient visits and US\$4.59 for normal deliveries. Payment for "quantity" is conditional on "quality," which includes FP aspects. Health facilities subsequently pay health workers part of the performance payment based on their performance.
Malaria Booster project in Zambia supports PBF pilot in different districts (using carrot and stick method)	The World Bank and HRITF	Health centers, with part of this RBF payment subsequently benefitting the health care workers.	RBF payments are provided to health centers for "quantity" (based on a predetermined unit fee) for each of nine MCH health indicators, including one for FP: total number of users of modern temporary FP methods at the end of the month. Payment is conditional on the "quality" scoring.	Quality is ensured through "carrot and stick" method. The quantitative quality assessment includes availability of FP methods and an analysis of the records of ten FP cases to assess the justification of methods recommended, used, and prescribed compared to methods indicated on the basis of questioning, history, and physical examination; as well as verification and monitoring of the scheduled appointment. The FP indicators in the quantitative quality checklist account for 17.8% of all points that facilities can earn for quality.	Health centers are paid US\$0.60 for each user of modern FP method at the end of the month. In comparison, \$0.20 is paid for outpatient visits and US\$6.40 for a normal delivery. Payment for "quantity" is conditional on "quality," which includes FP aspects. Health facilities subsequently pay health workers part of the performance payment based on their performance.
Health System Performance Project in Benin supports PBF pilot (using carrot and	The World Bank and HRITF	Health facilities (public, private/NGO), with part of this RBF	RBF payments are provided to health facilities for "quantity" (based on a predetermined unit fee) for 18 health indicators,	Program applies the "carrot and stick" method. FP indicators account for almost 4% of all points that facilities can earn for quality from the	Health facilities can receive US\$3 for each new and continued FP acceptor. In comparison, US\$7 can be paid for a normal delivery and US\$0.60 for an

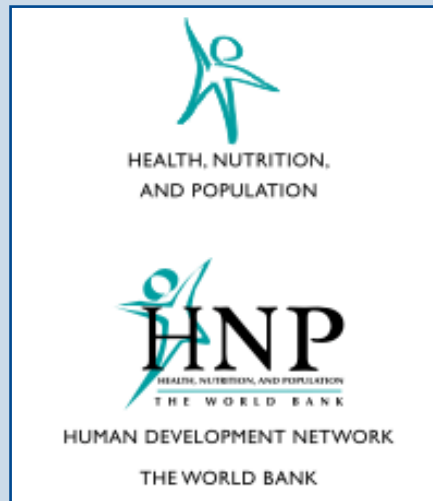
RBF program example	Funding agency	RBF recipient	Indicators and FP-linked payment mechanism	Quality assurance mechanism, with a FP focus	FP payment compared to payment for other health services
stick method)		payment subsequently benefitting the health care workers.	including 1 for FP: New and continued users of modern temporary and long acting FP methods. Payment is conditional on the "quality" scoring.	checklist.	outpatient visit. Payment for "quantity" is conditional on "quality," which includes FP aspects. Health facilities subsequently pay health workers part of the performance payment based on their performance.
Sierra Leone	The World Bank	Public health facilities. In absence of public health facilities, private, FBO, and NGO health facilities are contracted. Part of the health facility RBF payment subsequently benefits the health care workers.	RBF payments are provided to health centers for "quantity" (based on a predetermined unit fee) for each of six health indicators, including one for FP: Number of women and men newly accepting contraception by pills, injection, implant or surgical method at the facility (or through outreach by facility staff) during the relevant month. If a client had previously received contraception but had interrupted the contraception for at least one year, she/he is counted as a new acceptor. Final payment for "quantity" is calculated based on a quality score linked to each quantity indicator, which for FP is linked to properly completing the FP register. Hence, a reduced fee is provided for unsatisfactory entry.	Program applies the "carrot and stick" method through nine cross-cutting indicators. There is no direct link with FP in these cross-cutting indicators.	US\$0.23 for each new and current user of modern FP methods. In comparison, payment for normal delivery is about US\$2.30 while there are no payments for outpatient visits under this program. Payment for "quantity" is conditional on "quality" of FP registry completion. Health facilities subsequently pay health workers part of the performance payment based on their performance.
