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Thematic Studies Series 2:
Pathways to Universal Access to Reproductive Health Care in Asia

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Glossary

ADB	Asian Development Bank
AFD	French Agency for Development
ART	Anti-Retroviral Treatment
ARV	Anti-Retrovirus
BCC	Behaviour Change Communication
BHUs	Basic Health Units
CAAFW	Cambodian Association for Assistance to Families and Widows
CBHI	Community-based Health Insurance
CBO	Community Based Organisation
CEDAW	Convention on Elimination of All Forms of Discrimination Against Women
CFDS	Cambodian Family Development Services
CHHRA	Cambodian Health and Human Rights Alliance
CI	Contracting In
CIDA	Canadian International Development Agency
CO	Contracting Out
CRC	Convention on Rights of the Child
CSES	Cambodia Socio-economic Survey
CSI	Civil Servant Insurance
CSMBS	Civil Servant Medical Benefit Scheme
CUPs	Contracting Units for Primary Care
CYPs	Couple Years of Protection
DALY	Disability-adjusted life year
DFID	UK Department for International Development
DHS	Demographic Health Survey
DOT	Directly Observed Treatment
DPT	Diphtheria, Pertussis and Tetanus Vaccination
DRG	Diagnosis-related-group
EmOC	Emergency Obstetric Care
ESSIs	Employee Social Security Institutions
EU	European Union
FATA	Federally Administered Trial Areas
FMO	Female Medical Officer
GDI	Gender Development Index
GDP	Gross Domestic Product
GEM	Gender Empowerment Measure
GOP	Government of Pakistan
GRET	Group de Rechereches et d'Echanges Technologiques
GSM	Green Star Marketing
GTZ	German Technical Co-operation
HDI	Human Development Index
HEFs	Health Equity Funds
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HNI	HealthNet International
HSIP	Health System Improvement Project
HSSP	Health Sector Support Project
ICPD	International Conference on Population and Development
IEC	Information, Education, Communication
ILO	International Labour Organisation
IUCD	Intrauterine Contraceptive Device
IUD	Intra-uterine device
JFPR	Japan Fund for Poverty Reduction
JHU/CCP	John Hopkins University Center for Communications Progra,s
JSI	John Snow Inc Research and Training Institute
KfW	Kreditanstalt fur Wiederaufbau
KSM	Key Social Marketing
LDC	Least Developed Country
LHV	Lady Health Visitor
LHW	Lady Health Worker
LPRP	Lao People's Revolutionary Party
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MoF	Ministry of Finance
MOH	Ministry of Health
MOPW	Ministry of Population Welfare
MSF	Medecin sans Frontiers
NEM	New Economic Mechanism
NGO	Non-Governmental Organisation
NHA	National Health Assembly
NHSO	National Health Security Office
NSDP	National Strategic Development Plan
NSEDP	National Socio-Economic Development Plan
NWFP	North West Frontier Province
ODs	Operational Districts
PAIMAN	Pakistan Initiative for Mothers and Newborns
PAVHNA	Pakistan Voluntary Health and Nutrition Association
PBC	Performance Based Contracting
PDR	People's Democratic Republic
PH	Provincial Hospital
PHA	People's Health Assembly
PHCEP	Primary Health Care Expansion Project

Glossary

PPP	Purchasing Power Parity
PRSP	Punjab Rural Support Programme
PSI	Population Services International
RACHA	Reproductive and Child Health Alliance
RHAC	Reproductive Health Association of Cambodia
RHCs	Rural Health Centres
SHI	Social Health Insurance
SKY	Insurance for our families (Acronym in Khmer language)
SMP	Social Marketing Pakistan
SQH	Sun Quality Health
SRH	Sexual and Reproductive Health
SSO	Social Security Organisation
SSS	Social Security Scheme
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Disease
TBA	Traditional Birth Attendants
UC	Universal Health Coverage Scheme
UHN	United Health Network
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
VCT	Voluntary Counselling and Testing
VHVs	Village Health Volunteers
VMA	Voucher Management Agencies
WB	World Bank
WHO	World Health Organisation

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INTRODUCTION

Pathways to Universal Access to Reproductive Health Care:
Case studies of four countries from Asia

1. Pathways to Universal Access to Reproductive Health Care: Case studies of four countries from Asia

1.1 Universal access to reproductive health – a pipe dream?

The historic 1994 International Conference on Population and Development (ICPD) identified, in its Programme of Action, "Universal Access to Reproductive Health" as a goal to be achieved by 2014.[1] The road to the implementation of the Programme of Action has been all but smooth and marked by stiff political opposition from powerful countries, failure by donors to honour their funding commitments and sidelining of reproductive health in the Millennium Development Goals (MDGs). After persistent advocacy efforts, the 2005 World Summit acknowledged sexual and reproductive health as important for achieving gender and health-related MDGs. In his subsequent report, the UN Secretary General recommended the inclusion of "Achieve by 2015 universal access to reproductive health" as target – 5b, which is related to MDG 5, "improve maternal health".[2]

Progress to date suggests that achieving MDG's target – 5b, may remain a pipe dream for a long time to come. A comprehensive report assessing the progress of ICPD's Programme of Action in 12 Asian countries in 2009, 15 years after the Conference, was produced by Asian-Pacific Resource and Research Centre for Women (ARROW). According to this report, not a single country had achieved all the ICPD targets. For example, unmet need for contraception and unwanted fertility was still a major issue for less-educated, low-income women residing in remote or hard-to-reach areas. Informed contraceptive choice was nowhere practised by service providers. Male responsibility for contraception had remained as rhetoric. The 80% skilled attendance at birth had not been achieved in 7 of 12 countries and access to emergency obstetric care was far from accessible for women in many countries. Access to safe abortion was restricted by law and unsafe abortions continued to be an important cause of maternal deaths.[3]

Anyone interested in achieving universal access to reproductive health services needs to be concerned with costs of providing such services and ways of financing the services. According to recent reliable estimates, an average of US$30.4 billions per year would need to be expended between 2009 and 2015 in order to make available a comprehensive package of maternal health, family planning and sex-education interventions.[4] Average donor-funding for reproductive health since 2005 is a paltry one-fifth of the average annual donor shares needed through 2015.[5] The major responsibility for harnessing resources to finance universal access to reproductive health services clearly rests with national governments. It is against this backdrop that this monograph documents the trajectories traversed by four Asian countries in terms of health system reforms and ways in which this has facilitated or impeded universal access to reproductive health care.

1.2 Locating universal access to reproductive health care within the framework of universal health care coverage

We strongly endorse this view upheld by several reproductive health advocates that universal access to reproductive health services has to be considered as an integral component of advocacy for universal health care coverage.[6]

Universal coverage is defined as "access to adequate health care for all at affordable prices".[7] The universal coverage by health services is now widely perceived, all over the world, to be one of the core obligations, which any legitimate government should fulfil vis-à-vis the health care needs of its citizens. Achieving universal coverage involves progress in three dimensions:

- Removing financial barriers to accessing care and providing financial protection from catastrophic costs to users of health care services;
- Increasing the extent of health care coverage: what services are included in an Essential Services Package and provided at subsidised/no costs;
- Increasing the extent of population coverage: who is covered.[8]

Health care services in most developing countries are financed by a mix of financing mechanisms. Usually, there is a basic package of services financed by tax revenue, and free at the point of service delivery. Governments also run health-insurance schemes that are tax-based or a combination of tax-revenue and other sources. These schemes may be free at the point of service delivery, or there would be a reimbursement after payment. Costs of other health services have to be met by out-of-pocket payment (OOP), or through a combination of different types of health insurance. In most low and middle income countries, the tax base is narrow because not many people fall within the category of tax-payers. The health sector also has to compete with other sectors for tax funding.

When there is a resource crunch, it is social sectors, such as health, that experience budgetary cuts. As a result, tax-funded government health services offer a very narrow range of services, cost-free, or at subsidised prices. Limited revenue would also mean that there may not be a sufficient number of health facilities or personnel to meet the needs of the population. The narrow range of services often excludes many essential reproductive health services. Consequently, people are forced to seek health care from private providers and thus, this incurs out-of-pocket expenditures which can sometimes be catastrophic and lead to impoverishment.

In an attempt to reduce the proportion of out-of-pocket payments by households, many Governments have been experimenting with pre-payment schemes, such as micro-insurance schemes for the informal sector. According to a review of health financing mechanisms from a gender perspective, although micro-insurance schemes usually and only involve modest premium payments, women (and others) who do not have cash incomes are unable to afford these.

More importantly, insurance schemes do not usually cover many reproductive health services which are "uninsurable" as stand-alone benefits because they are non-random and/or are high probability events. For example, pregnancy is a non-random event, and contraceptive services are high-probability services. They can only be efficiently covered if they are part of a broader benefits package.[9]

In some settings, government-run health insurance schemes, in response to popular demand (perceived or actual), have included comprehensive reproductive health services within the broad package of services offered.

Other governments have championed various types of public-private partnerships such as social franchising for financing and/or provision of health care services, and especially so in the case of reproductive health services. There is probably a role for franchising mechanisms in expanding the coverage of both populations and services in settings where the public sector is able to provide only a limited range of reproductive health services, reluctant to provide some reproductive health services because of political sensitivities, or has limited population coverage. However, there is now growing evidence that such mechanisms do not usually reach the poorer sections of the population. Public-private partnerships, therefore, may be a useful means of expanding population coverage in settings where there is a strong commitment from the public sector towards health care and investments that will strengthen the health systems in order to reach the poor.[10]

Universal access to reproductive health services, therefore, appears to be dependent on the government in taking the responsibility to provide a broad package of services that goes beyond maternal health care and family planning, either through government or private health facilities or providers.

Such services will have to be paid for from public funds – either exclusively through tax revenue or through a combination of tax revenue and voluntary or compulsory pre-payments. In the case of pre-payment schemes, reproductive health services would have to be a part of a larger benefit package. In addition, Social Protection Schemes may be needed, covering specific population groups identified as 'vulnerable': low-income groups, indigenous populations, mothers and children. Even as universal health care coverage has begun to take root in many parts of the world as a fundamental human right, there are global forces diametrically pushing countries in the opposite direction.

Health reforms in many countries have been towards restricting the role of the state to stewardship in the health sector, being a regulator of the health sector, and increasing privatisation in service delivery as well as financing.

1.3 Country case studies included in this monograph

The present monograph examines the experiences of four Asian countries in reforming their health sector and the implications of these reforms for universal access to reproductive health services. The countries included are Pakistan, Lao PDR, Cambodia and Thailand. Each of these countries has undergone health reforms as part of larger economic reforms. Cambodia, Lao PDR and Pakistan have severely under-resourced their health sectors, whereas Thailand is relatively well-resourced in its finances. The trajectories of reforms in these countries are very different. In Pakistan, the health sector has been swept in the direction of increasing privatisation and farther away from universal health care coverage.

Access to reproductive health services is poor and inequitably distributed. Cambodia and Lao PDR also have limited public investment in health, but are experimenting with substantial donor funding and Social Protection Schemes to ensure access to essential health care for low-income groups. Both countries appear to be making conscious efforts to progress towards a greater and larger health care coverage, in which Cambodia has been more successful than Lao PDR. Access to reproductive health services is also relatively better in Cambodia

when compared to Lao PDR, and low-income women are assured of basic maternal health care where facilities exist.

Thailand, however, offers a contrast, with the public sector predominantly funding health care provisions and Thailand has been successful in achieving the Universal Health Care Coverage through its Universal Health Care Coverage Scheme implemented since 2001. A comprehensive range of publicly financed reproductive health services are available to a vast majority of the population at little or no cost. Examples from the case study appear to validate the position of universal access to reproductive health care, which cannot be viewed or advocated in isolation but has to be a demand vested in the larger quest for universal healthcare coverage.

Each of the four case studies begin with a general background of the country, which provides an overview of the health sector and its system, especially in its financing, followed by traversing the history of privatisation as well as progress towards universal coverage. Each case study then examines how these larger changes in the health sector have affected universal access to quality reproductive health services.

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CHAPTER 1

CAMBODIA

1. Background

Cambodia is located in South East Asia, bordering Thailand, Laos and Vietnam. The country faced almost three decades of conflict, including a war (1970-75) followed by brutal killings of more than a million Cambodians by the Khmer Rouge regime of Pol Pot (1975-79) and civil conflicts and disturbances thereafter. Since 1999, there has been some political stability. The economy was centrally planned during the Khmer Rouge regime, and the transition to market economy has been underway since the mid 1990s.

1.1 Economic growth and human development

Cambodia is among the poorest countries in the South East Asian region with a per capita GDP of US$ 2086 in PPP[1] dollars in 2010.[2] The country has witnessed rapid economic growth in recent years. During 2004-06, it had a double-digit growth, and in 2007, it was 10%.[3] The rate of economic growth declined in 2008 to 7% as a result of the global economic slow down.[4] The discovery of possibly significant volumes of offshore oil and gas and inshore minerals has improved the economic outlook for the country.[5] The garment and tourism sectors contribute most to the GDP. Cambodia's overwhelming dependence on these two sectors makes the country vulnerable to external shocks.[6]

The benefits of rapid economic growth in Cambodia have been unequally distributed. In 2007, the richest 10% of the population had an income of close to 12 times that of the poorest 10% of the population.[7] A little less than a third (30%) of the population lived below the national poverty line during 2000-2008.[8] Although this marks a significant decline in the incidence of poverty from 45-50% in the mid 1990s, [9] a large proportion of the non-poor have an income barely adequate for subsistence. Cambodia Socio-Economic Survey 2004 (CSES) found that 90% of the poor lived in rural areas; and poverty had decreased at a much slower pace in rural as compared to urban areas.[10] About 50% of the country's poor live in the Tonle Sap and Mountain/Plateau regions.[11]

In 2010, Cambodia was ranked 124 of 179 countries in terms of human development.[12] Although the adult literacy rate (age 15 and above) was almost 78% according to the 2008 census, Cambodia still has a long way to go in terms of educational attainment. More than 56% of the population above 25 years of age had not completed primary school and less than 3% had completed secondary school.[13] More than a third of the population (39%) did not have access to potable drinking water, while a vast majority (71%) did not have access to improved sanitation facilities in 2008.[14]

1.2 Gender equality profile

Cambodia has among the lowest levels of gender equity in Asia, with a Gender Development Index (GDI) rank of 116 in 2009, with only four Asian countries (Bangladesh, Nepal and Pakistan) ranking below it. In the same year, its Gender Empowerment Measure (GEM) rank of 91 was fifth from the bottom for Asian countries. Asian countries like Bangladesh, Indonesia, Pakistan and Sri Lanka ranked below Cambodia.[15]

The adult literacy rate for women (71%) was far lower than that for men (85%) according to the 2008 census. Gender gaps in education widened together with the level of educational attainment: only 39% of women had completed primary or lower secondary as compared to the 52% of men, and as for completing secondary school or education at the tertiary level, the women percentage (2.4%) was less than half of the men's (5.6%).[16]

Women's economic activity rate was 61% in 2008, about the same as that for men, which was 62.5%.[17] The agricultural sector and garment industry are main sources of women's employment. Beyond these, women are primarily engaged in the informal sector as traders and vendors and constitute 49% of self-employed retail traders.[18]

The prevalence of domestic violence against women is very high. The Demographic and Health Survey (2005) found that a fifth of ever-married women between the ages of 15-49 had experienced physical violence since age 15, and 10% had experienced such violence within the 12 months preceding the survey. Moreover, 3% of ever-married women had experienced violence during pregnancy.[19]

The trafficking of women and children is a major problem in Cambodia. Some women and children are trafficked to Thailand and Malaysia mainly for labour and commercial sexual exploitation, where as some children are in Vietnam and Thailand to work as beggars. An estimated 100,000 commercial sex workers are in Cambodia, and it is believed that there are about 5000 child prostitutes in Phnom Penh alone.[20]

2. Health Sector

2.1 Population, health and sexual and reproductive health status

Cambodia's population was just under 14 million according to the 2008 census.[21] About 34% of the population constituted children below 15 years of age, and only 4.3% of the population consisted the elderly

(60+ years).[22] The total fertility rate declined steeply from 5.8 in 1990 to 3.4 in 2008.[23]

Cambodia has a relatively poor health indicator when compared to its South-East Asian neighbours. Life expectancy at birth, although improving, was only 62 years in 2008 – 59 for males and 64 for females. Infant mortality rates had declined from 86 per 1000 live births in 1990 to 69 in 2006: 76 per 1000 for male and 62 per 1000 for female infants. What is most impressive is the decline recorded in the under-five mortality rates – from 116 per 1000 live births in 1990 to 89 in 2008: 97 per 1000 for male and 82 per 1000 for female children.[24]

In 2004, communicable diseases constituted a major share (67%) of healthy years of life lost, while non-communicable diseases accounted for 25% and 8% for injuries. Cambodia also has a high prevalence of tuberculosis: 680 per 100,000 populations (2008) and the HIV prevalence among adults aged 15 years and above was 0.8%.[25] Malaria is endemic in Cambodia and remains as one of the primary causes of mortality. The number of malaria outbreaks is reported to have decreased, as also the incidence of malaria, which fell by more than one-third, from 15.05 cases per 1,000 in 1995 to 9.60 cases per 1,000 in 2001.[26]

Besides, Cambodia had a high maternal mortality ratio of 540 per 100,000 live births in 2005, according to the estimation of WHO.[27] The Demographic and Health Survey 2005, on the contrary, reported a slightly lower maternal mortality ratio of 472 per 100,000 live births.[28] On another matter, the performance of reproductive health services has been relatively poor. During 2000-2006, only 27% of pregnant women had made at least 4 antenatal visits and less than half (44%) of all deliveries were attended by a skilled attendant. Only 40% of women, who are within the reproductive age, were using any method of contraception, and only 27% were using a modern method.[29] The proportion of births by c-section was a low 1.8%, indicating a high percentage of unmet need when it comes to emergency obstetric care.[30] Box 1 illustrates the difficulties women encounter in accessing health care especially when there are complications in delivery.[31]

The Abortion Law of Cambodia, effective since November 1997, is one of the most liberal in Asia. However, the availability of safe abortion services is very low, and a study carried out in 2002 reported that unsafe abortions accounted for 20-29% of all maternal deaths.[32]

BOX 1: WOMEN'S EXPERIENCES OF ACCESSING DELIVERY CARE IN CAMBODIA[33]

Case 1:

[She] delivered a baby at home. Delivery was normal. Two days after delivery, she developed a fever. It was a high fever that lasted four to five days. A day after the fever started, she had severe bleeding. She used two or three 'sarongs", a type of long skirt, to try to stop the bleeding, but it was too severe. She lost consciousness three times during the night. Her family called a private practitioner in their village. He was not officially trained, but knew how to give injections. The practitioner gave her a bottle of IVD, and then prescribed traditional medicines in addition to the Western medicines that she took. Six months after her delivery, when I visited her, she still felt tired.

Case 2:

This woman had twins.... A TBA delivered (her) first baby at her home. The first delivery was relatively straightforward. The woman had labour pains for a short time and the baby was born. The pain then stopped and after eight hours, the second baby was not yet born. The family got anxious and decided to take her to the referral hospital. But the road was bad and she could not travel on the back of a motorbike. The neighbours decided to carry her on their shoulders to the health centre first. While she was being carried, her husband rushed to the health centre by bicycle. The health centre staff then called the referral hospital by radio, asking for an ambulance.

The referral hospital immediately sent an ambulance and a midwife. Shortly after the woman arrived at the health centre, the ambulance also arrived. She was taken to the referral hospital and safely delivered the second baby."

2.2 Personnel and infrastructure

The Ministry of Health is the provider of all health services available in the public sector. There are two-tiers to its structure.

At the lower tier are health centres serving a catchment to a population of about 8000-10,000 people and there is at least one referral hospital in most of the operational districts, a provincial hospital in each of the twenty-four provinces, eight regional centres, and national hospitals. National hospitals are also centres of clinical training, including medical specialisation training.[34]

Public health infrastructure is grossly inadequate with only one hospital bed per 10,000 population (2000-06).[35] Public health facilities may not always be functional because of the acute shortage of trained health personnel. During 2000-09, there were only two physicians, and eight nursing and midwifery personnel per 10,000 population.[36]

A 2006 midwifery review found that 51% of health centres were without a secondary midwife – and hence, the capacity to save the lives of mothers or newborns should complication arises was non-existent.[37]

One important contributing factor is the several decades of war and civil disturbances had a major impact on the overall health system. Only 50 doctors were reported to have survived at the end of the Pol Pot regime in 1979, on top of that, many health facilities were damaged and non-functional.[38]

2.3 Health financing

For a poor country, Cambodia spends a large amount on health. The per capita expenditure on health in PPP$ in Cambodia was $108 in 2007, and the total expenditure on health, in terms of the GDP percentage, was 5.9% in the same year.[39] The poor health outcomes signify inefficiencies in the health system.

Health financing is predominantly from private sources, i.e. the out-of-pocket expenditure of households. Although the per capita government expenditure on health more than doubled between 2000 and 2007, from 12 PPP dollars to 31 PPP dollars, the public expenditure on health accounted for only 29% of total health expenditure in 2007 (this is an increase in proportion when compared to the 22.5% in 2000).

Development assistance from abroad significantly contributes to the total spending on health (16.4%) in 2007, while the rest was met from out-of-pocket expenditure of households.[40]

2.4 Recent policies for reforming the health sector

Cambodia's health reform process started in 1995 with the Health Coverage Plan aimed at strengthening the delivery of services. Since then, a series of reforms in the health sector have tried to address issues related to financing, improving human resources and infrastructure, bettering the quality of care and providing equitable access to health care services.[41]

The Health Strategic Plans, HSSP-1 and HSSP-2 brought about further reforms with massive financial backing from international donors. Currently, Cambodia's Health Strategic Plan 2008-15 (HSSP-2) guides all decisions in the sector. HSSP-2 has three overarching objectives: [42]

- To reduce maternal, infant and child morbidity and mortality, and to improve reproductive health
- To reduce morbidity and mortality from HIV/AIDS, malaria, TB and other communicable diseases
- To tackle the emerging burden of non-communicable diseases and injuries.