Public and private sector health care facilities are contracted (in, e.g., Burundi and Nigeria) are contracted based on performance. RBF payments are provided to health facilities based on quantity and often adjusted based on equity considerations (for facilities in disadvantaged situations and/or remote areas). An additional bonus can be earned based on the quality of services (<i>so-called carrot and carrot method</i>).					
National PBF Scheme for health facilities in Burundi (using carrot and carrot method)	70% from Ministry of Finance and 30% from development partners	Public, private, NGO, FBO health facilities, district and national hospitals, district and provincial health units, with part of this RBF payment subsequently benefitting the health care workers. There is	RBF payments are provided to health facilities for "quantity" (based on a predetermined unit fee) for 24 indicators. At health center and hospital level, including two FP indicators: Total of new and existing users accepting a three-month course of modern temporary FP methods as well as a separate indicator for implants or IUD. At hospital level, an additional FP indicator: for tubal ligation and vasectomy. Payment for	Quality is ensured using a "carrot and carrot" method, whereby a health facility can earn up to 25% more of its regular monthly earnings based on its quality scoring. The quality measure is calculated using 60% of the score obtained through the quantitative quality checklist and 40% from community client satisfaction surveys. The quantitative quality checklist includes seven indicators on FP, which account for 4.8% of all points that facilities can	Health Centers receive US\$2.03 per month for total number of women using modern FP method and US\$6.70 per month for new IUD acceptors. Hospitals receive US\$6.77 per month for new users of IUD and implants; US\$2.20 for total number of women using modern FP method each month, and US\$27 for acceptors of permanent method (vasectomy/tubal ligation) each month.

RBF program example	Funding agency	RBF recipient	Indicators and FP-linked payment mechanism	Quality assurance mechanism, with a FP focus	FP payment compared to payment for other health services
		ongoing work on the design of RBF targeting community level providers.	"quantity," which includes the FP indicators, is adjusted for "equity." In addition, a health facility can earn up to 25% more of its regular monthly earnings if it attains 100% of its "quality" scoring. This method is called "carrot and carrot."	earn for quality. The seven quality indicators are privacy in FP room; consultations conducted by qualified personnel (at least a nurse); availability of FP methods; availability of wall posters or image box to demonstrate FP methods; FP card available and up-to-date; group IEC meeting held before FP consultation and existence of updated IEC report; and the health center has reached at least 90% of quarterly target for oral and injectable contraceptives established in their action plan.	In comparison, US\$4.60 is paid for normal deliveries and US\$2 for outpatient visits. An additional bonus can be earned for "quality," which includes FP aspects. If the facility achieves less than 100%, it receives only a fraction of the 25% bonus payment. There is no bonus payment for scores between 50% and 70%. The facility is penalized for a score below 50% by losing 25% of its previous quarter earnings. Health facilities subsequently pay health workers part of the performance payment based on their performance.
Nigeria State Health Program Investment supports PBF pilot in three states (using carrot and carrot method)	The World Bank and HRITF	Health facilities and district health departments called local government authorities (LGAs), with part of this RBF payment subsequently benefitting the health care workers.	Payments are provided to health facilities for "quantity" (based on a predetermined unit fee) for each of the 21 to 22 indicators, which include 2 FP indicators: Total of new and existing FP users; and number of implants and IUDs. An additional FP indicator at the hospital linked to permanent FP methods. Payments are adjusted based on "equity." In addition, a health facility can earn up to 25% more of its regular monthly earnings if it attains 100% of its "quality" scoring.	Program applies the "carrot and carrot" method, whereby a health facility can earn up to 25% more of its regular monthly earnings if it attains 100% of its quality-related target goals. Ten FP indicators account for 8.8% of all points that facilities can earn for quality at the health facility level and 6.2% at the hospital level. The ten FP indicators are at least one qualified staff in FP; confidentiality in consultancy room; FP methods available and visible in demonstration box for potential user; staff correctly calculates number of clients expected monthly for oral and injectable FP methods; business plan contains strategy to achieve FP target; adequate stock of oral and injectable FP; IUD and implant method available and staff trained to use it; referral system in place for client seeking permanent FP method; FP cards available and filled appropriately.	Health centers receive US\$1 for new and existing FP users and US\$2.50 for implants and IUDs. Hospitals receive US\$4 for new and existing FP users, US\$7 for implants, and US\$ 12 for vasectomy and tubal ligation. In comparison, US\$12 is paid for a normal delivery and US\$1 for outpatient visits. Health facilities can earn an additional bonus for "quality," which includes FP aspects. If the facility achieves less than 100%, it receives only a fraction of the 25% bonus payment. There is no bonus payment for scores between 50% and 70%. The facility is penalized for a score below 50% by losing 25% of its previous quarter earnings. Health facilities subsequently pay health workers part of the performance payment based on their performance.
Health Sector Development Support in Zimbabwe supports RBF pilot in several	The World Bank through HRITF	Health facilities in targeted rural districts, with part of this RBF payment	Payments are provided to health facilities for "quantity" (based on a predetermined unit fee for each of the health indicators), which		At health center level US\$2.5 is paid for FP visits. At hospital level US\$30 is paid for each tubaligation. In comparison, a health center is paid

RBF program example	Funding agency	RBF recipient	Indicators and FP-linked payment mechanism	Quality assurance mechanism, with a FP focus	FP payment compared to payment for other health services
districts		subsequently benefitting the health care workers.	include the FP indicators. In addition, a health center can earn up to 50% (and a hospital 75%) more of its regular monthly earnings if it attains 100% of its "quality" scoring. If the facility achieves less than 100%, it receives only a fraction of the bonus payment. Health facilities subsequently pay health workers part of the performance payment based on their performance.		US\$0.16 for each new OPD consultation and US\$12.5 for a normal delivery; while at hospital level US\$25 is paid for a normal delivery, US\$80 for a complicated delivery, and US\$140 for a C-section. Health facilities subsequently pay health workers part of the performance payment based on their performance.
Community health workers (CHWs) are rewarded/paid for delivering FP methods or referring clients (India, Rwanda)					
Community Performance-Based Financing (CPBF), Rwanda whereby CHW cooperatives are rewarded based on the performance of their CHW members, including referral for FP services	Ministry of Health Rwanda, the World Bank, and HRITF	CHW Cooperatives consisting of community health workers in the catchment area of health facilities are paid by these health centers based on performance of the CHW cooperative. Incentives are given to increase the capital of the CHW cooperatives. The cooperatives in their turn start income-generating activities to the benefit of the individual members. 30% of the cooperative reward goes to individual members of the cooperative, 70% must be reinvested in income-generating activities undertaken by the cooperatives.	29 indicators of which 12 indicators on pay-for-reporting and 17 indicators on pay-for-indicators, including 2 on FP: number of new users of modern FP methods referred by CHW cooperatives to health center and number of regular users of modern FP methods at health center.	In the pay-for-reporting scheme, 50% of the size of the reward given to CHW cooperatives is based on timeliness, completeness, and accuracy. The other 50% of the size of the reward is based on the quality of the cooperative (e.g., legal status, cash book, regular meetings), which is assessed quarterly. There is no direct link with FP in the quality indicators used for payment.	Among the five MCH-related services, referrals of new users of FP methods are paid the highest, at US\$2.7 per referral. Each regular user of modern FP at the health center is worth US\$0.16. In comparison, accompanying a woman for institutional delivery is rewarded US\$2.5, and growth monitoring is rewarded US\$ 0.16 per child visit.

RBF program example	Funding agency	RBF recipient	Indicators and FP-linked payment mechanism	Quality assurance mechanism, with a FP focus	FP payment compared to payment for other health services
Intragovernmental transfers					
Result-based fiscal transfers from national to subnational levels of government to cover a share of health service package insurance costs					
Plan Nacer, Argentina: A maternal and child health insurance program for uninsured children under six years old, pregnant women, and women after 45 days after delivery	The World Bank, 2004–12 (Phase I closed in 2010; Phase II to close in December 2012)	Provincial health ministries (province-level governments) that subsequently pay health care facilities.	<p><i>To Provinces:</i> Plan Nacer covers a benefit package that includes 80 MCH services. Of the per capita payment of about US\$4 per person/per month, 60% is transferred by the national government to the provincial government based on the number of eligible enrolled women and children; and the remaining 40% is linked to achievement of ten tracer MCH indicators with one of the tracers linked to FP, defined as: % of eligible postpartum clients received sexual and reproductive health consultation within 45 days after delivery.</p> <p><i>To providers:</i> The provinces transfer funds to the contracted health care providers through a fee-for-service mechanism, which includes FP services.</p>	The national government defines Quality Matrix or protocol for delivery of the interventions. Regular supervision takes place. No direct link in payment to provider or province for "quality" of FP service.	Payment of the 40% capitation amount to the provinces is dependent on performance linked to ten tracers; the weighting of each of the tracers is equal (and thus US\$0.16 out of each US\$4 is linked to FP indicator). Comparison of payments to providers is not possible given that each province sets the prices for the health services included in the benefit package.