Means to strengthen the health system have been identified and also, through which these objectives will be achieved. HSSP-2 identifies five key strategies for strengthening the health system: [43]

- Providing integrated health service delivery
- Ensuring an adequate level of health financing and effective use of finances
- Addressing human resource needs in the health sector
- Strengthening health system governance
- Strengthening health information systems

In 2006, Cambodia issued the ambitious *"National Strategy for Reproductive-and Sexual Health in Cambodia 2006-2010"*. The strategy outlined the expansion of services in a number of areas: [44]

- Contraceptive community-based distribution
- Essential and comprehensive neonatal/postnatal care
- Linked RH and HIV services
- Adolescent SRH services
- Gender-based violence identification and referral services
- Abortion services

There is no mention in the strategy of how the country proposes to meet the financial, infrastructural and human resources needed for such an expansion.

Concerned about the slow progress in reducing maternal mortality ratios in the year 2007, the government introduced a "*Fast Track Initiative for the*

Achievement of MDG-5".[45] This initiative included government incentives for midwives for live birth deliveries in health facilities as well as improved quality of pre-service and in-service training for midwives. The expansion of the Health Equity Funds was expected to complement these in improving access to delivery care for women. The efforts made and outcomes are discussed in a later section.[46]

3. Privatisation in the health sector

3.1 The private sector in health

All forms of private health care were banned in Cambodia till the late 1980s. When the transition to market economy happened in the early 1990s and private practitioners were permitted to practice, untrained informal health care providers had become ubiquitous. Village drug-sellers continue even today to provide most private health care.

However, there has been a rapid expansion also in the number of physicians and health facilities operating in the private sector, especially in Phnom-Penh. A 2000 report notes that there was over-prescription in the private sector, resulting in unnecessary drugs and injections.[47] The poor quality of care given by formal private health providers is confirmed in a WHO study using "mystery patients".

The study found that 49% of consultations with a sample of Phnom-Penh based private physicians resulted in potentially hazardous treatment, including gross errors in dosages of medications prescribed, incomplete courses of antibiotics, pressure to have inappropriate surgical or other invasive procedures and failure to recommend urgently needed investigations.[48]

Cambodia is also said to be characterised by pharmaceutical "anarchy". In 1979, there were no pharmacies or pharmacists in the country. By 1994, when licenses were given to pharmacies, the country was full of unlicensed, out-of-date and substandard preparations.[49]

Irrational dispensing of unnecessary and inappropriate drugs by pharmacists and unqualified drug sellers still constitutes the only health care that a majority of Cambodians receive.

3.2 Health reforms and privatisation

Promotion of the private sector as the main engine of economic growth has been the Cambodian government's main economic strategy since the mid 1990s. This is also true in the health sector. The National Strategic Development Plan (NSDP) 2006-2010 mentions that it is of great priority to "*elicit, encourage and involve [the] private sector in [the] provision of health care, both in urban and rural areas."*[50]

However, there seems to be an attempt to balance privatisation with strengthening the public health sector with the goal of moving towards universal coverage by 2015. For example, the NSDP also mentions protecting the poor from high costs of health care and improving access to care through infrastructural development and deploying additional personnel.[51]

In addition, Cambodia is also experimenting with mechanisms to provide safety nets to protect the poor from catastrophic illnesses and to ensure that affordability does not become a barrier to access. HSSP-2 envisages the setting up of a national Social Health Insurance Scheme for those working in the formal sector and those who are civil servants. Community-based health insurance for the informal sector, and private insurance and user fees are meant for those who can afford them with the purpose of to financing the health sector.[52]

Thus, Cambodia has introduced user fees and encouraged private sector involvement in providing health services through contracting arrangements, both of which are measures for privatisation. At the same time, The Health Equity Funds for the poor and Community-based Insurance Schemes have been set up with the aimed of removing barriers to access health care services when suffering from illness, especially for low-income groups.

The efforts of the privatisation of health financing and its impact on equitable access to health care are describe in the next section. This is followed by an overview of the Health Equity Funds and Community-based health insurance, also taking into account, other new initiatives and their impact on mitigating barriers to health care access.

3.3 Introduction of user fees

User fees were instituted by the Ministry Of Health in 1996, through the Health Finance Charter. The intention was to do away with informal charges being levied in health facilities. There was a clear policy on exemptions for those who could not afford to pay.[53] Almost all the user fees collected (99%) were to be retained by the respective health facilities and 49% of it was set aside to supplement staff salaries.[54]

Data on cost of health services available from various studies and from the *Cambodia Demographic and Health Survey* in 2005 indicate that costs of

treatment were high and unaffordable to the poor.[55] The average cost of a single illness episode treated in a public facility was US$15.52, including costs of transportation, food, medication, administrative and other fees. Comparable costs in private facilities were only marginally higher, at US$18.62.[56, 57] In case of serious illnesses, the cost of treatment could be many times higher. A study of treatment for dengue in children in a low-income rural setting found that villagers were reported to have spent an average of US$34.5 and up to US$150 on a single episode of dengue in children. Those not granted a fee exemption in a public facility spent a mean cost of US$ 49.29 (between the range of US$ 25-150).[58] The sum spent includes both direct and indirect costs.

Some studies on the impact of user fees indicate that utilisation of health care services have increased in hospitals. For example, a 2001 study on the impact of user fees in hospitals concluded that there was an increase in utilization.[59] At the National Maternal and Child Health Hospital, there were reports of increased patient satisfaction, higher utilization of the services, higher bed –occupancy rates and increased number of deliveries in the hospital.[60] A study of five national hospitals in Phnom-Penh found that hospitals, which received a higher level of revenue from user fees and consequently, paid a higher supplemental salary to hospital staff , had also significantly higher bed-occupancy rates.[61]

However, higher utilisation following the introduction of user fees may have specifically benefitted some health facilities. For example, the user fees are reported to have worked better in health facilities where donor investments led to improvement in the quality of services provided.[62] Another setting in which utilisation increased despite an increase in user fees was when health services were provided for by contracted NGOs. This was the case, for instance, in Pereang Operational District, where the contracting NGO had significantly increased the user fees and provided no waivers for the poor.[63]

Many studies suggest that user fees kept patients away and services were under-utilised. For example, mothers' perceptions of the high cost of health care resulted in significant delays in seeking health care for children with dengue in a rural area.[64] Another study from Kirivong Operational District also found that uncertainties of cost and treatment following the introduction of user fees in a referral hospital led patients to delay seeking care, and to first consult with private providers.[65]

User-fees may also have created a "medical-poverty trap" for many health care seekers. Eight of twelve rural women in a 2003-04 study reported how they raised the money needed for treating dengue fever in their children by taking loans and selling their property and other goods. One woman said:

I had no money to buy food; I spent it all on serum that I bought myself and the doctor only did the perfusions. I bought injections and syringes. I had no money for a bed fee. I had to tell my mother to stay and look after my child in the hospital and I came back to find (borrow) money. [66]

In Kirivong Operational District, 40% of all hospital users had to borrow money to pay for the costs of hospitalisation both before and after the introduction of user fees. However, 3% of respondents in the post-user fee period reported having to sell their land in order to repay the loan because of the high overall cost of health care. Much of the high costs of health care for an episode of hospitalisation were a result of seeking health care from private providers before being hospitalised.[67]

Ironically, the cost of private health care seems to have increased alongside the introduction of user fees in public facilities. For example, in Kirivong province, the average consultation costs with drug-sellers doubled from US$2.7 before introduction of user fees to US$5.4 when user fees were charged at the provincial hospital, and the cost of treatments by qualified private practitioners tripled from US$6 to about US$20.[68]

Those living in poverty were affected, the worst, because of the increase in cost of care, in both the private and public sectors, and the poor implementation of waivers and exemptions in public facilities. There was no uniformity in exemption policies across the country. For example, one-fourth of the population served by Roveing health centre was granted exemptions from user fees in 1999 while in the Pereang Operational District did not grant any waivers but fees were kept generally low.[69]

The conflict of interest for health workers in allowing exemptions may have contributed to very low levels of exemptions for the poor. According to one study carried out in two villages of Kampong Cham district in Eastern Cambodia, health centre staff received a supplementary income of US$5 on average per month from revenue gained from user fees, while staff members at the referral hospital received around US$25.[70] In 1999, only 18% of health facility users had been given exemptions as the country recorded a below-poverty-line population of 36% during the same period. Bigger hospitals tended to offer fewer exemptions and waivers because every exemption meant a loss of a much higher level of income and hence, a bigger loss to health workers. For example, the National Maternal and Child Health Centre in Phnom-Penh had given exemptions to only 4-7% of its patients during the first three years of the introduction to user-fees.[71]

Another reason for the increased financial burden of health care on the poor would be the continuation

of informal fees even after introduction of user fees, albeit at reduced levels. Even though supplemental salaries paid to health staff almost doubled their salaries, the total income of health staff is reported to account for, at best, a fourth of the amount needed for a family's basic living expenses.[72]

For many, the increased financial burden would result in untreated morbidity. The introduction of user fees in the Kirivong referral hospital brought about a major change in the socio-economic profile of users. The proportion of users who were landless decreased from 16% to 7% while the proportion of motor-bike owners – signifying a better economic status – increased from 17% to 25%.[73] However, a huge gap, in terms of inequities to access health services, were reported in a 2008 World Bank program appraisal document. An individual from the top consumption quintile was 5 times more likely to use hospital services than an individual from the poorest quintile.[74]

3.4 Contracting of health services

The Ministry of Health carried out an experiment in contracting with NGOs for the delivery of health services during 1999-2003. After this initial experimentation phase, the project expanded to more districts in remote provinces. By 2008, there were 11 Operational Districts experimenting with the contracting of services.[75]

From 1999 to 2003, two models of contracting were experimented with: [76]

■ Contracting Out (CO): Contractors had full responsibility for delivering a specified package of services in an Operational District and were required to achieve specific health targets. They directly employed staff, managed the delivery of services and had full control over resource allocation and disbursement.[77]

■ Contracting In (CI): Contractors provided only management support to health staff employed by MOH. They had management authority over staff but did not directly employ them. Contractors were provided with recurrent operating costs through a supplementary budget and had full management control over the allocation and disbursement of this budget supplement. They had to follow all government rules and regulations with respect to the resources provided by the government.[78]

Nine Operational Districts were included in the experiment, comprising of two contracted-out, three contracted-in and four 'government' districts which had the same nominal supplementary budget for staff incentives and operating expenses as the CI districts, but were fully managed by the District Health Management Team. All districts at the base-line had extremely poor health service coverage, and similar socio-economic indicators.[79] Contractors were selected through international bidding and all the winning bidders were international NGOs.[80] The contracted NGOs were required to provide a minimum package of services defined by the Ministry of Health. The preventive services included in the package are immunisation, family planning, antenatal care, delivery care and provision of micro-nutrients, besides basic curative care.[81]

An evaluation in 2003 by the World Bank with regards to this experiment found that the coverage rates of health services had increased in all the nine districts. However, coverage increases were larger in contracted districts compared to government districts. CO districts tended to do better than CI districts in general. Details of achievements in reproductive health services are discussed in the next section.[82]

The evaluation also reported that poorer sections of the population benefited more in the CO and CI districts as compared to government districts. The use of curative health services in district hospitals by 50% of the lowest income group increased more than ten-fold in CO districts and almost five-fold in CI districts. The increase in government districts was a modest 82%.[83] At the same time, out-of-pocket expenses for the bottom-half of socio-economic group reduced by $53 per capita. This was achieved through reduction in use of inefficient services and reduction in travel expenses by making services available closer to home.[84]

A study of CI experience in one district provides important information on the management and quality-control aspects of contracting. The contracting NGO, after some initial experimentation, entered performance-based sub-contracts with health centre chiefs and hospital directors for management of staff. The awarding of the sub-contracts was a competitive one. Health facilities that were poorly managed or failed to meet their output targets had their contracts cancelled and replaced by contracts with other health-centre managers. Monitoring activities were consistently carried out, including house visits to ex-patients to interview them about the quality of services received and whether any informal charges were levied. Financial incentives for health staff substantially increased their incomes. Quality of services improved, and along with this, utilisation of services increased drastically, ranging from 117% to 740% for different services, during 1998-2001. This increase happened despite the substantial increase in official user fees without any waivers for the poor. A study carried out in 2001 discovered that out-of-pocket expenditure had declined by 40% to US$10.7 from US$17.9 in 1998 because informal charges were rarely demanded.[85]

While there is no doubt that contracting increased

utilisation of services and in many instances, also the quality of care, the claim to equity is not convincing. Contracting addresses many supply-side constraints, but is unlikely to have altered demand-related constraints significantly. It may be true that the bottom-half of the population spent less out of the own pockets, but without a further break-down of users by their income, it is unclear whether utilisation by the poorest sections increased. The increase in user fees in contracting districts and the absence of any motivation to apply exemptions are likely to have prevented low-income groups from accessing services. One detail lends credence to our argument that is following the introduction of Health Equity Funds in ODs with contracting, there was a sharp increase in utilisation. At the same time the level of paying inpatients remained steady. It would be valid to conclude that the increased demand is from people who did not previously pay for and therefore, did not use services.[86]

4. Efforts at ensuring access to health care: Health equity funds and Prepayment schemes

4.1 Health Equity Funds

Health Equity Funds in Cambodia were a response to the twin problems created by the introduction of user fees: on the one hand, the inability of low-income groups to pay for health services and consequently forgoing services or getting deeply indebted; on the other, the resource constraints and conflict of interest on the part of health facilities and staff which made non-functional fee waivers for the poor.

External NGOs working in Cambodia began experimenting with alternative approaches to address these problems including the Health Equity Fund (HEF). The Health Equity Fund is a fund set up to reimburse health facilities the fees they forego by not charging the poor.

The poor get free services and the health facilities do not lose any revenue. Health staff gets a share of total user fees earned – those from paying patients and from the HEF – as supplemental salary. The HEF is thus seen as a win-win solution for all concerned.

The first HEF was established in 2000 in Sotnikum Operational District, where the Medecin sans Frontiers (MSF) and UNICEF had introduced the “New Deal” project in 1999 which increased the salaries of the health staff in return for better performance, without charging any informal fees and without providing prescriptions to private pharmacies.[87] Several HEFs rapidly followed, and by 2006, 29 HEFs were reported to have been providing to a coverage of about 1 million poor people.[88]

Administration

Each HEF is autonomous. All have some basic features in common. There are at least three entities involved: a donor, providing the financial resources; a catalyst who is overall responsible for the design, technical support and management of the HEF; and a fund operator at the local level, responsible for identifying the poor on the one hand, and reimbursing the health facility on a monthly basis, on the other.

Almost all donors are international NGOs or bilateral donors and the fund manager is typically an international NGO. Sometimes the same international agency is both the donor and the manager of the fund.[89]

In the first few HEFs, local operators were Cambodian NGOs with considerable experience in community-based work. Subsequently, many community-based organisations have been functioning as local operators, including Buddhists monks from local pagodas in Kirivong Operational District. In this instance, the monks also helped raise a part of the required resources from the local families. Table 1 summarises the major donors, catalysts and local operators involved in 24 HEFS covered in a 2006 evaluation study.[90]

Criteria for eligibility and process of identification

While all HEFs support the ‘poor’, there are differences across HEFs with regards to criteria to be eligible for support. Usually, characteristics of the ‘poor’ within a given setting are developed based on the views of knowledgeable local observers. The most commonly used characteristics include occupation of the head of household, marital status and number of dependents, quality of housing and ownership of land or livestock.[91] In Kirivong, where the characteristics were drawn up by the District Chief Monks and Deputy Governors, a person was eligible for support from HEF if s/he belonged to a household living in a mud or wood house, owned less than half hectare of land, and had a daily household income of 4000 Riels (US$1) or less. In addition, the household had to fulfil one or more of the following criteria: does not possess luxury goods such as a television or motorcycle, does not own farm animals, and having, at least, seven members who are economically inactive.[92]

After listing the criteria for eligibility, the eligible population is identified in one of two ways. Active identification or pre-identification is done by surveying

Table 1: Details of organisations involved in running 24 HEFs in 2006

ORGANISATION		NO. OF SCHEMES IN WHICH INVOLVED
DONORS		
Belgian Technical Cooperation		7
European Union		2
EU/Canadian IDA		1
Health Sector Support Project (HSSP) supported by ADB, WB, DFID, JFPR		5
Swiss Red Cross		2
UNICEF		1
USAID		5
Volunteer Service Abroad UK		1
Managing agencies		
Belgian Technical Cooperation		7
German Technical Cooperation GTZ		1
Health Net International		7
Swiss Red Cross		2
UNICEF		1
University Research Company		5
Volunteer Services Abroad UK		1
Local Operators		
Action for Health		11
Buddhists for Health		1
Cambodian Association for Assistance to Families and Widows (CAAFW)		2
Cambodian Family Development Services (CFDS)		5
Cambodian Health and Human Rights Alliance (CHHRA)		1
Equity Fund Steering Committee		1
Hospital Committee		1
Pagoda Funds		1
Urban Sector Group		1

Source: Annear, P. L. 2006. "Table 5", in the Study of financial access to health services for the poor in Cambodia. Phase 1: Scope, Design and Data Analysis. Consultant report submitted to the Ministry of Health, WHO, AusAID and RMIT University. Phnom Penh. Pp. 22-23.

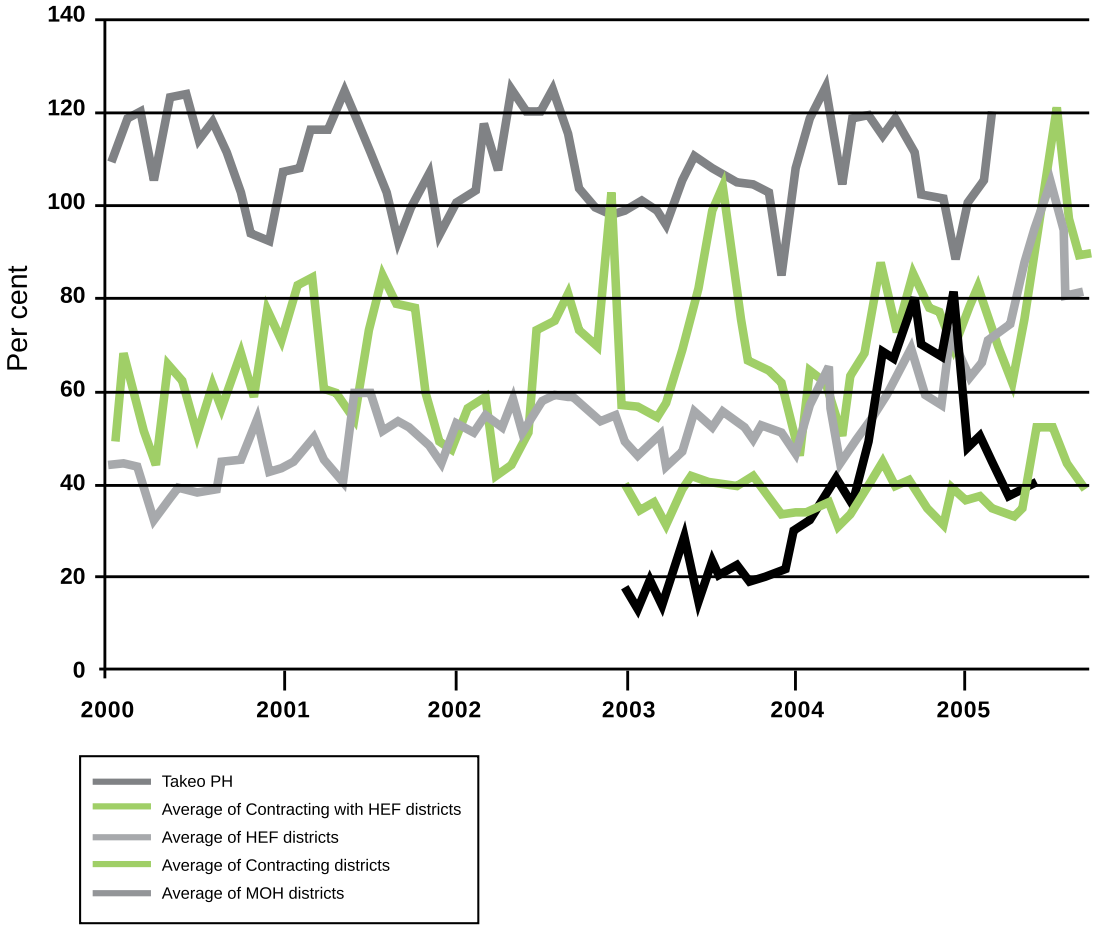
a district's population and drawing up a list of those eligible for HEF assistance. Those identified are given some kind of identifying document which can be produced when they go to a health facility, in order to avail exemption from paying fees.[93]

Passive identification involves the determination of eligibility after a person has arrived at a health facility. The local operators have HEF staff stationed at the participating health facilities. If a person coming to a facility lacks money to pay the user fee, s/he is referred to a HEF staff member, who asks a series of questions about the person's household. If the person is found to be poor according to the HEF's definition, then the staff member arranges for the patient to receive HEF support. HEF staff members within a facility also visit wards to identify whether there are others who may have been able to pay the admission fee but only by borrowing against productive assets. In passive identification, HEF staff also makes house visits to cross-check and confirm that a person was indeed eligible for HEF support.[94]

Benefits package

HEF funds are used only for reimbursing health services made available in government health facilities. As of 2006, mostly inpatient (and in some instances outpatient) services in referral hospitals

Figure 1. Average referral hospital bed occupancy rate by type of district.



Source: Annear, P. L. 2006. "Figure 1", in Study of financial access to health services for the poor in Cambodia. Phase 1: Scope, Design and Data Analysis. Consultant report submitted to the Ministry of Health, WHO, AusAID and RMIT University. Phnom Penh: Pp.26.

were reimbursed, because health centres charge comparatively much lower fees. Only 7 of 24 HEFs examined in a 2006 evaluation study covered health centre services. Of these, the Kirivong HEF exclusively supported health centres.[95] Restricting HEF support to referral hospitals could result in patients bypassing health centres in order to benefit from the free services. It may be important to consider covering health centre costs through HEF (and not only referral hospitals) because this could help redirect health-seeking behaviour of the poorest from self-medication to government primary-care facilities.[96]

HEF benefit typically consists of paying the user fees on behalf of the poor patient. In most instances, HEF pays 100% of the user fees. But there are also patterns where the proportion of support depends on how poor the patient is. Some HEFs also provide other benefits. A 2007 study of four HEFs (Svay Rieng, Pearang, Kirivong and Sotnikum) reported that the Svay Rieng Fund paid 50-100% of user fees depending on how poor the patient was. In addition, the Fund also bore the referral transportation costs and gave a daily food allowance to those who received a 100% support in terms of fee payment. The Pearang HEF, which also provided all these benefits, paid for costs of approved health services outside the health district in case of referral.[97]

Provider payment

A study of four HEFs reported that all schemes compensated providers on the basis of flat rate fees fixed officially for various services in government health facilities. Reimbursement was made on a monthly basis. In two facilities, the provider was paid only 70-90% out of the user fee exemption, while in the other two, 100% reimbursement was made. The process was kept simple and transparent with limited transaction costs.[98]

Impact on utilisation of health services and on indebtedness

An evaluation of 24 HEFs and other social protection schemes carried out in 2006 reported that HEFs had substantially increased health service utilisation rates in referral hospitals, as measured by bed occupancy rates.[99] Figure 1 compares the bed occupancy rates of referral hospitals using the HEF schemes with referral hospitals that have been contracted in or out, and those in which HEF schemes operate in an Operational District where health services have been contracted. The bed occupancy rate in Takeo Provincial Hospital which has been operating at over 100% capacity for several years serves as the benchmark.

It is evident that while MOH hospitals operate between 40-50% capacities, the average for HEF districts shows an increasing trend since 2000 and stood at 100% by 2006. When HEF schemes were implemented in contracted districts, the utilisation rates were even better.[100] What was the impact on utilisation of health care services by the poor? Time-series data available for the longest operating HEF in Sotnikum referral hospital shows that while inpatient admissions increased sharply after HEF was introduced and HEF patients accounted for 40% of inpatients by 2006, fee-paying admissions remained constant.

It may be deduced that the increase after 2000 is because HEF provided access to many who were otherwise excluded from services, i.e. the poor.[101] A 2004 study of six rural hospitals with HEF support found that most of the assistance (93.5%) by HEF in these hospitals went to very poor or poor patients, with only 6.5% of the better-off groups receiving assistance from HEF. This estimation was on the basis of an asset index calculated from data gathered through a bed survey within hospitals.[102] The leakage was almost nil (1%) according to the subjective assessment of the researchers who carried out the survey, other factors such as respondents' clothing, attitude and oral expression were taken into account.[103]

The above studies show that HEF assistance goes almost exclusively to the poor, and has resulted in utilisation of inpatient services by those who had found hospital care unaffordable in the past. There may be a substantial proportion of the poor who are still unprotected from catastrophic health care expenditure. The study of six hospital revealed that there were many inpatients, who were not receiving HEF support in the poorest groups. More than half (51.6%) of the poorest 40%, according to the asset index, were not supported by HEF, and according to the assessment of surveyors, 35% of the poorest and 70% of the poor were not covered.[104]

Hence, those assisted by HEF may still be at risk of catastrophic health care expenditure, especially when the assistance does not cover expenses other than hospital user fees. An early study of HEF beneficiaries in Sotnikum referral hospital found that hospitalisation fees represented only 32-35% of all costs. Food costs accounted for 38-42%, transportation for about 20% and other costs, 8%. Although Sotnikum HEF paid for all these categories of a patient's expenditure, HEF support covered only 40% and 56% of total average spending by the poor and poorest groups respectively.[105] A WHO study in 2009 found that up to 36% of HEF patients from rural areas still borrowed money for the current episode of care, in addition to older debt. In the urban area, borrowing for the current episode was much less among HEF patients (4%) compared to those who were not supported by HEF (17%).[106]

While HEF coverage may not prevent catastrophic health expenditure in all instances, there is evidence suggesting that it reduces the proportion of indebted households in a population. A study of the HEF in Phnom-Penh urban area explored the impact of health-care costs on indebtedness by comparing a squatter settlement covered by HEF with another not covered by the scheme. The study found that total indebtedness in the HEF covered settlement was 17%, significantly lower than the proportion of indebted households in the non-HEF area (47%). The difference was most pronounced for recent debts (incurred within the past 30 days): 9% in HEF covered settlement as compared to 26% in the control area. The controlling variables like age, sex, years of schooling, and chronic disease, those living in squatter settlements without HEF coverage were 3.4 times more likely to have a recent debt and 2.5 times more likely to have an old debt.[107]

Evidence is scanty on the proportion of the poor with untreated morbidity and the inability to gain access to health care services and the changes after the introduction of HEF schemes. The distance from the health facility and age, gender and family size and structure influenced "not-seeking" behaviour or even delayed the health care seeking behaviour, according to studies carried out in Sotnikum and Kirivong Operational Districts. Another important factor was lack of information about eligibility for an equity fund, which may have been because these studies were carried out in the first few years after HEF schemes were well underway.[108]

The future of HEFs

Overall, HEFs have proven to be an effective way of removing financial barriers to health care through the introduction of user fees, which seem to be better option than offering waivers. HEFs are also an important source of funding for government health

facilities, and therefore, making it more likely to be supported by providers. In Chhlong referral hospital, for example, the revenue added to the existing income from full user fees was around US$2000 per month, and could be as high as US$5000.[109] What is in question is the sustainability of this model, which is heavily dependent on external funding. HEFs cannot be expanded or even sustained without a continued financial commitment by international and bilateral donors.

The success of HEFs has prompted the government to include this as part of its strategy for universal coverage. In 2007, the government included subsidies for the poor in its budget with the intention of up-scaling under HSSP2. In that same year, the Ministry of Planning developed a standardized approach for identifying the poor applicable throughout the nation. This was part of an effort to establish more uniformed procedures across HEFs after the initial 5-6 years of experimentation. The Ministry of Health also developed Guidelines for Health Equity Fund Implementation to encourage the harmonisation and standardisation of implementation and reporting arrangements.[110]

4.2 Community-based health insurance schemes (CBHI)

Community-based insurance schemes were first launched in Cambodia in two provinces – Kandal and Takeo-in 1998 by the French NGO GRET (*Group de Rechereches et d'Echanges Technologiques)*. This scheme known as SKY[111] is currently the largest CBHI scheme in Cambodia and is aimed at households dependent for income on the informal sector. Enrolment is voluntary, and membership is for entire families. Members can enrol any time of the year, and there is a one-time enrolment fee equivalent to two months' premium.

Households pay their premium on a monthly basis, and subscription is for a cycle of six months. Premiums vary by nature of employment of household head (informal, semi-formal and formal), and by number of members in the household (1, 2-4, 5-7 and 8+). The lowest monthly premium, for a single person in the informal sector is about US $2/- per month and the highest, for a household of 8+ members employed in the formal sector is US$8/- (2008 figures). For formal sector employees, 50% of the premium is paid by the employer.[112] The scheme stimulates a stable and long-term membership through waiting periods before enrolment and penalties for drop-out, to discourage bias selections, wherein only those with a health problem join and quit after the problem is addressed.[113]

The benefit package is described in Table 2 below, and includes pregnancy and delivery care. Subscribers could use these services from 28 government health centres and 9 rural hospitals. No money is involved when it comes to services provided at the facilities and no co-payment is required. Users have to respect the referral chain to receive services covered by SKY, especially services which are of a higher level. In April 2008, the scheme had 15,500 members in Phnom-Penh city, and six rural districts spread across four provinces.[114]

In 2008, user premiums covered only 31% of the costs and the scheme was subsidised by GTZ (German Technical Co-operation) and AFD (French Agency for Development). Financial sustainability was not perceived to be achievable with the current level of membership.[115] SKY contracts public health providers who sign a contract agreeing to adhere to minimum conditions such as quality of services, non-discrimination and longer opening hours, and are paid on a capitation-basis. Contracts are renegotiated every year.[116]

Based on the experience gained with SKY Insurance, the government of Cambodia has set up an inter-ministerial committee on Health Insurance, known as the Social Health Insurance Group. In 2005, the Social Health Insurance Group drafted guidelines for establishing insurance initiatives.[117] An independent evaluation of the schemes concluded that SKY-CBHI encouraged greater use of public health facilities by patients who had previously used alternative services, including expensive state hospitals and private providers.[118] Although similar to the other schemes, but because of the limited coverage of the overall population, SKY insurance remains an actor of limited significance in the health financing scenario in Cambodia.

5. Privatisation and sexual and reproductive health care services

The evidence of how privatisation has specifically affected sexual and reproductive health services is limited. In this section, we first look at what is known about the consequences of user fees and of contracting in order to gain access to quality SRH services.

We then examine the role of HEF and CBHI and recent government initiatives for a fast-tracking progress to MDG 5 in mitigating barriers to access. This is followed by a description of the role of newly emerging private SRH services in the form of social marketing and provider networks, and their implications for equal access to SRH services.

Table 2: Benefits package of SKY CBHI

■ Access to primary health care at health centre level including prescribed drugs
■ Access to specialised out-patient consultation and diagnostic tests (ultra-sound, laboratory, x-ray) at district and provincial level, after referral
■ Hospitalisation with drugs and all related diagnostic tests. No ceilings applied.
■ All ante-natal and post-natal care, simple and complicated deliveries after a waiting period of 6 months
■ Grant for member funeral expenses (US$12-US$24 in rural areas and US $90 in urban areas
■ Emergency transportation grant US$5
■ Pre-existing conditions and diseases are covered by the package
■ Long term treatment for chronic diseases
■ Hospitalisation for non-priority surgeries (e.g. cosmetic or plastic surgery, dental surgery)
■ Basic dental care, basic eye examination, glasses, hearing aids
■ High-cost surgery (e.g. open-heart surgery, organ transplant)

Source: International Labour Organisation(ILO). 2008. Cambodia: Sky Health Insurance Scheme. Bangkok: ILO Sub-regional Office for East Asia. Pp. 5.

5.1 User fees

Costs of reproductive health services were relatively high when compared to the economic status of the population. In Kampong Cham provincial referral hospital, for example, normal delivery and hospitalisation was fixed (1998) at 50,000 riels; and abortions later than 3 months gestations, as high as 200,000 riels (I US$= 4000 riels). The cost of a normal delivery in a health centre in the same province was 15,000 riels.[119]

One of the features in the introduction of user fees in government health facilities was that hospitals were allowed to set their own scale of fees. Tremendous variations in the scale of fees are common across different hospitals. One study noted that the same service such as normal delivery could cost ten times more in a national hospital as compared to a district health centre.[120]

Indirect evidence points to the barriers created by user fees and related expenses in women's ability to access pregnancy and delivery care. According to the Demographic and Health Survey of Cambodia (2005), "getting money needed for treatment" was mentioned by 75% of the women of childbearing age as the most important reason why women were unable to access pregnancy and delivery care services.[121] The poorest women were most affected: 86% of women from the lowest wealth quintile stated this as the main reason, as compared to 54% in the highest wealth quintile.[122]

The fact that more than half the women even in the highest wealth quintile found it difficult to pay for pregnancy and delivery related care speaks of the gender-power inequalities limiting women's access to resources even in well-off households. We could not find information on costs and utilisation of other sexual and reproductive health services.

Table 3 provides evidence from the Cambodia DHS 2005 on the high degree of inequality in the access to pregnancy, delivery and contraceptive services by economic status, ten years after user fees were introduced in health facilities.

The largest inequalities are in access to delivery care. Women from the highest wealth quintile were 4 and 10 times more likely to have skilled attendance and institutional delivery respectively as compared to women from the lowest wealth quintiles.[123]

To what extent do the HEF and CBHI and other initiatives for achieving MDG 5 goals mitigate the barriers faced by women?

A comprehensive study which evaluated all HEF and CBHI schemes found that there was little data by sex, except for two referral hospitals. In these two hospitals, women and girls constituted more than 50% of all patients covered by HEF.[124]

Health Equity Funds include all referral hospitals in-patient care in their benefits package, and in some instances, also the costs of transportation and other non-medical costs.

One study reported that in Kirivong health district in Takeo province, the number of assisted deliveries among HEF beneficiaries was 2.3 per 1000 population per year and for non-beneficiaries, 8.8 during the base-line survey, and after a year, the rates were 4.4 and 9.8, respectively.[125]

Table 3: Rural-Urban and wealth-based inequalities in maternal and reproductive health care

Key indicators	Ratio in 2005	
	urban: rural	richest quintile: poorest quintile
% of all currently married women currently using a modern method of contraception	1.1	1.5
% of all currently married women with an unmet need for contraception	0.8	0.5
% of all women who had a live birth in the last 5 yrs who received ANC from a trained staff during last pregnancy	1.2	1.6
% of all deliveries in the last 5 yrs with assistance of trained staff (doctor, nurse or midwife)	1.8	4.3
% of all deliveries in the last 5 yrs which took place in a health facility (public or private)	2.9	10.4

Source: The World Bank. 2008. "Table 2" [quoted from Cambodia Demographic and Health Survey 2005] in Programme Appraisal Document on a Proposed Credit in the Amount of SDR 18.5 million to the Kingdom of Cambodia for a Second Health Sector Support Program (Report no. 42249-KH). Washington, DC: The World Bank. Pp.27.

However, as already noted, HEFs still leave a large proportion of the poor uncovered. Many do not know that they are eligible for equal fund coverage. The SKY CBHI also covers pregnancy and delivery care. However, we have seen that the coverage of CBHIs is limited, and they cater more to the non-poor than to poor households. The inequalities in access and the role of financial constraints in accessing pregnancy and delivery care point to the need for factoring in other costs such as loss of wages, transportation etc., that may be preventing women from accessing even the most basic of reproductive health services. More importantly, HEFs do not cover women in non-poor households, who may be unable to access financial resources to seek care because of gender power inequalities.

5.2 Contracting

Evaluation of the health impact of contracting in CO and CI districts indicated that there was a huge increase in the use of antenatal care, institutional deliveries and knowledge and use of contraceptives. Immunisation of children also registered an increase (Table 4).[126]
These figures indicate an impressive increase in utilisation rates for maternal health and contraceptive services. However, this does not tell us what the overall extent of coverage achieved in 2003 was. It is possible that the initial levels of utilisation were very low, that even a 400% increase in utilisation could still leave a vast majority of the population uncovered by services (e.g. the increase in utilisation could be from 5% to 20% or of a similar magnitude). There also remain questions about the equity effect. In many contracting districts, there was a substantial increase in official user fees without any waivers for the poor.

One study had indicated that in contracting districts out-of-pocket expenditure had declined (despite the increase in user fees) because there were no longer informal charges to pay.[127] Costs of services may, nevertheless, have been too high to be affordable for the poor. Poorer sections and especially women may also have been discouraged from using the services because of an anticipation of high costs. Whether or not coverage of maternal health and contraceptive services increased in contracting districts, and whether or not those from poorer sections were able to afford these services, need to be probed.

5.3 Social marketing and private provider-networks

Social marketing may be described as the application of marketing tools, concepts and resources to effectively deliver health products and services and motivate the use of those products and services. Products are charged at subsidised prices and distributed by commercial distribution systems to retail outlets. Behaviour change strategy seeks to promote access to and demand for goods and services by integrating health education with commercial brand advertising.[128] The subsidy may be provided by the government, or by a bilateral donor.

Private-provider networks consist of an affiliation of private providers who are members of an umbrella organisation. Members usually offer a standard set of services under a shared brand. The brand

Table 4: Mean change in health service coverage indicators in contacting in and contracting out districts as compared to control districts: 1999-2003

Items	Control (%)	CI (%)	CO (%)
Antenatal care	160.1	233.3	401.5
Facility delivery	0.0	225.1	142.0
Antenatal tetanus immunisation	149.1	148.6	400.0
Family planning knowledge (All)	307.4	317.4	599.5
Family planning knowledge (lower 50% socio-economic group)	271.0	301.4	559.5
Contraceptive prevalence rate	93.4	104.5	122.6
Child immunisation	55.7	81.8	158.1
Illnesses treated in a district health facility	81.7	490.5	1096.0

Source: Asian Development Bank (ADB). 2002. "Table A6.1", in Report and recommendation of the President to the Board of Directors on a proposed loan to the Kingdom of Cambodia for the Health Sector Support Project. RRP: CAM 32430. Manila: ADB. Pp.36.

name serves as a guarantee of the availability of a defined package of services that are of high quality, at clearly determined prices. Some networks evolve into 'franchising' programmes in which there is a controlling organisation, the 'franchiser' who provides ongoing monitoring and technical support to the franchised providers.[129]

Population Services International (PSI), an international NGO funded by USAID, is the only organisation engaged in the social marketing of reproductive health commodities and in running franchised clinics to provide selected SRH services.

PSI has been engaged in social marketing of condoms in Cambodia since 1994, selling the "*Number One"* brand of condom.[130] In 2003, a water-based lubricant, *Number One Plus* was introduced, targeted mainly at sex workers and men who have sex with men.

The "*Number One"* condom was estimated to hold more than 80% of the market share for condoms in Cambodia in 2004. A survey conducted in 2002 found that 97% of all brothels surveyed were using the Number One condom.[131]

Another brand of condom, "*OK condom"* was launched in 2004, and positioned as a product mainly for married couples and sweethearts.[132] These condoms were promoted as means for dual protection from pregnancy and STIs.

Other products socially marketed by PSI include the "*OK Pill*" contraceptive, the "*OK injection,* and a pre-packaged STI treatment kit, *"STOP-Z".*[133] The *OK Pill* was estimated to have been sold in over 2000 pharmacies and drug stores and the *OK injection, was* widely available in clinical pharmacies.[134]

In 2002, PSI/Cambodia launched the *United Health Network* (UHN) of local and international NGOs. PSI trains members of this network in social marketing and selling technique.

At the end of 2006, there were 36 UHN members in Cambodia, most of them involved in the social marketing of condoms and STI kits.[135]

PSI also created the "*Sun Quality Health"* (SQH) network of private sector clinics. At the end of 2006, there were 126 Sun Quality Health service delivery points in five provinces and Phnom Penh. Sun Quality Health clinics provide birth spacing counselling, and a range of spacing methods except the IUD.

They also distribute the STI treatment kits and provide Voluntary Counselling and Testing (VCT) services for HIV. According to a 2005 report to the USAID by the POLICY project, only a minority of these clinics in fact provided VCT services, and fewer still promoted the condom as a method for dual protection.[136]

From the limited description of social marketing and the Sun Quality Health provider network it appears that although only a limited range of sexual and reproductive health services are available through these clinics, they complement services available in public health facilities.

For example, the services available are for STIs, VCT services, and reversible methods of contraception. What are falling between the cracks are safe abortion services which are not likely to have been provided by Sun Quality Health network because it is USAID-funded.

Due to the lack of studies regarding coverage, utilisation and quality of care provided in Sun Quality

Health clinics, a general critique of provider networks and social marketing which may be applicable to those in Cambodia can only be given.

Social marketing programmes and provider networks are interested in cost-recovery (at least partial) and sustainability. They are typically useful in expanding coverage to non-poor populations with ability to pay at least a part of the cost of services, in settings where some products and services are not otherwise available.

Even if subsidised by government or donors, they would find it financially unviable to expand coverage to the poor and geographically remote populations. This is because of low demand from these groups for products and services that they would have to be pay for; and also because commercial outlets for social marketing will be under-developed in remote areas.

Social marketing outlets and private clinics may be expected to be located in places with adequate purchasing power, connected by roads and transportation. This bias selection is likely to contribute to widening inequalities to access SRH products and services.

Issues about quality also emerge in social marketing arrangements. Social marketing of contraceptives appear to skew contraceptive method mix in favour of hormonal contraceptives, and to a lesser extent, condoms (which seem to be used much more for STI prevention than as a contraceptive).

Of greater concern is the prescription of the oral contraceptive pill and injectable contraceptives without screening for certain medical conditions, which the social marketing programme is usually not able to provide.

There is also no follow-up care to check for possible side effects from use of these contraceptives. Commercial interests and profit-driven motives may in fact lead the agent to underplay risks of the method.

Similarly, although there is mention of quality control and supervision in provider networks, it appears that the exclusion of some services (such as VCT and promoting dual protection) by providers in individual Sun Quality Health clinics could not be prevented. It is also not clear as to how PSI will be able to prevent unnecessary prescriptions and procedures, especially in settings where the patients may view these as indicative of 'high-quality' care.

User-perspective studies as well as independent assessments of the technical quality of care are needed to ascertain the relative social costs of social marketing and private provider networks when weighed against the potential benefits of expanding coverage.

5.4 Social Protection Health Schemes

A number of "social protection health scheme", like initiatives, appear to have been started in 2007 or later to specifically support access to safe motherhood interventions for the poor.

In mid 2007, the government of Cambodia introduced a delivery incentive scheme. According to this scheme, midwives and other health personnel receive an incentive of US$12.5 for each live birth attended in a referral hospital and US$15 for each live birth attended in a health centre.