Plan Sumar Program, Argentina; Provincial Public Health Insurance Development Project. This program targets uninsured children and youths under 20 years old and women 20 to 64 year old.	The World Bank, 2012–15	Provincial health ministries (province-level governments) that subsequently pay health care facilities	<p><i>To Provinces:</i> Plan Sumar covers a benefit package that includes MCH, preventive, and high complexity services. MCH services will be eligible after Plan Nacer completion. Of the per capita payment of about US\$1.5 per person/per month, 60% is transferred by the national government to the provincial government based on the number of eligible enrolled women and children; and the remaining 40% is linked to achievement of 13 tracer indicators with 1 linked to FP, defined as: % of eligible adolescents between 14-19 and women under 25 received sexual and reproductive health consultation.</p>	The national government defines Quality Matrix or protocol for delivery of the interventions. Regular supervision takes place. No direct link in payment to provider or province for "quality" of FP service.	Comparison of payments is not possible given that each province sets the prices for the health services included in the benefit package.

RBF program example	Funding agency	RBF recipient	Indicators and FP-linked payment mechanism	Quality assurance mechanism, with a FP focus	FP payment compared to payment for other health services
			<i>To providers:</i> The provinces transfer funds to the contracted health care providers through a fee-for-service mechanism, which includes FP services.		
Donor to country-level funding RBF programs					
Funds from donors to countries are disbursed conditioned on performance related to policy, coverage, and quality indicators, including indicators on FP results.					
Salud Mesoamerica 2015 in Central America (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama) and state governments in Mexico	Donors and founders: BMGF, Instituto Carlos Slim de la Salud, and AECID. Cofinanced by country governments (about 40% to 60%). IDB is the general administrator. Governments executes funds.	National governments in Central America (Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama) and a state government (Chiapas) in Mexico.	Governments are partly (50%) reimbursed for their contribution to the Salud Mesoamerica initiative when achieving 80% of all 8 to 12 health indicators at 18, 36, and 54 months. These disbursement indicators were negotiated between IDB and countries based on a General Framework, which include one to three FP indicators: percent of health facilities without stock outs of modern temporary and long-acting FP methods; unmet need for contraception, and use of any modern contraceptive methods among women in need of contraceptives; and discontinuation rate. FP is also indirectly measured by other indicators, such as postnatal care performed according to the norm.	Quality at the facility level is strengthened with training in EMOC, technical assistance, dashboards, and "internal quality assurance monitoring subsystems/teams," and compliance with norms standards and indicators. In addition, the following considerations were taken into account when selecting the FP indicators for the program: (i) required not to link FP targets to specific providers, (ii) counseling must be ensured prior to acceptance of the method, and (iii) countries must ensure informed consent in line with international technical and ethical guidelines and the country's norms, respecting the Tiahrt Amendment and other laws issued by the US Congress that are currently used in the region to ensure that FP decisions are voluntary and informed. In addition, SM2015's interventions is being offered to indigenous population in the same equitable way they are being offered to the rest of the population, respecting and guarding that no person (indigenous or not) receives care in a forced or coercive way that violates human rights and fundamental freedoms of the all people as stated in article 3 of ILO Convention 169.	Countries that achieve 80% of all 8-12 indicators will be reimbursed for approximately 50% of their contribution (which currently ranges between 0.5 and 4 million). Governments can subsequently spend these funds freely in the health sector.
*Modern FP methods include temporary FP methods (condoms, vaginal methods, orals, and injectables); long-acting FP methods (implants and IUD) and permanent FP methods (tubal ligation and vasectomy)					



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