This was in addition to the user fees that they were authorised to charge. This was a nation-wide initiative. This initiative is reported to have increased the proportion of deliveries attended by skilled birth attendants from 36 in 2006 to 52 in 2008, while the proportion of institutional deliveries more than doubled, from 16% in 2006 to 36% in 2008.[137]

Another intervention to address demand-side constraints is the Voucher Scheme. From early to mid 2007, the Ministry of Health and the Belgian Technical Cooperation initiated a voucher scheme to complement the HEF with the objective of increasing access to safe delivery care for poor women.[138] This scheme was launched in three Operational Districts of Kampong Cham province: Cheung Prey, Prey Chor and Chamkar Leu. Non-governmental organisations were selected to act as Voucher Management Agencies (VMA).

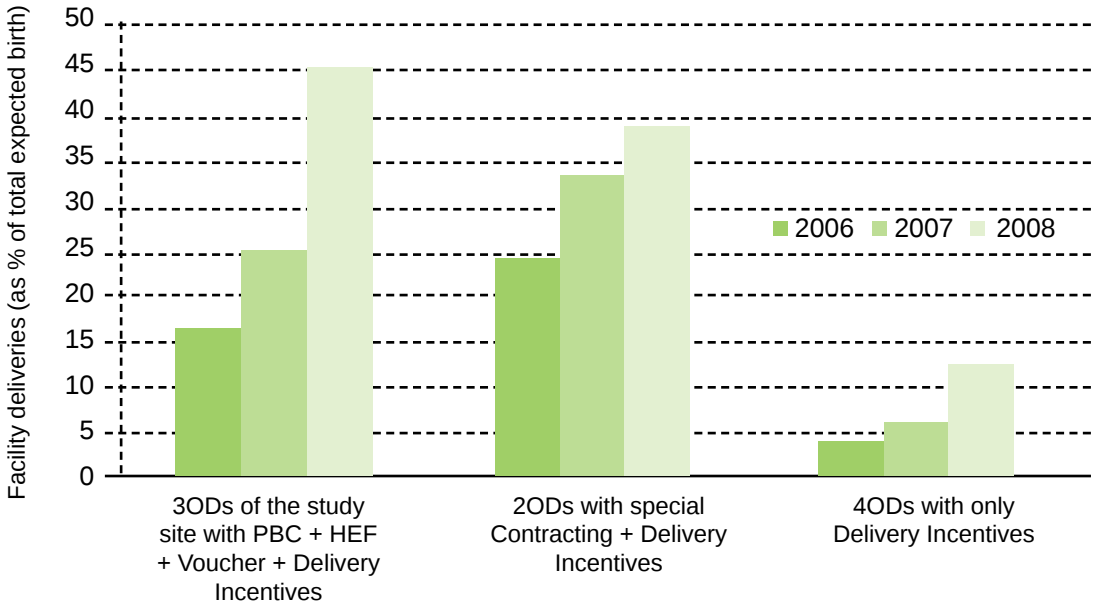
Poor pregnant women were identified by these agencies using the same eligibility criteria as for HEF. Each eligible woman received a voucher with five detachable coupons.

The coupons entitle the woman for free services at the health centre, bearing the transportation costs for five round trips between home and the health centre and referral from the health centre to hospital in case of complications. Free services are provided for three antenatal visit, delivery and one post natal visit.

Thirty of 42 health centres with the necessary infrastructure and human resources were selected to provide services under this scheme. At the end of each month, the VMA pay the contracted health centres on the basis of number of coupons and the price of user fees, which are US$7.7 for a normal delivery and US$0.25 for each antenatal or postnatal visit. Cash advances are paid by the VMA to the health centre for reimbursing the transportation cost of voucher holders on the basis of a pre-defined price list.[139]

The three Operational Districts also had other initiatives in place. The Performance Based

Figure 2: Comparison of facility deliveries in three groups of ODs in Kampung Cham 2006-2008



PBC = Performance-Eased Contracting HEF = Health Equity Fund: OD = Operational Health District

Contracting (PBC) scheme had been introduced in 2005 and by 2007 covered all government health facilities in these three Operational Districts.

Under the PBC arrangement, contracted facilities receive financial incentives related to certain process and output indicators, support for staff training and for drugs and supplies. As already mentioned, HEF were also in place in these Operational Districts.[140]

A study examining the performance of the voucher system in these three Operational Districts was carried out in 2008. The three ODs had four interventions: performance based contracting, delivery incentives, Health Equity Funds and the Voucher Scheme.

Health centres in these were compared to the health centres in two ODs which had special contracting and delivery incentives, and with another group of health centres in four other ODs with only delivery incentives.

The results showed that the number of deliveries in health facilities with the voucher scheme complementing the HEF, along with PBC and delivery incentive schemes had the highest increase in the number of facility deliveries: from 16.3% of expected deliveries in 2006 to 44.9% in 2008 (Fig 2 below).[141] Voucher and HEF beneficiaries constituted 41% of poor women who had delivered during the study period, and many of the voucher users had had their previous deliveries at home.

These results are promising, and we hope that the initial gains have been subsequently sustained.

5.5 The role of national non-governmental reproductive health organisations

No discussion of the work on reproductive health in Cambodia would be complete without a description of the contributions of two large national reproductive health organisations: The Reproductive and Child Health Alliance (RACHA) and the Reproductive Health Association of Cambodia (RHAC).[142]

RHAC was formed in 1996, several years ahead of RACHA, which was established in 2003. Both organisations had their origins in family planning. RHAC grew out of an USAID-funded family planning project of the international NGO, Family Planning International Assistance, while RACHA was created as a consequence of a partnership between three USAID-funded projects in Cambodia.[143]

RHAC operates clinics which provide STI/HIV and other reproductive (including maternal) health care and child health services. RHAC works with HealthNet International (HNI) to implement the government's Health Equity Fund in one Operational District of Prey Veng province. It provides training to improve the technical and managerial capacity of government health personnel to increase women's access to publicly provided reproductive health services.[144]

RACHA does not provide health services but supports the Ministry of Health in increasing coverage and access to local public health services, to improve the quality of these services and to positively

influence the health-seeking behaviour of women and communities. RACHA has been engaged with training midwives in life-saving skills, supplying home-birth kits to traditional birth attendants, and promoting contraceptive use (among other things) through networks of Buddhist nuns and laity.[145]

No published source could be found evaluating the contributions of these and other NGOs according to the availability, equitable access and quality of reproductive health services.

6. Concluding remarks

Cambodia is a low income country with a very poor health infrastructure and human resources. The country suffered devastating losses during the Pol Pot regime, when health facilities were destroyed in the wars and civil unrest and health professionals were victims to the mass killings of intellectuals.

Although a poor country, Cambodia spends close to 6 % of its GDP on health. Health outcomes are poor, with high levels of mortality and morbidity, indicating the high level of inefficiency in the system. Public funding accounts for less than a third of the total health expenditure (about 29%), and the system is also heavily dependent on external funding, which accounts for 16% of total health expenditure.

Two-thirds of the total health expenditure is met from out-of-pocket expenditure by households. The poor pay a lot of money but receive very poor returns in terms of appropriate health care. Given the level of poverty in the country, having to spend on health care causes tremendous economic hardship and many households are impoverished because of catastrophic health expenditure.

Against this backdrop, Cambodia has initiated a series of somewhat contradictory reforms in the health sector. On the one hand, it has supported further privatisation of financing health care through the introduction of user fees even in government facilities, both in those run by the health department and those contracted to private providers.

It has also given support in terms of the policies which deal with introduction of social marketing and private provider networks, especially when it comes to the payment of products and services.

On the other hand, it has introduced policies aimed at achieving universal coverage: through Social Health Insurance for the formal sector; CBHI for the informal sector and HEF for those unable to make any premium payments. HEFs have indeed increased access to health care for the poor, but they have not been able to offer adequate financial protection to many, because the benefits package usually covers only in-patient care in referral hospitals.

A high cost of transportation is another challenge, because hospitals are few and far between. Although the non-poor earn more than the poor, there are many in the non-poor category, who may be unable to meet the costs of health care.

CBHI caters mainly to the non-poor, and have limited coverage. The logic of erecting formidable barriers to access through user fees and then creating mechanisms to remove these barriers for the poor, with heavy donor funding, is not clear.

As for SRH services, we find that the availability of safe delivery care is seriously limited due to the shortage of skilled birth attendants, as well as the high non-medical and medical costs of delivery care. Despite HEF and CBHI coverage of delivery care, large inequalities exist in which the richer quintile have the advantage, in coverage by skilled attendance at delivery and by institutional delivery.

HEF, despite its extensive coverage, still fails to cover a substantial proportion of the poor, including women. The delivery-incentive scheme and the experimental voucher scheme for maternal health care complementing HEF both show promising potential.

More studies are needed to be done in order to examine the sustainability of the increase in proportion of institutional delivery, which these interventions have brought about. Financial sustainability of multiple incentive schemes for health providers also needs to be evaluated.

More importantly, HEF does not cover women from non-poor households who may not have the money to seek health care, and on whom the households may not feel obliged to spend large sums of money, especially for treating non-life threatening conditions

With the MDG 5A driving all efforts and investments in women's health, there is the danger of all other reproductive health services taking the back seat. For example, the use of modern methods of contraception is as low as 27%.

Abortion mortality is high despite the liberal abortion law, but there is no mention of abortion services covered either by HEF or CBHI, and it is not clear whether an NGO like RHAC is able to provide safe abortion services given its dependence on USAID funding. In principle, HEFs are supposed to cover all other inpatient and outpatient gynaecological care, but in practice, this may be difficult to realise without substantial increases in human resources and infrastructure. Social marketing of contraceptives and condoms would help increase access to these products to those with ability to pay, and are to that

extent, a useful complement to existing services. Provider networks similarly offer paying patients an option to public health care. However, they do not offer a number of essential SRH services including RTI treatment, abortion services and delivery care, and screening, diagnosis and treatment for reproductive cancers.

Overall, it seems that Cambodia's efforts to make essential health care, including SRH services, universally available at affordable costs is more of an aspiration than a plan based on an assessment of ground realities. Universal coverage by SRH services, in particular, would call for a number of specific measures, for example:

- Investment in constructing and staffing a sufficient number of basic and referral health facilities so that services can be accessed within 1-2 hours of travel

- Investment in creating a large enough cadre of health providers skilled to provide essential SRH services including delivery care and safe abortion services

- The inclusion of basic SRH services in an Essential Services Package (ESP) publicly financed and made available free of charge to women

- Expansion of the range of services available through private provider networks and the possibility of subsidised or free care to those unable to pay (for example, through tie-ups with HEF).

ENDNOTES

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CHAPTER 2

LAO PDR

1. Background

Lao PDR is a mountainous and thinly populated land-locked country in South East Asia bordering Vietnam, Thailand and Cambodia. The country is divided into 17 provinces.

Lao PDR was under French colonial rule until 1954 and under a monarchy after independence from the French until 1975, when it declared itself a People's Democratic Republic with centralised planning and one-party rule under the leadership of the Lao People's Revolutionary Party (LPRP). The period 1954-1975 was one of turmoil, marked by political struggle, civil war and bombing by the United States of America during the Vietnam war. While the LPRP continues to hold political power, there has been a transition from a command economy to a market economy since the mid 1980s.[1]

1.1 Economic growth and human development

Lao PDR is ranked as a Least Developed Country (LDC). Its per capita GDP in 2005 was 2039 PPP[2] US dollars.[3] Agriculture contributes around 42% of the GDP (2006) and employs nearly 80% of the labour force. The industrial sector contributes to a little more than 32% of GDP, and the service sector, nearly 26%.[4]

The definitive transition from a command economy to a market economy in Lao PDR began in 1986 with the introduction of the New Economic Mechanism (NEM). The collectivisation of agriculture was abandoned.[5] Price control measures were lifted, and subsidies previously given for the basic needs of consumers were eliminated. State-owned enterprises were given autonomy and their subsidies and privileges were discontinued. Several new taxes were also introduced. In 1987, government discontinued state monopoly on foreign trade in several commodities.[6]

Economic reforms fostered an era of rapid economic growth. In the 1990s, real GDP grew at an average rate of 6.3%. This was despite a major shock to the economy following the collapse of the Soviet Union, a major source of aid to Lao PDR. The growth rates were 7.5% in 2007 and projected at 7.9% for 2008.[7]

Poverty in Lao PDR declined steadily from 46% to 33% during 1992-2002, and the poor were becoming less poor on average. During the same period the share of the poorest quintile in national consumption declined from 9.6% to 8%, indicating an increase in income inequalities during 1992-2002.[8] Information from different studies indicates that poverty is concentrated in the rural and remote highland areas where ethnic minority communities live.[9] Provinces which have ethnic minorities with more than 60% of their population also tend to have a high prevalence of poverty.[10]

Although its income per capita is among the lowest in the world, Lao PDR ranks as a country with a medium level in its human development, with a Human Development Rank of 130 out of 177 countries. Its net primary school enrolment rate was 84% in 2005. However, more than a third of those who enrolled in primary school did not complete grade five, and only 38% went on to enrol in secondary school.[11]

Living conditions of the people appear to have improved since the mid 1990s. Access to safe water increased from less than 20% in 1995 to over 50% in 2002/03. The share of households living with access to some kind of latrine increased from one third to one in two; there was a rise in the access to normal or pour-flush toilets from 1 in 7 in 1995 to 2 in 5 in 2002/3.[12]

1.2 Gender equality profile

The government of Lao PDR is committed to gender equality and gender mainstreaming is high on the agenda of the country's poverty eradication strategy.[13] The 1991 Constitution of Lao PDR guarantees equal rights for women and men.

Laws related to marriage and divorce also provide equal rights to women and men. Lao PDR's inheritance law endorses the same inheritance rights for women and men, boys and girls. The country has ratified the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) in 1981 and the Convention on Rights of the Child (CRC) in 1991.[14]

Lao PDR had a Gender Development Index (GDI) of 115 in 2005 as compared to a HDI of 130. The gender gap in educational attainment was not very wide. The ratio of female to male gross primary, secondary and tertiary enrolment rates in 2005 were 0.88, 0.76 and 0.72 respectively.[15]

Gender disparity was greater in terms of economic activity and income earned. A little over half of all women (54%) above 15 years of age participated in the workforce, 89% in the agricultural sector. Women's economic activity rate was 67% compared to that of men's, but women's estimated earned income in 2005 (1385 PPP US dollars) was only about half of what men earned (2692 PPP US$).[16]

Political participation by women has increased significantly: the percentage of women in parliament rose from 6.3% in 1990 to 25.2% in 2007. All the same, there were, however, no women represented at the ministerial level.[17]

There is great variation in the status of women across Lao PDR's different ethnic groups. The Lao-Tai group is matriarchal, and land is passed on to the daughter. This is not the case for the ethnic minority groups. Residence after marriage is matrilocal among the Lao-Tai, while others follow the patrilocal or bilocal pattern.[18]

Violence against women is reported to be common among women in Lao PDR. A 2003 survey covering 1000 women found that almost half the women interviewed reported experiencing some form of intimate-partner violence: mental violence – 35%, physical violence – 17%, and sexual violence – 1.6%. Close to two per cent of the women who were currently experiencing violence said that violence continued during their pregnancies.[19]

Unfortunately, women do not have legal recourse against intimate-partner violence. There is no law, which specifically addresses domestic violence. On the contrary, Article 22 of the Penal Law of 1992 provides exemption from penal liabilities for physical violence between close relatives as it not considered an act of "serious" nature if the person abused does not lodge a complaint.[20]

Rapid social and economic changes in recent decades have brought with it new problems including migration and trafficking of women. A number of organisations are involved in helping with the rehabilitation of trafficked women. However, the lack of limited data/information on this issue impedes effective government intervention.[21]

2. Health Sector

2.1 Population, health and sexual and reproductive health status

The population of Lao PDR was 5.7 million in 2005, of which about 20% lived in urban areas. About 40% of the population was under 15 years of age, and 3.5% above 65 years of age.[22]

There have been improvements in health indicators over the past decades. Life expectancy at birth increased from 52 in 1990 to 62 in 2008 (61 for males and 63 for females). The infant mortality rate declined from 108 in 1990 to 48 in 2008 (53 for males and 41 for females), and under-five mortality rate decreased from 157 in 1990 to 61 in 2008 (65 for males and 58 for females).[23, 24]

Communicable diseases, malnutrition and reproductive health contribute most to the disease burden, despite significant declines in the prevalence/ incidence of some communicable diseases. For example, the prevalence of tuberculosis declined from 360 per 100,000 population in 2000 to 260 in 2008. The incidence of malaria also declined from 9.1 per 1000 in 2000 to 4.3 in 2008.[25]

Lao PDR joins countries with high HIV prevalence rates and is at risk of an increasing burden because of the disease. Prevalence rate in 2007 was estimated to be 200 per 100,000 in population in the age group of 15-49 years.[26]

Progress towards achieving a reduction in maternal mortality appears to be slow. While national statistics report maternal mortality ratio to be 405 per 100,000 live births in 2005, the rate estimated by the WHO and UNICEF was 660. The MDG target is an MMR of 175 per 100,000 live births by 2015.[27] Three times as many maternal deaths are estimated to take place in rural as compared to urban areas of the country.[28]

The Lao Reproductive Health Survey 2005 reported that only 18.5% of all births were attended by skilled personnel. Almost 85% of all deliveries took place at home. There is substantial rural-urban divide in place of delivery. In urban areas, 51.2% of deliveries were in a health facility; in rural areas with roads, the proportion of deliveries in a health facility was 9.8%; and in rural areas without roads, the proportion of institutional deliveries was only 2.1% .[29]

Unsafe abortion is likely to be an important contributor to maternal deaths, although there is scant information on this. Abortion is illegal in Lao PDR except for saving the life of the mother.

The total fertility rate declined, steeply, from 6.4 during 1970-75 to 4.05 during 2002-05.[30] About 17% of girls in age group of 15-19 years either already had a child or were pregnant at the time of the survey. There is as yet a high unmet need for contraception, and the contraceptive prevalence rate for currently married women in the reproductive age group was 35% for use of modern methods and 38% for use of any method. Active male involvement in family planning and their use of contraceptive methods has been minimal.[31]

It is not surprising, given the very low utilisation rates of pregnancy and contraceptive services, that as recently as from 2000 to 2006, less than 3% of all women had had mammography or PAP smear.[32]

The government of Lao PDR introduced the National Reproductive Health Policy in 2005, and committed itself to improving the reproductive health status, especially of women.[33] The extent to which this translates into action on the ground remains to be seen.

The nutritional status of children is cause for concern. Two in five children below five years of age were

underweight for their age (1996-2005), and 14% of infants were born with low-birth weight.[34] Over a third of all 1-year-old children had not received three doses of DPT immunisation in 2006. During 2000-09, only about 18% of children below 5 years of age slept under an insecticide impregnated bed net; and less than 9% of them received any anti-malarial treatment for fever.[35]

Studies report that the utilisation of health services was low, in general. A majority of those who fall ill opted for self-treatment either with home remedies or by purchasing drugs from private pharmacies.[36] Public facilities, especially district hospitals and health centres are under used. According to the Lao Economic and Consumption Survey-4, only 10% of people experiencing a temporary health problem sought treatment with health facilities or providers, with this breakdown in figures, 11% for the urban population, and 8% and 13% respectively for rural areas without and with roads.[37]

2.2 Personnel and infrastructure

Health facilities in the public sector consist of provincial and district hospitals and health centres. Provincial hospitals provide tertiary level care and are also centres for training and technical supervision. There are two levels of district hospitals, and only type A hospitals are equipped to carry out surgeries. Likewise, there are large and small health centres at the sub-district levels basically providing preventive and promotive health care and a limited range of curative services. At the village level, there are usually 1-2 Village Health Volunteers (VHVs) per village who have received 3 months of training to provide basic curative care.[38]

Lao PDR is perhaps among the only country in the world where decentralisation, which happened in 1987, was quickly followed by recentralisation only five years later, in 1992. Decentralisation affected the district and provincial health services of poorer regions negatively. During the period of decentralisation, each province was required to retain its own revenue and use it for operating public services, including the health system. Local governments had to meet salaries and routine operating costs for district and provincial health services. The costs of drugs were subsidised by the provincial government. Many of the poorer local governments did not often have the money to pay staff salaries and were unable to maintain buildings, equipments and vehicles. Disparities between wealthier and poorer provinces increased.[39]

Another blow to the health sector came with the economic crisis of 1990-95. Health infrastructure was seriously damaged and the number of beds in health centres declined by two-thirds. While other infrastructural facilities like roads subsequently recovered during 1995-2004, the number of health centre beds remained the same.[40] In 2000-09, there were only 12 hospitals or health centres per 10,000 population.[41]

On top of that, there is a serious shortage of health personnel in the workforce. During 2000-09, there were only 3 physicians and 10 nursing and midwifery personnel per 10,000 in a population.[42] According to a 2005 document, a third of the district hospitals lacked a doctor, and there was a severe shortage of paramedics. Only 6% of the doctors were from ethnic minorities, rendering social access to health services was difficult for these minorities groups. There was an acute shortage of female staff, limiting women's access to health services for cultural reasons.[43]

2.3 Healthcare financing

In addition to the paucity of health facilities and personnel, the health system of Lao PDR uses a fraction of the government's finances. The total expenditure on health was 4 % of GDP in 2007. Government expenditure on health accounted for 18.9% of total health expenditure in 2007, a decline from 32.5% in 2000. External funding as a proportion of total health expenditure declined steeply from 30.3% to 14.5%, and out-of-pocket expenses by households increased from 67.5% to 81.1% of total health expenditure as a consequence. The per capita total expenditure on health in PPP$ was 84 in 2007, of which only 16 PPP$ were contributed by the government.[44]

Table 5: A comparison of government spending on health and education, Lao PDR, 2003-06

	2003/04	2004/05	2005/06
Overall spending in health (billions of kips)	180	324	226
Overall spending in education (billions of kips)	457	649	1026
Health expenditure as percent of total budget	4.5	6.2	3.6
Education expenditure as percent of total budget	11.5	12.5	16.5

Source: The World Bank. 2007. "Table 6", in Lao PDR Economic Monitor. Vientiane: The World Bank Office. Pp.12.

The government's spending on health lags far behind the amount the government uses for the education sector.[45] The government's spending on education both in actual terms and as a proportion of the government's budget has been increasing, while for health, the amount fluctuates, and is currently below 2003-04 levels (Table 5).

3. Privatisation in the health sector

3.1 The private sector in health

When Lao PDR was established in 1975, all health services were provided by the government, and there was no private health sector, yet. When the New Economic Mechanism was adopted in 1986, private health facilities began to appear. In 2009, there were 878 registered private clinics, mostly in urban areas, run by public health staff after their working hours. The eight northern provinces had very few private clinics and there were none in two of these provinces. In 2009, there were 1949 registered private pharmacies in Lao PDR, co-existing with many unlicensed drug shops and illicit drug vendors. Currently, the first private hospitals are about to start operating and the regulations are more or less in place.[46]

3.2 Health reforms and privatisation in the health sector

The private-sector driven economic growth is identified by the sixth National *Socio-Economic Development Plan (NSEDP 2006-10) as the first of its four strategic interventions, which would enable the continued evolution of Lao PDR "towards a private sector-led economy with modern governance, while keeping a strong focus on human and social development".*[47]

Privatisation in health has been mainly through the introduction of cost recovery measures. At the same time, various steps have been taken within the health sector in the direction of universal coverage. In other words, even while private financing in health has been introduced through user-fees, social health protection mechanisms are also being set to prevent catastrophic health expenditures and unmet need for health care because of inability to pay.

In 2005, a Law on Health Care was passed, outlining plans for health financing and social health insurance. According to the Law on Health Care, all citizens regardless of sex, age, ethnic, origin, race, religion or socioeconomic condition had the right to receive health care in an equitable manner. The government has also initiated a social health insurance for employees in the formal sector since 1999 and community-based health insurance since 2002.[48]

We first describe below the consequences of the introduction of cost-recovery measures in health and its impact on equitable access to health care. The following section describes the Health Equity Funds and Community-based health insurance schemes and examines the evidence of their success as social protection mechanisms in health.

3.3 Introduction of user fees: The Revolving Drug Funds

From a system of free-at-point of delivery services, the Lao public health services moved definitively towards private financing through out-of-pocket expenses due to Decree 52 of 1995. This Decree introduced a formal cost recovery for purchasing drugs and services in government health facilities. Decree 230 in

Table 6: Cost recovery as a proportion of total health budget and total recurrent cost, northern provinces of Lao PDR, 2006

Provinces	Cost recovery as % of total health budget	Cost recovery as % of total recurrent costs
Xaignabouri	21	83
Oudomxai	38	26
Louangphrabang	26	27
Bokeo	24	16
Houaphan	17	11
Xiangkhouang	22	18
Phongsali	8	9
Louang		
Namtha	33	23
Average	24	18

Source: Asian Development Bank (ADB). 2007. "Table A1.3" in the [Proposed Asian Development Fund grant of the Lao People's Democratic Republic for the] Health Systems Development Project. Manila: ADB. Pp. 34.

1997 expanded the Revolving Drug Fund.[49] Exemptions were provided for school children, students, monks and novices and poor people. Hospitals were allowed to keep up to 80% of the revenue to meet their costs for running the hospitals.[50]

By 2008, Revolving Drug Funds, which include income from drugs and supplies consumed, were implemented in 86% of all health facilities. Patients are charged 25% above the purchase costs and the revenue generated is retained by the facility to pay for recurring expenses.[51]

Cost recovery through Revolving Drug Fund plays an important role in financing recurrent costs. Table 6 provides data on cost recovery for eight northern provinces.

Revolving Drug Funds are also operational at the village level, and were reported to be made available in about 1000 villages, according to a 2008 report. A fee is levied for curative care and drugs provided by Village Health Volunteers, which goes into the Fund.[52]

There were previously no charges for services provided, except for nominal charges for inpatient rooms. In 2005, the PM issued a Decree on Fees and Charges (Decree no.381), which permits all government agencies to charge for all services and products provided.[53] The MoF Decree 1646, in detailed, gives the prices for various services, thus, centralising price-fixing.[54] In practice, not all services were charged a user fee. The government only collected fees when issuing patient booklets (in which patient's case history would be recorded), and dispensing medicines.[55]

Privatisation has negatively impacted on quality of health care services. Dependence on the Revolving Drug Fund as a source of revenue for hospitals and health centres has given rise to over-prescription and providing patients with unnecessary drugs on request. Drugs are also often over-charged up to 40% above cost price.[56] In a study of Revolving Drug Fund in health facilities within the Vientiane Municipality, users expressed dissatisfaction with the functioning of the Fund for a number of reasons. One, drugs were available only during the day-time, which was inconvenient, and compared this negatively with private pharmacies which were open at night. Users felt only a limited sense of ownership with regards to the Revolving Drug Funds.[57]

In addition, health care services have become unaffordable to low income groups. The World Health Survey of Laos (2003) reported that the average cost of inpatient visit ranged from US$15 at Health Centres to US$90 at central hospitals. A 2007 survey covering mainly a non-rural population reported that the total costs of $150 for one episode of inpatient care, including $85 for treatment bills for uninsured persons.[58] This amounts to 100 times the average daily expenditure of 33.5% of the population who live below the national poverty line of US$1.5 a day.

It is to be expected that the poor are often driven to penury by the cost of health care. In 2004, about a third of households in the poorest quintiles had to sell their possessions, for instance, 29% borrowed from relatives to pay for health services. The comparable figures for the richest quintiles were 5% and 7% respectively.[59]

Unequal access to quality health care has been reported by one of the few studies that has examined the consequences of user-fees for access to health care carried out during 1999-2000. The study compares access to health care services following introduction of cost recovery in two groups of peoples from different socio-economic status (SE1: higher status; SE 2: lower status) from three provinces from the north, centre and south of the country. Prevalence of morbidity was 28% among the higher socio-economic status group as compared to 66% in the lower socio-economic status group. All lower socioeconomic group members with a health problem reported difficulty in paying for health care. While all higher socioeconomic group members with a health need were seen by a physician, the majority of members of the lower socioeconomic group sought help from a pharmacist, without examination or diagnosis but based on their own requests. The choice of provider for this group depended predominantly on cost of care.[60]

The study also found that very few of the 30 from the lower socioeconomic group who had used a public hospital had obtained fee exemptions. Many did not know about it, and those who did may have been discouraged by the cumbersome procedures involved. They had to produce a poverty certificate from the village chief, and in addition, they had to see and obtain the approval of a senior hospital staff.[61] Studies by the Ministry Of Health and WHO in 2003 also confirm that very few (less than 1%) of the people using public health services in some of the poorest districts received any exemption.[62]

The poor are unable to access health services not only because they cannot afford the cost of actual services and drugs, but perhaps also the income they could lose from taking off on working days and incidental costs such as transportation related to visiting a health centre/hospital.

Attempts to increase the number of health facilities have not benefitted everyone equally. According to a survey by the Primary Health Care Expansion Project (PHCEP), in 2004, 53% of villagers in the eight northern provinces served by the PHCEP were located within a one-hour walk from a hospital or health centre, but 16% had to travel for more than

4 hours to reach a health care facility.[63] The same study also discovered marked inequalities in utilisation of health care. Inpatient admissions among rural households in the highest quintile were 42.4 per 1000 persons per year, as compared to only 15.9 for rural households in the lowest quintile.[64]

4. Efforts at ensuring access to health care: Health Equity Funds (HEF) and Community-Based Health Insurance (CBHI)

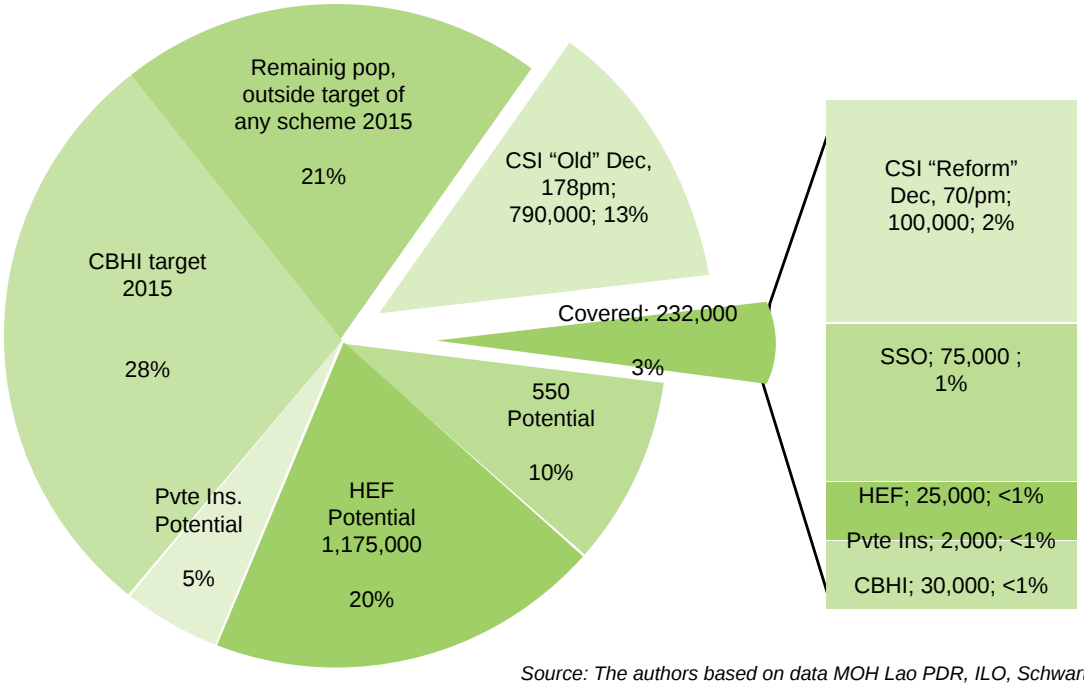
The health system in Lao PDR operates mainly on a fee-for-service basis, financed by out-of-pocket payment by households. Those employed in the formal sector are covered by insurance. Public sector employees are covered by the Civil Servants' Scheme, and the Social Security Organisation caters to employees in the private sector. Community-based health insurance (CBHI) is targeted towards those working in the informal sector while Health Equity Funds are meant to benefit those living below the poverty line.

Figure 3 below shows that only about 3% of the population was insured in 2007 but a negligible proportion was covered by CBHI and HEF. Even if the coverage expanded by 2015 as planned, a fifth of the population would remain outside any scheme.[65]

4.1 Health Equity Funds

In order to increase access to health care and protect the poor from further impoverishment because of health-related expenditure, the government of Lao PDR is experimenting with Health Equity Funds (HEF). Three different schemes have been implemented since 2003, covering 14 districts in the North, South and Central regions of the country. All three were started and are funded by international agencies and cover rural areas, including three very poor districts.[66] One of the Funds began through the Swiss Red Cross in 2003 and is now operated by Lao Red Cross. A second was initiated in 2004-05, co-funded by the Luxembourg Development and the Belgian Technical Cooperation, and is managed by the Provincial Health Equity Fund Office. The third HEF was started in 2006, co-funded by the Belgian Technical Cooperation, and is managed locally, by a committee formed of district health authorities. Under the Health System Improvement Project (HSIP) of the World Bank, National Guidelines for Health Equity Funding have been developed, which includes a model suitable for meeting the specific needs of ethnic minorities.[67]

Figure 3: Social protection coverage in Lao PDR, 2007



Source: The authors based on data MOH Lao PDR, ILO, Schwartz B.

Source: Thome, J.M.; Pholsena, S. 2007. "Health financing reform and challenges in expanding the current social protection schemes", Chapter 3 in UN Economic and Social Commission for Asia and the Pacific. Promoting Sustainable Strategies to Improve Access to Health Care in the Asian and Pacific Region. Bangkok: UNESCAP.

Table 7: Utilisation rates for existing HEF programmes, 1st semester, 2007

Indicators	Nambak	Vientiane Province	Sepone
Out-patient department			
HEF cases per month	220	299	84
HEF % of total cases	15%	2%	7%
Utilisation rate HEF beneficiaries	9%	30%	13%
Utilisation rate non-HEF beneficiaries	34%	20%	38%
In-patient department			
HEF cases per month	26	51	33
HEF % of total cases	9%	4%	28%
Utilisation rate HEF beneficiaries	4%	1%	5%
Utilisation rate non-HEF beneficiaries	2%	1%	8%

Source: Ministry of Health Lao PDR; UNESCAP; WHO; ILO. 2008. Review of Ongoing Health Financing Reform in Lao PDR and Challenges in Expanding the Current Social Protection Schemes. Vientiane: Ministry of Health Lao PDR. Pp.63.

The poor are pre-identified in the village in all three schemes using a means-testing questionnaire or a list of screening questions. In the scheme managed by Lao Red Cross, post-identification in the health facility is also allowed. In all instances, the HEF pays for services obtained at the provincial and district hospitals and health centres. Both inpatient and outpatient services are covered. Transportation by ambulance is provided in all instances for referral to the provincial hospital.[68]

Payment to providers is currently on an itemised fee-for-service basis, leading to predictable problems of moral hazard and over-prescription and over-medicalisation of health care, and this needs to be reviewed and replaced by more sophisticated mechanisms of provider-payment currently emerging. Management of HEF in places where these are run by health department staff also poses major challenges in terms of finding staff with the right mix of skills. Identification of the poor has proven costly and the proportion identified is lower than the proportion known to be below the poverty line in these districts.[69] Insecure funding is another major challenge, because of dependence on external donors. Furthermore, HEF remains small-scale and is separate from the other social protection mechanisms for the formal sector, limiting the scope for risk-pooling. The schemes are being constantly reviewed and improved upon, and it is hoped that a model of HEF suitable for conditions in Lao PDR would eventually emerge.

A review by the Ministry of Health presents data for the first six months of 2007 on utilisation of health services by HEF beneficiaries in the three HEF programmes. Utilisation by HEF beneficiaries was lower than non-beneficiaries in two out of the three schemes, both for out-patient and for in-patient care (Table 7). In other words, HEF may have increased access to health care for a small number of people who could not use health care because of high costs. However, it covers only a small proportion of poor even in the small number of districts where it is operational. Further, cultural barriers to health care access remain an issue for ethnic minorities and women.[70]

4.2 Community-based health insurance schemes (CBHI)

The implementation of the non-profit, voluntary CBHI schemes began in Lao PDR since 2002, and by 2005, four pilot schemes were reported to be operating in seven districts of four provinces.[71] Five new schemes were scheduled to begin operation by 2008, and several others are being planned.[72] These schemes are under the Ministry of Health, formalised by government regulations. They are managed by the District Management Committees and supervised by the Ministerial Management Committees.[73]

The population covered by the CBHI is mostly the non-poor working in the informal sector in urban and rural areas. Premiums are levied per family, and are set according to a progressive flat-rate adjusted because of the size of a family. A CBHI volunteer collects the amount every month. Specific hospitals are contracted under the scheme and are paid on a capitation basis depending on the number of beneficiaries registered with them. All primary, secondary and tertiary medical care obtained at the contracted hospitals are covered by the benefits package including drugs supplied according to the essential drugs list.[74]

Coverage by CBHI in the four pilot schemes, however, increased very slowly. In 2007, coverage by the

scheme was estimated to be around 10% of the target population. Of enrolled households, only 40% paid their monthly premium on time. Consequently, transaction charges were high.[75]

Premiums paid by households cover only a small part of the scheme's total cost, and a substantial contribution is made by the district governments. The sustainability of these schemes is therefore a concern. Other problems experienced include high membership drop-out rates and late payment of premium, moral hazard and adverse selection. Hospitals contracted under the scheme have no incentive to provide services to those enrolled in CBHI because the hospitals can raise more revenue through out-of-pocket payment for drugs and services. The staff members are also reluctant to shoulder the additional patient load without additional incentives.[76]

No published evaluation of the impact of CBHIs on access to health care was to be found.

5. Privatisation and sexual and reproductive health care services

5.1 Availability of SRH services

Publicly funded basic SRH services unavailable to a significant majority of Lao women

Sexual and reproductive health care services appear to be underdeveloped in Lao PDR. This has to do with two factors: one, the relatively poor availability of any formal health services, whether in the public or private sector, and the low priority that seems to be accorded to SRH services.

Table 8 presents information on access to health services across different regions of the country, which indicates the inaccessibility of health services to a vast majority of the population.

Table 8 shows that 42% of the rural population in settings without roads lived more than 10 kilometres away from a health centre providing basic services. Assuming that all health centres are well equipped with drugs, supplies and staff (which we know is not the case), even basic sexual and reproductive health care such as treatment for reproductive tract infections including STIs is not available to a large population, and neither is there basic maternal health care or attendance for normal delivery.[77]

Table 8 also reveals that more than two-thirds of the population in rural areas with road and close to 90% of those living in rural areas without road have to travel more than 10 kilometres to reach a hospital. Only a small fraction of hospitals are equipped to perform surgeries, which means that emergency obstetric care is unavailable to the vast majority of rural women in Lao PDR.[78]

The low priority accorded to SRH services is evident from the Minimum or Essential Services Package (Table 9 in the following page). The SRH services included are the barest minimum: treatment of STIs, antenatal care, delivery care at health centre and district hospital levels and treatment of abortion complications and complications of delivery at inter-district hospitals.

Basic emergency obstetric and neonatal care is available mostly in district hospitals type A, and a small number of district hospitals type B. No contraceptive services are mentioned at the health centre level, and surgical sterilisation is to be made available only at the inter-district hospital. HIV testing is not available except at the provincial hospital level. Services not included in the ESP are not supported by public funding, and given the paucity of health personnel, thus, these services are very unlikely to be provided in public hospitals and health centres.[79]

In other words, even the most basic maternal and other sexual and reproductive health care services are unavailable from the public sector (publicly provided and/or financed) to a significant proportion of Lao women.

Table 8: Access to health services in villages of Lao PDR

	% of people by distance to nearest hospital			% of people by distance to nearest health centre			% of people having 8+ hours to	
Kilometres	<=10	11-30	31+	<=10	11-30	31+	Nearest Hospital	Nearest Health Centre
Lao PDR	27.3	39.3	33.4	57.6	35.3	7.1	3.0	0.9
Urban	75.4	17.9	6.7	86.5	10.8	2.7	0.0	0.0
Rural with road	20.0	47.2	32.7	57.7	38.7	3.6	4.2	1.3
Rural without road	11.3	29.1	59.6	27.1	50.5	22.4	3.0	0.8

Source: National Statistics Centre (Lao PDR). 2010. Lao Expenditure and Consumption Survey 2007-08. Vientiane: Committee for Planning and Investment, Government of Lao PDR. Pp. 6.

Table 9: Sample Services Packages by Health System Level Assuming the Availability of Inputs

Level at which Service is Provided	Service
Village	■ Health education and promotion ■ Limited preventive and curative services (appropriate use of drug kits, distribution of deworming medication and contraceptives) ■ Early detection and referral of communicable diseases ■ Support for Health centre Outreach services ■ Safe home deliveries ■ Early detection of complicated pregnancy and delivery
Health centre	■ Microscopy for malaria ■ Directly Observed Treatment (DOTs) for tuberculosis, including devolution to villages ■ Diagnosis and treatment of STIs ■ Preventive services (Expanded Programme of Immunisation, impregnanted bed net distribution and redipping, micronutrients) ■ Neonatal resuscitation ■ Safe delivery for normal pregnancies ■ Medication before referral of complicated deliveries/pregnancies ■ Manual removal of placenta (Type A health centres) ■ Minor surgery and referral
District Hospital	■ Treatment of cases of communicable diseases and referral of severe complicated cases ■ Blood tests for diseases other than HIV ■ Support to Health centres, village health volunteers for expanded programme of immunisation, impregnated bed nets, sanitation and IEC ■ Nutritional rehabilitation of severely malnourished children ■ Treatment of severe anaemia ■ Basic non-surgical obstetric care and referral ■ Emergency case management and referral ■ Family planning services
Inter-District Hospital	■ Infectious disease outbreaks and case management ■ Treatment of severe cases of communicable diseases (e.g. cerebral malaria, severe dengue fever, typhoid, tetanus, meningitis) ■ Female and male sterlisation ■ Emergency surgery ■ Laboratory diagnostic services ■ X-Rays (with appropriate architectural design and trained staff) ■ Manual removal of placenta ■ Emergency treatment of incomplete abortions ■ Assistance to complicated deliveries (with trained staff in basic obstetrics and adequately equipped)

Source: The World Bank. 2005. "Table 4.1" in the [Project appraisal document on a proposed grant in the amount of SDR 10.4 million to the Lao People's Democratic Republic for a] Health Services Improvement Project. Washington: The World Bank.

SRH services in the private sector mostly through informal providers and pharmacists

Given the very small number of private clinics in Lao PDR, and the absence of any private hospitals, it would appear that the formal private sector does not provide the much-needed emergency obstetric services or any major SRH service. Recently, the Ministry of Health has approved five private hospitals to function in the main cities.[80] As of now (mid-2010), it seems that private informal providers fill in the vacuum.

Population Services International (PSI), an international NGO, has been active in Lao PDR since 1998. The social marketing of condoms to prevent HIV and STIs was the first initiative of PSI in Lao PDR. In 2006, PSI/Lao introduced 1-STOP, pre-packaged male STI treatment kits. In addition to launching the STI kit, PSI's sexual and reproductive health technical advisors conducted trainings on the management of STIs for clinic-based medical doctors in Vientiane. PSI-trained doctors have become the focal point for a medical network intended to provide high-quality health services as well as PSI products to a wide variety of at-risk males.[81]

5.2 Equity in access to SRH services

The non-availability of all but the barest minimum SRH services in the public sector means that women

have to rely on informal health providers, or travel outside the country to seek services. One of the studies cited above did find that one of the sources of treatment for patients from a high socio-economic group was health facilities in neighbouring Thailand. This gives rise to inequitable access.

The introduction of payment for services and drugs in health centres and hospitals have disproportionately affected the poor, including poor women. There are very few studies (in English) that focus specifically on sexual and reproductive health services. Those that are available remark on the high cost of care and how the services are unaffordable.

The poverty-status of villages made a difference to the place of delivery. According to the LECS-III (2003), about 35% of women living in non-poor villages gave birth in hospitals, compared to 15% of women in poor villages.[82, 83]

According to the Lao Reproductive Health Survey of 2000,[84] the cost of transportation for EmOC was very high, and anecdotal evidence placed these rates at between US$100 and US$700.[85] Many women, therefore, did not utilise EmOC even when services existed within a reasonable distance, resulting in the high proportion of maternal deaths happening in homes.

There are also important differences across ethnic groups in the utilisation of delivery care services. While the majority of women of all ethnic groups delivered at home, a higher proportion of Laoloum (the main ethnic group) women delivered in a public health centre as compared to other ethnic groups.

For example, 85% of Hmong women delivered at home compared to 63% of Lao-Tai. An estimated 24 out of 25 Mon-Khmer women delivered at home. Given the very poor availability of basic amenities in villages inhabited by ethnic minorities, home deliveries may pose an increased risk for them then for others groups.[86]

Untreated sexual and reproductive morbidity among women are likely to be widespread. Two vignettes of untreated morbidity in women reported in one of the studies cited above may represent but the tip of the ice-berg. These are the data provided:

"In Luang Prabang, a young mother with a nine month old baby and unemployed husband had been bleeding for 3 months. The family already borrowed 100,000 kips from a neighbour who charged 30000 kips interest. They could no longer afford treatment."[87]

"A 70 year old woman from Vientiane suffering from frequent urination; was asked to do blood and urine tests in the hospital, which cost 100,000 kips, She could not afford and did not have the tests done."[88]

What about the equity implications of social marketing initiatives such as the STI kits? Social marketing is targeted at a segment of the market that can afford to pay, and is able to reach geographic areas where there is "effective demand" for goods and services. They will be able to cater mainly to the urban sector and the well-connected rural villages, leaving out low-income groups and those living in poorly connected villages, as well as ethnic minorities.

6. Concluding remarks

Lao PDR is a poor country with a rapidly growing economy and progressive integration into the global market. Availability of health services is hampered by geographic terrain, paucity of human resources and infrastructure. Although health is mentioned as one of the major priorities in its economic strategy, investment in health has remained low as compared to the education sector.

Compounding the problems of low availability and difficult physical access has triggered the introduction of cost recovery in publicly provided health services. The little that is available by way of health services has become unaffordable to large sections of the population. Social protection mechanisms in health such as HEF and CBHI are still in their initial stages and cover a very low proportion of the population.

Paucity of health care services is most dramatic in the area of sexual and reproductive health care. Only delivery care and STI treatment are featured in the Essential Package of Health Services suggested by the ADB. Antenatal care, delivery care and emergency obstetric care services are available to a very small minority.

Payment for services imposes a further barrier and one consequence is that the vast majority of women developing pregnancy-related complications die at home. Anecdotal evidence also points to the high burden of untreated sexual and reproductive morbidity in women.

This case study is limited by the very small number of studies and scanty data and information available on sexual and reproductive health services per se. Studies are urgently needed to document more completely the extent and nature of sexual and reproductive health needs and the extent of unmet need for SRH services; as well as the health and equity consequences of privatising (in the form of cost recovery and social marketing) SRH products and services.

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CHAPTER 3

PAKISTAN

1. Background

Pakistan was officially constituted in 1947, with the partition of British India into India and Pakistan. When originally formed, it consisted of two geographically unconnected parts: West Pakistan and East Pakistan, divided in space by the Indian subcontinent. In 1971, East Pakistan which had an overwhelming Bengali-speaking population broke away following a liberation war to form the new country of Bangladesh.

Pakistan has had a chequered political history marked by military coups, wars with India related to the territory of Kashmir, the war in Afghanistan in the 1980s and post September 11, 2001, civil disturbances and frequent changes in governments.

Pakistan is divided into four provinces: Balochistan, Khyber Pakhtoonkhwa (erstwhile N.W.Province), Punjab and Sindh, and three federal territories: Islamabad Capital Territory, Federally Administered Tribal Areas and Federally Administered Northern Areas.[1]

1.1 Economic growth and human development

The per capita GDP of Pakistan in 2005 was PPP$ 2370.[2] During the five-year period ending 2006-07, the economy maintained the momentum of high growth of about 7% per annum. The service sector was the major driver of rapid growth experienced during this period.[3] Economic growth declined in 2007-08 to 5.8%, as a result of internal and external shocks to the economy, ranging from political crises and rising petroleum prices.[4]

According to the 2001 Household Integrated Economic Survey, the proportion of Pakistani households below the National Poverty Line increased from 26.8% in 1992-93 to 32.1% in 2000-01, and subsequently declined by about 10% in 2004-05. This was attributed to the strong economic growth after 2000. Further analysis reveals that while people were lifted above the poverty line, most of them were still vulnerable to economic setbacks.[5] The population below US$ 2 per person per day was as high as 73.6% during 1990-2005. In other words, the vast majority of Pakistan's people live barely above subsistence level.[6]

In terms of inequalities in income/expenditure, the richest 10% had an income/expenditure that was 6.3 times that of the poorest 10% of the population in 2002.[7]

Pakistan does relatively poorly in terms of human development as compared to economic growth, and also in comparison with other countries at the same economic level. Its HDI rank in 2005 was 136, below that of much poorer countries in the region like Lao PDR, Bhutan and Myanmar.[8]

However, much improvement has been made in recent years in some social indicators such as education. Pakistan's net primary enrolment rate jumped from 33% in 1991 to 68% in 2005, and 70% of those who enrolled in first grade reached grade 5. Access to sanitation improved during 1990 to 2004, from 37% of the population in 1990 to 59% in 2004. Similarly, the proportion of those with access to an improved source of water increased from 83% in 1990 to 91% in 2004.[9]

1.2 Population, health and sexual and reproductive health status

The population of Pakistan was 158.1 million in 2005.[10] About 35% of the population in 2005 lived in urban areas. Pakistan has a large population of young people. Just over a third of the population (37.2%) was below 15 years of age, and roughly 4% were above 60 years of age.[11]

Pakistan's mortality and health indicators compare poorly with its South Asian neighbours. Life expectancy at birth in 2006 was 63 years, 62 years for males and 63 years for females. In the same year, the infant mortality rate was 78 (86 for males and 71 for females), and the under-five mortality rate was 97 per 1000 live births (98 for males and 96 for females).[12]

Communicable diseases and maternal and neonatal conditions contributed most to the burden of disease (2002) and accounted for 70% of health years of life lost, followed by non-communicable diseases (21%) and injuries (8%). Prevalence of tuberculosis was 263/100,000 population (2006), while prevalence of HIV was 86 per 100,000 (2005).[13]

The maternal mortality ratio in 2005 was estimated to be 320 per 100,000 live births. Total fertility rate was estimated to be 3.6 in 2006, and adolescent fertility rate per 1000 women stood at 24.[14]

Close to one-third (31.3%) of children under 5 years of age were underweight for their age during 2000-06. This was an improvement from a rate of 39% during the 1990s.[15]

Data on utilisation of some of the health services shows a dramatic improvement after the year 2000. For example, coverage of infants under one year of age by all three doses of DPT vaccine jumped from 61 in 2000 to 83 in 2006. Births attended by skilled health personnel are reported to be 54%

for the period 2000-06 as compared to only 19% during 1990-99. In contrast only a small proportion of women (27.6) of reproductive age in 2006 were using any method of contraception; only 3% of women had had a PAP smear screening for cervical cancer, and a mere 1% had undergone mammography for detection of breast cancer.[16]

1.3 Gender equality profile

There are wide variations in the status of women in Pakistan across class, place of residence and ethnicity. Patriarchal structures are stronger in rural and tribal settings as compared to the urban areas and for women from high-income groups. However, unequal rights and opportunities are embedded in the legal system and in social practice.

Article 25 of the 1973 Constitution of Pakistan guarantees equality before law, irrespective of sex, race and class and empowers the government to initiate affirmative action to promote women's rights. On the other hand, under the Muslim Family Law women have unequal rights to inheritance, termination of marriage and natural guardianship of children. Polygamy continues to be permitted. A series of discriminatory laws introduced during the Presidency of Zia-ul-Haq during the late 1970s have worsened these disadvantages. The Hudood Ordinances of 1979 equated rape with adultery. In 1984, a Law of Evidence was promulgated according to which the value of the testimony of two women was equated to that of one man in financial transaction.[17]

Socially, men and women occupy different worlds. There is strict segregation by sex, and women are required to observe *purdah* in public spaces. A preference for a strong son still prevails. The notion of *izzat* or male honour is linked to the sexual "morality" of the women within their families and communities, resulting in strict control over women's sexuality and physical mobility, adherence to which is ensured by threat of violence.[18]

Pakistan ranked 125 in terms of Gender Development Index (2005) and had a higher HDI as compared to GDI, implying that gains in human development have not accrued equally for women and men, with women at a disadvantage. In 2005, the ratio of female to male gross enrolment rates in primary and secondary levels were about 0.75, i.e. three-fourths as many girls as boys were in primary and secondary schools. In the same year, a third of Pakistan's women aged 15 and above was engaged in remunerative work, which is about 40% of the male work participation rate. Most of women workers in rural areas work in their own farms, while in urban areas, the informal sector is the major source of employment. Despite having a woman prime minister more than once, only 20% of parliament members were women in 2005.[19]

In Pakistan, domestic violence is reported to be widespread across all classes. A 1987 study by the Women's Division reported that women in about 80% of households experienced domestic violence. The official figure of women murdered in 1998 was 1974 and the majority of women were killed by their husbands, brothers, father and in-laws. Many women are also victims of rape (706 reported cases in Punjab alone, for 1998), but the Hudood Ordinance requires four adult male Muslims of good repute to have been actual witnesses of rape or the rapist to confess as proof of rape. Most rape cases therefore go unreported and under-reported, because failure to prove rape may cause the woman to be charged with adultery.[20]

2. The Health Sector

2.1 Personnel and infrastructure

The government health delivery system in Pakistan consists of four tiers[21]:

- Outreach services at the community level providing immunisation, malaria control, maternal and child health and family planning services
- Basic Health Units (BHUs) providing basic curative and preventive services for a population of about 10,000 to 20,000
- Rural Health Centres (RHCs) providing more extensive outpatient care and also basic inpatient care (with 10-20 beds), equipped with x-ray and laboratory facilities, and able to perform minor surgeries covering a population of between 25,000 and 50,000.
- *Tehsil* (Sub-district) headquarter hospitals with x-ray, laboratory and minor surgical facilities and also specialist care. They typically have 40-50 beds and serve a catchment area of about 100,000 to 300,000 people.
- District headquarters hospitals catering to 1-2 million populations, having close to a hundred beds and provide all the services as Tehsil hospitals and may include a few more specialised services.
- Tertiary care hospitals providing specialised and referral services, located mainly in big cities and coming directly under the provincial Secretary of Health.

Health resources are woefully inadequate in Pakistan. During 2000-07, there were only 12 hospital beds per 10,000 populations for the country as whole. Most recent data (2000-06) show that there were only 8 physicians for a population of 10,000, and even fewer nursing and midwifery personnel (only 5 per 10,000). It is not as if

community and traditional health workers make up for the non-availability of formally trained health personnel, given that there are only 4 community or traditional health workers per 10,000 population.[22]

2.2 Healthcare financing

The total expenditure on health has declined in a period of rapid economic growth, from 2.5 % of GDP in 2000 to 2.1% in 2006. The government's share of total expenditure also declined during this period, from 20% in 2000 to 17.5% in 2006. At the same time, the proportion of external resources in total health expenditure increased from 0.9% to 3.6%. Out-of-pocket expenditure on health remained the main source of financing for health care in Pakistan at both time points, at about 80 % of all health expenditure in 2000 as well as in 2006. The per capita total health expenditure was 49 PPP US dollars in 2006.[23]

The contribution to health financing by health insurance has been limited. The Employee Social Security Institutions (ESSIs) are quasi-public autonomous organisations at the provincial level, funded entirely by a contribution from employers amounting to 7% of one's salary. Any establishment with more than 10 employees is required by government regulations to register for ESSI coverage, especially for employees who earn less than Rs.3000 per month. The ESSIs run their own network of health facilities and also pay for some types of care in public and private health facilities.[24]

There are also several private insurance firms selling third-party health insurance coverage usually purchased by private firms for their employees.[25]

3. The private sector in health

The formal private health sector consists typically of small clinics, 'maternity homes' and 'nursing homes', along with small and medium sized hospitals with an average of 30 beds. It also includes registered practitioners from different systems of medicine (Allopathy Unani and Homeopathy) and physicians and paramedics working in the public sector and running their clinics after office hours. The not-for-profit sector in health mainly consists of NGOs providing family planning and other reproductive health services.[26]

Most of the hospitals in the private sector have facilities only for basic surgical, obstetric and diagnostic procedures, and are not equipped to provide emergency medical care.[27] Only 30% of the private health care facilities are located in the rural areas, which have 70% of the country's population. Three-quarters of all hospital beds in the private sector are located in nine big cities of Pakistan: Abbotabad, Faislabad, Hyderabad, Karachi, Lahore, Multan, Peshawar, Quetta, and Rawalpindi/Islamabad. There is also a large informal private health sector, including traditional birth attendants who conduct a significant proportion of all deliveries.[28]

3.1 Health reforms and privatisation

Privatisation in Pakistan's health sector was part of the overall project of privatisation of the economy that started in 1998. *Pakistan carried out its nuclear tests in 1998 and had economic sanctions placed upon it as a consequence. The country plunged into a serious foreign exchange crisis because the flow of investment as well as bilateral and multilateral aid decreased sharply. The World Bank, IMF and Asian Development Bank provided loans to help Pakistan out of its crisis, in addition to rescheduling bilateral as well as commercial loans. In turn, the country was required to implement a Structural Adjustment Programme, which included privatisation of the economy.*[29]

In the same year, the World Bank produced a *Health Care Strategy Paper* for Pakistan which recommended restricting the public sector's involvement in health to provision of pure "public goods" and full cost recovery for all other services to be introduced in phases. Another important recommendation was that the health sector should enter into partnerships with the private sector for technical support as well as provision of government-financed health services. The *Strategy Paper* specifically recommended handing over a major part of the responsibility for reproductive health services to NGOs on output-based contracts, funded by the government whilst entering into contracts with private providers for delivery services.[30]

A number of policy and legislative measures were implemented in the Punjab and Khyber-Pakhtoonkhwa (erstwhile North West Frontier) provinces soon after the *Strategy Paper* was released. Teaching hospitals were bestowed with greater "autonomy" *inter alia* to set their own fee schedules in order to become more financially viable. In addition, user fees were put in place in all health institutions in the public sector. In Punjab, Khyber-Pakhtoonkhwa and in other provinces, the government also contracted out, to non-governmental organisations (NGOs), the management and service delivery functions of public health facilities. The government also entered into partnerships with international and national NGOs and bilateral donors for technical support in management and service delivery. Social franchises were established to promote health service

delivery by private health providers. Each of these interventions had implications for reproductive health services.

4. Privatisation and reproductive health services

The privatisation of reproductive health services has happened as for all services, through the introduction of user fees and hospital autonomy; through contracting private services by the public health sector; and through specific forms of public-private partnerships such as social franchising.

4.1 User fees

One of the most common modes of privately financing public health services is through charging fees for services provided. Government health facilities in Pakistan have levied a small service charge for several decades. Following health reforms, user fees were introduced or increased in a number of teaching hospitals in the Punjab and Khyber-Pakhtoonkhwa (erstwhile North West Frontier) provinces.

According to one source reporting on health care privatisation in Pakistan,[31] following the formation of Board of Governors in all the teaching hospitals of the Punjab province, user fees were introduced for various health tests that used to be free, such as x-rays and blood tests. The average cost was about Rs. 50-60. Registration fees increased from Rs. 2 to Rs. 10-20.[32]

A 2009 newsletter from the UN Office for the Coordination of Human Affairs reported that medical care was becoming unaffordable to the citizens of Pakistan, at large. *"Fewer and fewer people consult doctors. Fees have not gone up, but the cost of medicines is high, and even when they see a doctor they often cannot follow up on care, as medicines are beyond their budget",* says the newsletter, quoting a general practitioner from Lahore.[33]

The implications for delivery care are available from a 2000 study carried out in government hospitals in Karachi. The study reported that the mean out-of-pocket expenditure for normal delivery was around Rs 590, or about 20% of the monthly income of about two-thirds of the respondents in the study.[34] The situation seems to have subsequently deteriorated with inflation and the increasing costs of drugs. Another commentary on privatisation reported that in 2003 normal delivery in a public hospital cost about Rs. 2000-Rs. 2500 while c-sections cost about Rs. 5000.[35]

4.2 Contracting out publicly financed services to the private not-for-profit sector

This section discusses the experiences of the *Chief Minister's Initiative on Primary Health Care*, one of the well-known experiments in contracting out publicly financed health services to private not-for-profit organisations in Pakistan. One reason for the choice of this project as a case example is that the project has been operational for several years and has been evaluated more than once.

A pilot was launched in one district of Punjab province, Rahim Yar Khan, in March 2003. The district government entered into a Memorandum of Understanding with the Punjab Rural Support Programme (PRSP), a national NGO,[36] to manage all the 104 basic health units in that district.[37] By the end of 2003, the pilot was extended to 12 districts and in 2005, to 23 districts of the province. [14] In 2007, the newly elected federal government initiated the *People's Primary Health Care Initiative* based on the Rahim Yar Khan model which now operates in 69 districts of Pakistan.[38]

According to the Memorandum of Understanding, Punjab Rural Support Programme was given administrative and financial control and authority over all basic health unit buildings and equipments, in addition to receiving from the government the same amount of money monthly as was previously allocated for running these units. They were to provide basic curative services, co-ordinate with front-line workers to provide maternal and child health, and family planning, plus other health prevention and promotion services.[39]

Punjab Rural Support Programme introduced a number of innovations. It clustered 2-3 basic health units together and placed them under the charge of a single medical officer. The medical officer's salary was increased from Rs 12,000 to Rs 30,000, and s/he was required to live close to his area of work. A district project management unit was responsible in managing all basic health units within the district. Physical infrastructure was improved by securing additional funding from the district government. Women medical officers were recruited on an experimental basis in one sub-district of Rahim Yar Khan, and each of them served five basic health units.[40]

Three evaluative studies carried out in 2005, 2006 and 2009 are available in the *Chief Minister's Primary Health Care Initiative*.[41] Each of these adopted slightly different methodologies, but all were based on primary data collected from the facilities and users. The 2009 study included interviews with key informants from the health sector.

The first two evaluations found that there was a significant increase in utilisation of basic health units because the facilities remained open at regular hours and drugs were available, which previously was not the case. Because basic health units serve rural areas, this may be seen as increasing equity in access to services.[42]

However, there were important gaps in the availability of reproductive health services.[43] The 2006 study found that although basic health units were meant to provide maternal and child health and family planning services and curative care for gynaecological problems, they were only providing antenatal care, some delivery and post-partum care. The BHU was staffed by a Lady Health Visitor (LHV) to provide reproductive health services, with back-up support from the weekly visits of the female medical officer (FMO). Clients as well as FMOs felt that these weekly visits were too infrequent to be of real help to patients. A *dai* was to be appointed in each BHU to provide support to the LHVs but this post remained vacant in most BHUs. Deliveries could be conducted only till 2.30 pm daily, which was the closing time for basic health units. Most basic health units did not have the equipment to carry out even normal deliveries and women medical officers often brought their own instruments.[44]

Only a few tests for reproductive health needs were carried out, such as pregnancy tests. Even basic haemoglobin estimation tests were not available. Contraceptive supplies and services and abortion services were not available in any of the Punjab Rural Support Programme facilities in Lahore district. This was because family planning services were delivered by the Lady Health Worker (LHW) who was part of the Ministry of Population Welfare (MOPW). The Female Medical Officers reported receiving requests for abortion services which they were unable to provide. There was no relationship with local *dais*, no system to encourage them to refer patients to the BHUs and no schemes for training *dais* or integrating them into the BHU set-up in any way.[45] [17] Another major limitation was that the programme did not update nor keep any data on maternal mortality or morbidity or on reproductive health conditions for which treatment or care was sought.[46]

The only information on the quality of services is from the 2005 study which reported that drug availability, quality of provider-client relationships and quality of clinical care were poor in the contracted-out basic health units of the Rahim Yar Khan district as well as government-run basic health units in a control district.[47]

The 2009 study compares different Primary Health Care "models" in Pakistan and provides insights into the difficulties faced by the Punjab Rural Support Programme's project. Non-integration of national programmes at the basic health unit level posed a major problem. Family planning, for example, was a vertical programme directly administered by the federal ministry of population welfare, while immunisation was part of another vertical programme under the federal ministry of health. Project managers of the Punjab Rural Support Programme had no authority over the workers of these programmes. This affected the delivery of preventive and promotive services through basic health units, including contraceptive services.[48]

Secondly, there was little cooperation on the part of government health managers with the Punjab Rural Support Programme in matters such as filling staff vacancies, approving additional posts and ensuring drug availability. District health officials appear to have been at best indifferent and at worst, hostile to the Punjab Rural Support Programme, because they perceived the programme to have been implemented top-down without adequate consultation with them. One government health manager said in the key informant interview that given the same magnitude of resources and authority (as the Punjab Rural Support Programme) they (the government health department) would be able to better manage the basic health units. Another person said that the problem of large scale movement of medical professionals from the public to the private sector was the reason for poor performance of basic health units and that contracting out did not solve this problem. He drew attention to the further fragmentation of health service delivery between basic health units managed by private NGO providers and secondary hospitals managed by government health department. For example, referral mechanisms between the two had not been streamlined, thus, compromising the continuity of care for patients.[49]

There were also difficulties in team building at the level of the basic health unit. Paramedical and administrative staff whose salaries had not been increased resented the three-fold increase in medical officers' salaries.[50]

No information could be found on whether steps have been taken to address these difficulties in the Punjab province. If no steps were taken, then the wisdom of hasty expansion of the model with an annual expenditure of about 270 million Pakistani Rupees (roughly 30 million US dollars)[51] may be questioned.

4.3 Social franchising

Social franchise programmes in health have mainly consisted of creating networks of private medical practitioners or other health providers offering a

standard set of services under a shared brand. The brand name serves as a guarantee of the availability of a defined package of services that are high quality, at clearly determined prices.

Some remain as networks, and may evolve into 'franchising' programmes in which there is a controlling organisation, the 'franchiser' who provides ongoing monitoring and technical support to the franchised providers.[52]

Green Star Marketing and Key Social Marketing are two major social franchising networks of private providers in Pakistan, engaged in providing what they call reproductive health services. An estimation of DFID and USAID annual expenditure is £1.5 million and US$ 10 million, respectively, in supporting these social franchising networks during 2003-2009,[53] in addition to out-of-pocket spending by users to purchase products and services from their health facilities.

Green Star Marketing (GSM)

Pakistan has one of the major and perhaps, to date, the most successful social franchising projects for the delivery of reproductive health services. It is known as the Green Star Network, set up for the provision of contraceptive services, initiated by Population Services International (PSI). Green Star Network started as a contraceptive social marketing project in 1986, with USAID support. In 1991, PSI founded a non-profit local NGO called Social Marketing Pakistan (SMP), to market condoms and this is the organisation that runs Green Star Network.[54]

When USAID support was withdrawn in 1993 because Pakistan refused to sign the nuclear non-proliferation treaty, PSI continued to operate using its own reserves. Since 1995, the German Government, through Kreditanstalt fur Wiederaufbau (KfW) provided substantial funding to continue the condom social marketing, and to design and launch the social franchising programme, Green Star Network.[55] USAID funding resumed in 2003 for a five year period (2003-08), while the DFID and UNFPA have committed to providing funding for commodities during the same period. USAID's support extends also to the Key Social Marketing Programme described later in this report.[56]

SMP is a partner of the Ministry of Population Welfare (MOPW), Pakistan. For the government, using an NGO to deliver reproductive health services helps get around social sensitivities surrounding these services. The government does not provide SMP with any money for the project but channels funds via the Economic Affairs Division. Green Star or SMP submits monthly reports to the government.[57]

The Green Star social franchising programme is comprehensive, with five components: medical training, reliable supply, public education, technical support and quality control, and ongoing monitoring. Four types of franchisees are included in the Green Star Network, all of which receive contraceptives at subsidised costs and training from SMP. The contraceptives are imported by PSI, through SMP, which also packages and markets the contraceptives at subsidised costs to the franchisees of this Network.[58]

Green Star #1 is comprised of 2000 female doctors, all private practitioners, in the network, who receive a 40 hour intensive course on all contraceptive methods, including IUD insertion, hormonal contraceptive prescription, and management of side effects and counselling.

Green Star #2 has 4250 private doctors, mostly men. They receive a one-day training in reproductive health and all contraceptive methods except IUD insertion. The male doctors are expected to motivate men to talk with their wives about contraception, to take responsibility for family planning and to support their wives when they choose to adopt a method.

Green Star #3 consists of 2580 pharmacists who receive a half-a-day training in all contraceptive methods, counselling and reproductive health. This group is likely able to serve many low-income people who tend to consult a pharmacist before visiting a physician.

Green Star #4 has about 2200 female health visitors – women who make home calls or run small clinics. They receive a day's training in reproductive health, counselling and non-clinical methods of contraception. They usually serve the poorest neighbourhoods and also refer women to the female doctors who are part of the network.[59]

The range of services offered by Green Star to attract franchisees includes[60]:

- Access to subsidised and high quality contraceptives and clinical supplies
- Access to new medical techniques
- 40 hours of training for managing IUDs
- 8 hours of training for administering hormonal contraceptives
- Management support
- Advertisement for the brand
- Opportunities to network with medical professionals

The Green Star Network has marketed a total of 17 products and services. By 2004, Green Star had provided 1.4 CYPs (Couple Years of Protection). Independent research has shown that 74% of Green Star clients are from low income groups. The Network has grown to over 17,000 private sector

providers in 40 cities throughout Pakistan.[61]

In 2006, Green Star Marketing became a partner of the PAIMAN consortium (see next section) and set up "GoodLife" clinics providing maternal and child health care in addition to contraceptive services.

Key Social Marketing

Yet another social franchising initiative is the Key Social Marketing (KSM) Programme, which is funded by DFID through the Futures Group International, a US based Social Marketing organisation. KSM started receiving financial support from USAID since 2003. This programme is also aimed at promoting contraceptives, but is limited to oral and injectable contraceptives.

The Futures Group has joined with two pharmaceutical companies to market their brands of oral, emergency and injectable contraceptives under a social marketing logo – the Key – but at commercial (non-subsidised) prices.[62]

Franchisees of KSM include doctors, female health visitors, pharmacists, and select NGOs. This social franchising programme involves a very large network, with 10,000 doctors in private practice, 25,000 pharmacists and 1000 female health visitors, as well as selected NGOs.[63]

This project is said to assist the Government of Pakistan achieve its demographic goals as set forth in its Five-Year Plan. The Pakistan Medical Association has endorsed the KSM. By 2004, the KSM had provided approximately 245,000 CYPs.[64]

KSM's main strategy for reaching out to low-income women is through Mohalla Sangat meetings at the community level organised by a KSM provider. The Provider uses the Key audiocassette, which delivers accurate information about birth spacing and Key hormonal products to the clients in the privacy of their homes. The audiocassette contains a doctor's advice on how to choose and use an appropriate contraceptive method. The audiocassette also serves as a valuable counselling tool used by Key providers.[65]

Social franchises and equitable access to good quality, and comprehensive reproductive health services

Both Green Star Marketing and Key Marketing Service have been evaluated by donors more than once. Evaluation reports and studies have shown that these franchising networks have increased access to contraceptive services.[66] Compared to non-franchised private health facilities, these franchised facilities had a significantly greater volume of total clients as well as clients for contraceptive services.[67]

Since both the franchising networks have made major efforts towards community outreach, one may expect that the coverage of low-income groups would be high. However, the available data present a mixed picture. An early evaluation of the Green Star Network set in 1997, found that 74% of Green Star clients were from low-income groups, albeit from urban areas,[68] and a 2000 study found that 90% of Key Social Marketing clientele were low-income women.[69]

However, a 2004 study of social franchising for reproductive health services in three countries, including Green Star and Key Social Marketing in Pakistan, reported that these franchised establishments in Pakistan were associated with a wealthier clientele; and that this could be due to the location of the franchised facilities, which are mainly located in urban areas.[70]

The range of services provided by both franchising networks is extremely narrow. Green Star Marketing was supposed to provide a comprehensive package of reproductive health services, not only contraception but also post-abortion care, syndromic management of STIs, antenatal and post-partum care, emergency obstetric care, and neonatal care.

In practice, they provide mainly contraceptive services. Other reproductive health issues were rarely discussed with clients and there were no IEC materials on other reproductive health issues. Key Social Marketing promotes only oral and injectable contraceptives, its own brand of products. No other sexual or reproductive health service is provided.[71]

Evaluations of both networks were carried out in 2006 and the report has dwelt extensively on the poor quality of services provided. The problem may have its roots in the uneven and sometimes substandard quality of provider training. The 2006 evaluation report[72] narrates how the trainer demonstrating insertion of the Multiload IUD, a product provided by Green Star, was "*contaminating disposable 'clean' gloves, touching insertion instruments, failing to swab vagina and cervix with antiseptic solution before sounding of the uterus and insertion of the Multiload*". In Key Social Marketing, training was subcontracted to four organisations, and with so many trainers involved, the quality of training could not be standardised.[73]

The quality of counselling in Green Star clinics was not very good.[74] For example, not enough information was given about the side effects of

contraceptives. There was also a tendency to push clients towards choosing the IUD over other methods. Interviews with husbands of clients revealed that the husbands were concerned about the fact that their wives were having health problems related to the use of IUDs. While the cost of getting contraception was only between Rs 35-50, the cost of gynaecological treatment for dealing with side effects including secondary infertility could be higher than Rs. 2000.The same report[75] also observed that home visits by workers of Key Social Marketing to give information and to counsel women had turned into a routine and mechanical activity consisting of playing the Key audiocassettes and then clarifying any doubts.

Adherence to asepsis is noted as a problem in both networks. Green Star providers were observed as not adhering to infection control practices. Many clinics covered by the evaluation had unprepared instruments. Autoclaves remained locked up, implying that they had rarely been used. Hand washing before and after wearing gloves was not practised by providers.[76] On one specific day when a *Clinic Sahoolat* was taking place in a Green Star clinic:

The doctor was busy with her routine (out) patients… [paramedic] took the client for IUCD insertion. After examining the client it was found that there were no instruments on the trolley... (paramedic) started searching for instruments in the cupboard with the gloves on her hands. Meanwhile the client was lying exposed on the couch and pulled her own shawl on her exposed body due to embarrassment… the instruments (which were eventually located) were soaked in tap water in a kidney dish… While adjusting the size of the Multiload the thread came out of the adjusting tube and the Multiload and thread were on her (paramedic) hands. When suggested to use a new Multiload the suggestion was ignored and the same IUCD was inserted into the woman's uterus.[77]

Infection prevention in clinics of Key Marketing Services with qualified women doctors met quality standards, but this was not the case in the clinics where providers had only basic training and were not all medical doctors. Many women coming to these clinics suffered from reproductive tract infections.[78]

4.4 Pakistan Initiative for Mothers and Newborns (PAIMAN)

Besides the two large social franchising projects providing contraceptive and to some extent, reproductive health services, there is another large scale project on maternal and newborn health, funded by USAID. This is the Pakistan Initiative for Mothers and Newborns or PAIMAN project, a hybrid form of public-private partnership involving many technical support organisations. PAIMAN project is implemented through a consortium led by USAID's consulting agency JSI Research and Training Insititute Inc. PAIMAN's mandate is to assist the Government of Pakistan to improve the status of maternal and newborn health in Pakistan "*through viable and demonstrable initiatives".*[79] Table 10 presents details about the PAIMAN consortium's membership.

Established in 2004, in ten districts from all four provinces of Pakistan, the project currently (2010) covers 24 of 105 districts of four provinces, and four 'Agencies' (equivalent of districts) of Federally Administered Tribal Areas (FATA)[80] [81]. The project period was extended from five to six years ending in September 2010, and the total budget for the six-year project is reported to be US$ 92 million.[82]

PAIMAN undertook the following key interventions to improve access to maternal and child health services included: establishing health facilities to provide maternal-neonatal health and contraceptive services in urban areas through public-private partnerships; developing of a cadre of community midwives and helping them establish community-based birthing centres; training traditional birth attendants to improve the quality of maternal health care; providing ambulances; renovating health facilities; and training government health providers in essential surgical skills and life support. Though the project had three levels of indicators (outcome, output and activity level), only the activity and output data have been used for reporting and monitoring progress.[83]

Information on the achievements of project targets is available from a mid-term evaluation of the initial 10 project districts,[84] and from the annual report for the year October 2008-September 2009.[85] Two studies carried out in 2009 on the training of community midwives and traditional birth attendants evaluated the quality of training.[86]

The mid-term evaluation reported that in the initial 10 project districts, five of six project targets were met between 2005 and 2008. Births assisted by traditional birth attendants increased from 36% to 38 %; women who received three or more antenatal visits increased from 27% to 35%; pregnant women who received at least two doses of tetanus toxoid during the most recent pregnancy increased from 40% to 43% (i.e. the target was not met); women who had a postpartum visit within 24 hours of giving birth increased from 34% to 39%, and the upgrading of facilities to achieve the standard of quality set for safe birth and newborn care increased from 0 to 26.[87]

Table 10: Partners in the PAIMAN Project and their respective roles

Name of Partner	Nature of organisation	Role in PAIMAN
John Snow Inc (JSI) Research and Training Institute	A non-profit public health research and consulting organisation based in US and with 44 international offices	Solely responsible entity accountable to USAID for the successful implementation of the project. It provides leadership in all matters of public health and technical interventions for the project.
Aga Khan University	Pakistan's first private university founded in 1983	Assists in the review and design of training curricula and in assessing the impact of trainings
Contech International Health Consultants	A US-based international consulting organisation in the private sector	Oversees activities for strengthening the district health system
Green Star Social Marketing	A Pakistan-based social-marketing company	Responsible for the private sector component of PAIMAN including the development of models for public-private partnerships
John Hopkins University Center for Communications Programs (JHU/CCP)	Established in 1988 by the Johns Hopkins Bloomberg School of Public Health USA to focus on communication issues	Implements the BCC component of PAIMAN
Pakistan Voluntary Health and Nutrition Association (PAVHNA)	An umbrella body of over 40 NGOs and CBO members established in 1979.	Works on community mobilization activities in the Sindh province.
Population Council	A Non-profit non-governmental research organisation which is also a major consulting partner of USAID	Oversees the management of monitoring and evaluation component including operations research
Save the Children	A Leading US-based NGO working with children. Part of an alliance comprising 27 national Save the Children organisations	Oversees community mobilisation activities in the Punjab and NWFP and co-ordinates and implements all field training activities for the public sector in all the PAIMAN districts
National Committee for Maternal and Neonatal Health	Established in 1994 by the Prime Minister of Pakistan. It comprises of three members under the chairmanship of the Federal Secretary for Health GOP	Has been contracted to strengthen district midwifery schools
Mercy Corps	A US-based international relief and development organization	Oversees community mobilisation activities in Balochistan's PAIMAN districts

Source: Pakistan Initiative for Mothers and Newborns (PAIMAN). Retrieved 2 February 2009 from the Website: http://www.paiman.org.pk/aboutpaiman/overview.php

According to the 2008-09 annual report, the project targets were fully achieved for almost all 86 output indicators reported on for the period 2004-2009. The one exception is deployment of 50 ambulances for community-based emergency transport. Not a single ambulance had been deployed during the first five years, and it was scheduled to happen in the sixth year of the project.[88] During 2004-09, 600 franchised GoodLife clinics with private providers were set up by Green Star Marketing; 3020 women benefitted from *Clinic Sahoolats* (described in the previous section); infrastructure in 31 government health facilities was improved to enable the provision of maternal and newborn health services; 714 government health providers went through refresher training in midwifery skills; 2140 traditional birth attendants were trained to provide clean delivery care; and 1623 women were enrolled in a new 18 month course for community midwives.[89]

Output indicators, however, may not tell the whole story. One example is the achievement of the target

of upgrading 31 government health facilities of which 18 were upgraded to provide comprehensive emergency obstetric and newborn care. According to the mid-term evaluation in 2008, comprehensive emergency obstetric and newborn care facilities in four of the 10 districts were constrained in providing the requisite services because of the shortage of staff, and non-resident staff who were not available after 2 pm and shortages in blood supply. Providers who were interviewed reported that magnesium sulphate, a life-saving drug for managing eclampsia and pre-eclampsia, was not available in any of these centres. There was also a shortage of antibiotics in some facilities. In 2008, comprehensive emergency obstetric and newborn care facilities served only 6.6% of women who had obstetric complications in the project districts. Whether the situation subsequently improved remains to be seen from the end-line evaluation.[90]

The training of 550 private providers who were to run GoodLife clinics was also evaluated in 2008. The training did not include clinical practicum. The use of partograph and active management of third stage labour – both essential skills for conducting a safe delivery – were not included in the training curriculum. The report also remarked that data on whether delivery and emergency obstetric care was being provided was not available in many GoodLife clinics.[91]

The mid-term evaluation commented on the management challenges posed by PAIMAN's consortium structure, and the high number and geographic spread of activities. Staff of partner organizations was not seconded to the project and therefore did not constitute a stable project team. Also, the abundance of partners led to a complex division of labour and poor coordination in some activities. For example, four partners were implementing behaviour change communication activities at different levels and in different locations, and four partners were responsible for the training of different cadres of health providers on a range of topics.[92]

Evaluation of trained traditional birth attendants and community midwives found them wanting in skills essential for providing quality pregnancy and delivery care. A 2009 evaluation of the training of traditional birth attendants under the PAIMAN project compared 275 birth attendants randomly assigned for training in maternal and newborn health with 274 similarly assigned for training in general health. The evaluation found that the trained (in maternal-newborn health) traditional birth attendants (TBAs) did much better than the control group in terms of knowledge and skills. However, a majority of trained TBAs lacked important skills. For example, less than half the trained TBAs checked the size of the uterus during antenatal abdominal examination or checked for the baby's movement, and less than a third checked the baby's heartbeat.[93]

The training of community midwives was also evaluated in 2009 through an assessment of 174 community midwives who had passed their examinations in 2008 or early 2009.[94, 95] 40% (69 out of 174) of the community midwives were not residents in their respective communities at the time of the evaluation, although each of them was to have established a midwifery home in their communities after completing the course. The evaluation remarks on the huge wastage of resources this represents and recommends improving the recruitment strategy. The knowledge and skills of 106 community midwives from six districts, all of whom had been given equipment to start midwifery homes, was assessed. Only half the trainees had completed the training requirement, which is conducting 15 or more deliveries. None of the six districts completely fulfilled the training standards for each community midwife. Respondents fared poorly when their knowledge of danger signs during pregnancy, delivery and postpartum, were assessed and not even one of the 106 community midwives was able to identify all the danger signs included in the curriculum. While most could identify anaemia in women, only one-third could carry out a complete abdominal check-up of a pregnant woman, and only 9% of the community midwives could correctly perform all seven specific steps in conducting a normal delivery.[96]

The PAIMAN project has taken many steps towards promoting equity in access to maternal health care. First, it works in a few locations of Federally Administered Tribal Areas (FATA), a region with poor health infrastructure and coverage. Secondly, it has invested in building the capacity of government health professionals in emergency obstetric care and in creating a cadre of community midwives who will serve rural communities; and in training traditional birth attendants. Thirdly, it has upgraded health facilities to provide comprehensive emergency obstetric and newborn care. Finally, it has successfully established urban clinics run by private providers and providing services at subsidised costs.

Despite these commendable efforts, information currently available raises doubts as to whether these efforts have translated into improved access to maternal health care for women. The training quality of community midwives and traditional birth attendants is inadequate. Several health facilities, which were upgraded to provide comprehensive emergency obstetric care, are unable to provide these services owing to health system failures. It remains to be seen whether the quality of care in GoodLife clinics and their outreach programmes is significantly better than that observed in the mid-term evaluation in 2008 and earlier evaluations of Green

Star clinics (see previous section). In view of these facts, one cannot but wonder whether the outcomes justify the outlay of more than 15 million dollars a year.[97]

Other concerns include ownership and accountability of the project. The leadership of the project is vested in an international NGO and is accountable to the donor. Members of civil society or even residents of the districts within which the projects are operational may have limited say in decisions about what activities are undertaken, where and by whom, although these interventions are in the government sector.

More will no doubt be known after the end line evaluation to afford a more comprehensive assessment of the PAIMAN project's contributions in assisting the Government of Pakistan to improve maternal and newborn health status in the country.

5. Summary and conclusions

The health sector in Pakistan is being rapidly privatised. On the one hand, services in public facilities are substantially privately financed through user-fees, and on the other, the government is funding NGOs to run its health facilities in large parts of the country.

It appears that the limited range of maternal, reproductive and sexual health services is largely available through social franchising networks of private providers. International consulting organisations also play a lead role in setting the agenda in reproductive and sexual health, and in maternal health through the technical support provided in drafting policies, training health care providers in the public as well as in the private sectors and marketing equipments, contraceptive devices, clinical supplies and drugs.

What are some implications on the availability, affordability and quality of reproductive and sexual health services?

To begin with, it may be noted that reproductive health services provided by the social franchising networks GSM and KMS have been limited to contraceptive devices and to a lesser extent, surgical contraceptive services; anatenatal care, and to an even lesser extent, delivery care. In the case of contracting out to private sector of BHUs as in Punjab, it was again observed that contraceptive services were unavailable in some districts because family planning was the responsibility of the Ministry of Population Welfare. Availability of delivery services was rather poor. PAIMAN project focuses on antenatal and delivery care, to the exclusion of even contraceptive services. Although this paper has not discussed HIV/AIDS services, these again are provided through separate vertical projects. There is no mention of provision of any of the other reproductive health services. Services for men, single women and for adolescents are conspicous by their absence. Anecdotal evidence indicates that Balochistan and Khyber Pakhtoonkhwa do not consider reproductive health and family planning a priority and allocate few resources for them.[98]

The merits of integrated reproductive health services are well known. Fragmentation of reproductive health services in both the private and the public sectors, as is the case in Pakistan, besides erecting additional barriers to women's access to services, contributes to a high level of system inefficiency, causing wasteful spending of millions of dollars that the country can ill-afford.

In terms of equitable access, social franchising clinics are concentrated in urban areas, and not accessible to the majority of women living in the country's rural areas. One of the studies has pointed out that Paksitan's franchised clinics cater to relatively wealthier clients. The challenge in interacting with the 'for-profit' sector, such as social franchises to help expand coverage, is that populations that have hitherto not been reached by services are those who are also unable to pay and are living in economically under-developed areas.

The 'for-profit' sector will have limited interest in reaching such areas, because the demand for services that have to be paid-for will be low. PAIMAN's attempts at increasing access to basic and emergency obsteric care seem to be floundering because of staff and resource constraints and management issues within the public sector. It is too early as yet to know how successful this project will be in increasing access especially to the poorest and most marginalised groups of women. Given the poor availability relevant outcome data in the project, the impact on equaitable access to services may never be known.

Evaluation reports of franchised clinics raise serious concerns about the quality of care provided. Providers in many franchised clinics appeared to prefer and recommend the IUCD rather than other contraceptives, thus limiting a woman's contraceptive choices. Of greater concern is the fact that few physicians seemed to be screening women before dispensing contraceptive pills. The poor quality of training and of infection control practices is especially worrying in an era of the HIV epidemic and the spread of Hepatitis B infection. Clients did not attend franchised clinics because they thought these clinics were better or more affordable. It appears that they attended franchised clinics because there was simply no other source of reproductive health services available!

The limited information on upgraded public sector facilities under the PAIMAN project likewise raises concerns about the quality of care. Absence of essential life-saving drugs such as magnesium sulphate, limited availability of blood, and non-existence of standard referral procedures for obstetric complications are major failings in a CEmONC centre where women often arrive in a critical condition; these failings could contribute many unavoidable maternal deaths. The largely theoretical training of community midwives as well as physicians, and omission of or limited attention to essential life-saving skills, such as the use of partograph and active management of third-stage labour, are all serious gaps.

To summarise, privatisation in Pakistan's health sector has contributed little to increasing access to quality and comprehensive reproductive health services. It may instead have resulted in the spending of millions of dollars towards providing a limited range of fragmented and sub-optimal quality services to a fraction of its population, with poor returns in terms of the health and survival of its population, especially women.

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CHAPTER 4

THAILAND

1. Background

Thailand is located in South East Asia and is bordered to the north by Laos and Myanmar, to the east by Laos and Cambodia, to the south by the Gulf of Thailand and Malaysia, and to the west by the Andaman Sea and Myanmar.

After 700 years of absolute monarchy Thailand became a Constitutional monarchy in 1932. In the 75 years since then the country has been ruled by a series of military government interspersed with short periods in office by elected governments. There have been numerous constitutional changes, the most recent of them in July 2007 despite public controversy of several clauses as being regressive. This 2007 Constitution replaced the "People's Constitution" of 1997.

1.1 Economic growth and human development

Thailand had a per capita GDP of PPP$ 8643 in 2010[1], making it the fourth richest country in SE Asia after Singapore, Brunei and Malaysia. The average annual growth rate of the economy is estimated to be about 8% at the end of 2010.[2]

From 1986 to 1996 Thailand enjoyed a "boom" period with an average annual growth rate of 12.4%. In 1997 Thailand experienced a major currency crisis.[3] The growth rate of the Thai economy recovered in 1999.[4]

Thailand has a little over a tenth of its population (13.6%) living below the national poverty line during 2000-2006. However less than 2% of the Thai population earned less than US$ 1 per person daily while 25.2% earned less than US$ 2 per person daily during 2000-2007.[5] Furthermore, only 1.7% of the population lived in multidimensional poverty (2000-2008), suffering deprivation in at least three of the ten weighted indicators used to construct the multidimensional poverty index.[6]

The country is marked by considerable income inequality despite impressive economic growth. The share of income of the highest quintile of the population has increased from 49.8% in 1962 to 57.6% in 2001, while that of the lowest quintile declined from 7.9% to 3.9% (i.e. almost halved) during the same period.[7] In 2007, the average per capita expenditure of the richest 10% of the population was more than 13 times that of the poorest 10%, and the Gini index was 42.5.[8]

Thailand's Human Development Rank was 92 of 169 in 2010 and it is ranked among the first ten countries with a medium level in its human development. Its adult literacy rate during 2005-2008 was 93.5%. However, the country does not perform well in terms of educational attainments: only 21% of persons above 25 years of age have completed secondary education.[9] The percentage of employed working-age population (15-64 years) declined from 77.3% in 1991 to 71.5% in 2008. Only about half of those employed (46.6%) were in formal employment while 53.3% worked in the informal sector.[10]

1.2 Gender equality profile

The value of Thailand's Gender Inequality Index for 2010 was 0.586, where a value of 0 indicates perfect gender equality.[11] Gender gaps in education are small, with adult literacy rates (age 15+) for women at 92.6% as compared to 95.4% for men during 1999-2007. In 2007, more girls/women were enrolled in educational institutions at all levels (79.6%) as compared to boys/men (76.6%). Women's estimated earned income in 2007 was only 60% that of men's.[12]

Women's political participation increased from 2.8% in 1990 to 13% in 2007. Women also hold senior decision-making positions in the economy. In 2007, 53% of professional and technical workers in Thailand were women.[13]

Thailand's 1997 Constitution guarantees equal rights for men and women. The Family Law gives both parents equal rights to exercise parental authority and guardianship rights. Further, the Family Law makes no distinction between men and women in terms of inheritance rights.[14] Women are protected from polygamy legally and can ask for divorce if her husband has conjugal relations with another woman.

Women can own land under the same conditions as men. Conjugal property is jointly managed or handled by one spouse with the consent of the other spouse.[15]

While progress towards gender equality seems to be on track, there is still a long way to go before women enjoy security and safety. Violence against women including domestic violence is a major issue. In November 2005, the World Health Organization showed that 41% of women in Bangkok and 47% of women in rural areas had experienced physical or sexual abuse by an intimate partner.[16]

Violence against women is a criminal offence and penalties depend on the age of the victim, the degree of assault, and the physical and mental condition of the victim after the assault.[17] As a result of many attempts, domestic violence has now emerged as a critical public concern. The Domestic-Violence Victim Protection Act B.E. 2550 (A.D. 2007) has been enacted to protect women from domestic

violence. The Cabinet also endorsed the amendment of the Penal Code, Article 276 which has been and still is enforced to protect women from marital rape.

The trafficking of women and children is a serious problem in Thailand. It is the source from where women and children are trafficked into countries like Japan and Australia; a transit point for trafficked persons from neighbouring SE Asian countries, and also a destination of trafficked women and children, especially those from Myanmar, Lao PDR and Cambodia. Thailand criminally prohibits trafficking for sexual exploitation through its 1997 Prevention and Suppression of Trafficking in Women and Children Act, which prescribes penalties that are sufficiently stringent and that are commensurate with penalties prescribed for rape.[18]

2. Health Sector

2.1 Population, health and sexual and reproductive health status

Thailand had a population of 67.4 million in 2008 with about a fifth of its population aged below 15 years.[19] The country is witnessing population that is aging, with more than a tenth of its people in 2007 aged 60 and above. A greater proportion of women (11.6%) than men (9.7%) are elderly.[20] A third (33%) of the population lived in urban areas in 2008.[21]

Thailand enjoys an overall high status because of the health of its people and has made impressive gains in mortality reduction in the past few decades. Life expectancy at birth in 2008 was 70, 66 for males and 74 for females. The infant mortality rate has declined from 141 per 1000 live births in 1960[22] to 13 per 1000 births in 2008, 14 for males and 11 for females.

The under-five mortality rate in 2008 was 14 per 1000 live births, with a similarly higher rate for males (16 per 1000 live births) as compared to females 12 per 1000 live births). Only 9% of children under 5 were underweight during 2000-2007. Almost all (99%) children aged 1 years old were immunised against DPT and measles in 2008.

In the same year, 99% of urban and 98% of rural population had access to protected source of water and more than 95% of the population used improved sanitation.[23] These have contributed to the control of water-borne diseases.

Thailand is experiencing epidemiological transition, with communicable and non-communicable diseases each responsible for 42% and 40% of DALYs lost in 2004. Injuries accounted for 19% of DALYs lost. The prevalence of tuberculosis declined from 340 per 100,000 population in 1990 to 160 in 2008.[24]

While in-country sources report that maternal mortality ratio, too, have declined from 200 per 100 000 live births in the late 1980s to 45 in the late 1990s[25] and the country-reported maternal mortality ratio for 2000-2009 was as low as 14, WHO/ UNICEF in their report estimates a MMR of 110 per 100,000 live births in 2005.[26] Unsafe abortions may be contributing, significantly, to maternal mortality in Thailand. Abortion is illegal in Thailand except to save the woman's life or when the pregnancy is the result of rape. The induced abortion ratio was 19.5 per 1000 live births according to a study carried out in 1999 using case records from 787 government hospitals. Serious complications were observed in a third of the cases, especially among women whose abortions had been induced by non-health personnel.[27] Prevalence of HIV among those aged 15-49 was among the highest in Asia, at 1.4%.[28]

2.2 Personnel and infrastructure

Thailand has a pluralistic health service system with both the public and private health sectors playing significant roles. Health facilities in the public sector are organised under the Ministry of Public Health (MoPH), the facilities include regional hospitals with 500 beds or more; provincial and other general hospitals with 120 to 500 beds; community hospitals with 10-120 beds; and health centres operating at the sub-district or Tambon level.

In 2002, about 25% of the hospitals and 21% of beds were in the private sector. Private hospitals and clinics operated under the supervision of the Medical Registration Division, Department of Health Service Support in the Ministry of Public Health.

Almost half of all private hospitals (43.1%) have 50 beds or less where as 29.2% have more than100 beds. Bangkok and the central plains have a greater concentration of private hospitals as compared to the south, north and north east of the country.[29]

There is also a non-profit health sector which the NGOs managed and operate. The NGO's presence is especially significant in work related to HIV/AIDS. In 2004, more than 500 NGOs were financially supported by the Thai government to implement 577 HIV/AIDS projects and about 70 NGOs were supported by the government to undertake 182 general health projects.[30]

In terms of human resources, physicians are in short supply. The physician/population ratio was 3 per 10,000 during 2000-2009 as compared to an average 10 physicians for lower and middle income countries. The nurse-midwife/population ratio at 14

per 10,000 and hospital bed/population ratio at 22 per 10,000 during the same period corresponded to the averages for lower and middle income countries.[31] Distribution of health resources is highly inequitable, with a concentration in Bangkok and its vicinity. For example, data for 2004 shows that while there were 11 physicians, 35 nurse-midwives and 45 hospital beds per 10,000 population in Bangkok, in comparison to the figures for the North-eastern region were 1 physician, 9 nurse-midwives and 11 hospital beds per 10,000 population.[32]

2.3 Healthcare financing

The per capita total expenditure on health in PPP$ was 286, in 2007, which constituted 3.7% of the GDP. Health is predominantly publicly financed, with public expenditure accounting for 73.2% of the total health expenditure in 2007 and private expenditure at 26.8%. The contribution to health expenditure by external resources is negligible (0.2%).[33] Besides general tax revenue, the Thai government also allocates 2% of the excise taxes on tobacco and alcohol for health promotion activities carried out through an autonomous body, ThaiHealth.

The total health expenditure as a percentage of GDP rose from 3.5% in 1994 to 4.2% in 2008, and per capita health expenditure doubled, from US$ 86 to US$ 171 during the same period. The share of public funding increased from 46% of total health expenditure in 1994 to 75% in 2008.[34] Even during the period of economic crisis of 1997, the government of Thailand did not retract the budget allocated for services to the poor, but shifted allocation from capital account to recurrent expenses. A study carried out in 1998 showed that there was no shortage of drugs in public or private health facilities during the economic crisis and users' perception of the quality of health care remained high.[35]

There are now three public health insurance schemes in Thailand:[36]

Civil Servant Medical Benefit Scheme (CSMBS) covers all civil servants, their parents, spouses and children less than 18 years of age. This is financed by general tax revenue and covers about 6 million people or 10% of the population.

Those covered by the CSMBS have the freedom to choose their providers whether in the public or private sector. Providers are paid from the insurance on a fee-for-service basis with a 50% co-payment requirement for inpatient services in private hospitals.

The Thai Social Security Scheme (SSS) covers private sector employees. This scheme is financed by tripartite contributions of 1.5% of payroll by the employee, the employer and the government. This covers about 8 million people or 13% of the population.

Those that The SSS insures can choose between public facilities and specific private facilities registered under this scheme. The medical facilities registered are required to have at least 100 beds and a range of related facilities. Payment for providers is on a capitation basis.

The Universal Health Coverage Scheme (UC) covers 47 million or about 74% of the population.

During the period of economic boom as well as during the period of health reform following it, an interesting combination of high levels of investment to strengthen financial protection for the poor has co-existed with policy support for the private sector.

Section 3 below documents the development of Thailand's private sector in health since 1990 and especially its medical tourism industry in the period following the 1997 economic crisis. In section 4, is a description of the universal healthcare coverage scheme and its impact on equity and financial protection. Section 5 examines the implications of the universal healthcare coverage scheme on sexual and reproductive health services.

3. Privatisation in the health sector

3.1 Economic boom and the growth of the private sector

Privatisation in Thailand was essentially fuelled by the country's economic boom of 1987-1997, caused the increasing demand for private health care of international standards from wealthy Thais as well as the expatriate community.[37] Beds and doctors in for-profit private hospitals rose more than three-fold, from 9974 beds and 1094 doctors in 1987 to 29,945 beds and 3244 doctors in 1997. The proportion of beds in the private sector increased from 11.4% to 22.6% and the proportion of doctors in the private sector increased 11.4 % to 19.6% during this same period. This boom led to an oversupply of beds, as the bed-occupancy rate was only about 45%.[38]

Privatisation also led to the investment in complex and expensive medical technologies such as CT scanners and MRI machines, and in imported drugs rather than locally manufactured and/or generic drugs that were less expensive.[39]

The oversupply of beds, availability of sophisticated

and expensive medical technology and imported drugs and the profit-driven motives of private sector health facilities fuelled an era of irrational prescriptions, diagnostics, therapies and procedures. Unnecessary referrals from the public to private sector for those covered by CSMBS and SSS became the order of the day. There was also a brain-drain from the public to the private sector, thus, worsening the already serious human resource crunch in the public sector.[40]

The economic crisis of 1997 affected the demand for care in all private hospitals. Many private hospitals responded by entering into contracts with the government for the Social Security Scheme. For example, between 1998 and 1999 there was a 32% increase in the number of private hospitals joining the Social Security Health Insurance Scheme.[41] Another strategy for the survival of the private health sector following the economic crisis was to promote medical and health tourism.

3.2 Response to the economic crisis: Medical and health tourism

Because of the fall in local demands for private health care after 1997, private hospitals had to shift their focus to inviting patients from abroad. Devaluation and the low factor costs in Thailand gave it a competitive edge as compared to the US and Europe in terms of cost of medical care.[42] For example, in 2008 a heart valve replacement in Thailand cost only $ 10,000 as compared with $160,000 in the US and heart bypass surgery cost $11,000 compared to $130,000.[43]

There were other factors that contributed to the growth of medical tourism in Thailand. One was the growing demand from the Middle East following the September 11, 2001 attacks after which visas to visit the US became difficult to obtain.[44] Partnerships between many private hospitals and international medical-schools as well as health care institutions in Europe and the US had created a better image of Thai hospitals that are high quality and efficient medical treatment and care. In addition, many private hospitals have been accredited to international standards such as the ISO 900:2000.[45]

Bumrungrad hospital in Bangkok became the first internationally accredited hospital in SE Asia in 2002 and was at the forefront of the medical tourism industry. The number of international patients treated in this hospital grew from about 50000 in 1997 to 350000 in 2005.[46] The number of private hospitals involved in the medical tourism industry in Thailand is not very large: of 218 members of the Thai Private Hospitals Association only 33 target foreigners explicitly. All the same, its share of the medical tourism market is quite significant. In 2002, the number of foreign patients treated in Thailand (632,320) far exceeded the numbers in other countries of the region such as Singapore, Malaysia and India.[47] According to another source, the number of foreign patients visiting hospitals was 1.28 million in 2005 generating revenue of about 33 billion Thai baht. In the same year, approximately 60% of patients treated at Bumrungrad Hospital and 40% of patients at Samitivej Hospital were foreigners.[48]

Medical tourism is reported to be affecting access to health care in Thailand in two major ways. One, private medical care is becoming unaffordable to the Thai middle-class who may not want to use the overstretched public sector facilities. Two, the brain drain, which is drawing away highly qualified doctors and other health professionals from government-run hospitals to private hospitals has increased because of the much higher salaries and better working conditions offered by the larger “five-star” private hospitals catering to foreign tourists. This has further exacerbated the situation in government-run hospitals which is stretched beyond capacity because of universal coverage.[49]

4. The Universal Healthcare Coverage Scheme

Universal Coverage had for long been on the agenda of a group of reformers in the Ministry of Public Health, but this had not won the support of any government. Thailand adopted the Universal Health Care Coverage (UC) in 2001 when a new government won the election based on populist programme that included low-cost health care took office.

In early 2001, the newly elected government launched UC, also known as the *30 Baht health policy* because of the co-payment requirement of 30 baht for each ambulatory visit. This requirement has now been suspended, and ambulatory care is available for free at the point of service delivery.

4.1 Major features of UC

Eligibility

To be covered by the scheme, a person’s name has to be in the house registration of a given province. Each person insured receives a universal health card. Users are required to be registered at a primary health care facility. They have to show their identification cards when utilising services, they are also required to use public facilities and follow the referral system. For emergencies, however, any government health service can be accessed. Anyone

Table 11: Incidence of catastrophic health expenditure by quintile of consumption expenditure

Consumption expenditure	2000	2002	2004	2006
Quintile 1	4.0%	1.7%	1.6%	0.9%
Quintile 5	5.6%	5.0%	4.3%	3.3%
All quintiles	5.4%	3.3%	2.8%	2.0%

Source: Prakongsai, P.; Limwattananon, S.; Tangcharoensathien, V. 2009. "The equity impact of the universal coverage policy: Lessons from Thailand". Advances in Health Economics and Health Services Research Vol. 21: pp. 57 – 81

who bypasses the referral chain in non-emergency situations to go to a higher level of facility has to pay the full-cost of services at that level of facility out-of-pocket.[50]

Benefit package

The benefit package is comprehensive and includes curative services, health promotion, disease prevention and rehabilitative health care with a small number of exclusions. Treatment under the traditional Thai and alternative systems of medicine is also included in the benefit package. In 2006, ARV for HIV/AIDS was also included in the benefit package and in 2008; renal replacement therapy and influenza vaccine were added on as part of the benefit package.[51]

Payment mechanisms and service contractor

The National Health Security Office (NHSO) is an autonomous purchasing agency established to manage the National Health Security Fund and provide universal care to Thai citizens. From the government's side, financing comes from tax revenue.[52] Allocation is on a per capita basis, and this has risen from 1202 baht per person per month in the initial years to 2100 baht in 2008, before ARV and renal replacement therapies were included in the benefit package. Increase in the allocation for UC was in recognition of the under-financing that happened in the early years resulting in financial deficit in some public hospitals.[53]

The NHSO channels funds to providers through a system known as Contracting Units for Primary Care (CUPs). Each CUP serves the population of a local health district. It receives money from the NHSO and uses this to support local service units and pay for referrals.[54]

The system of CUPs marks a radical shift in funding its move away from urban hospitals to primary care. Most CUPs are in the public sector, and consist of district health networks including district hospitals and 10-15 of their affiliated health centres. Accredited private providers could gain CUP status if they could provide the full range of services including health prevention and promotion services.[55]

Payment by CUPs to provincial and tertiary hospitals is on a diagnosis-related-group (DRG)-basis.[56] For outpatient and preventive services, payment was on capitation basis, i.e. based on the population to be covered. There is a separate allocation for high cost and accident emergency care.[57] In 2008, a service fee was introduced for some preventive and promotive services and treatments of some diseases.[58]

The Scheme also covers many non-medical items. For example, health providers serving in remote areas are provided compensation for hardship. There is budget allocation to compensate patients suffering from fatal or non-fatal adverse events. Since 2007, there is an incentive to providers for improving quality of care.[59]

4.2 Impact of UC: Equity, economic protection and user satisfaction

A number of recent studies indicate that the Universal Healthcare Coverage Scheme has improved equity in health services. For example, because the scheme is predominantly financed by general tax, the rich pay more towards the scheme than the poor, i.e. UC is progressive.[60]

The district health system being the main service contractor promotes equity in access to health care. District hospitals and health centres are located closer to the rural poor and hence, more easily accessible to them, with minimal costs incurred for transportation.[61]

Incidence of catastrophic health expenditure – out-of-pocket health expenditure in excess of 10% of the total household consumption expenditure – fell after the introduction of UC from 5.4% in 2000 to 3.3% in 2002, 2.8% in 2004 and 2.0% in 2006.[62] In 2008, 21 of 76 provinces of Thailand did not have a single household that experienced impoverishment due to

health expenditure. This is in stark contrast to the situation in 1996 when 10 provinces had 3% or more households experiencing health impoverishment.[63] Also, a smaller proportion of households from the lowest consumption expenditure quintile (Quintile 1) experienced catastrophic health expenditure as compared to those from Quintile 5 (Table 11). With UC removing financial barriers to accessing health care, there would a major increase in demand as a result of a compromised in the quality of health care. A study on user perspectives on UC however found that more than 80% of UC members were satisfied with health providers, the availability of drugs and medical equipment. The wide benefit package, reduced health expenditures and designation of first-line care providers were identified as major strengths of the scheme.[64]

Table 12: Summary of the nine ICPD sexual and reproductive health services and the UC package coverage

ICPD SRH service	Covered by UC package			Not covered by UC package
	Preventive and promotion services	Curative services	High cost care	
Unplanned pregnancy and unsafe abortion	Sex education and family planning	Abortion in case of rape and risk to maternal health; treatment of abortion complications	NA	Safe abortion services for all
Maternal mortality and morbidity	Reduce unwanted pregnancy; Antenatal care	Essential obstetric care for first two children; treatment for complications (emergency care)	NA	
Reproductive tract infections including STDs	Sex education and promotion of condom use; screening for syphilis in high risk groups and in antenatal care	Treatment based on syndromic and laboratory approaches	NA	
HIV/AIDS	Sex education and promotion of condom use; premarital and antenatal counselling and HIV testing; opportunistic infections prophylaxis in some provinces; prevention of mother-to-child transmission among pregnant women	Definitive treatment for opportunistic infections and other palliative care		HAART
Reproductive tract cancers	Pap smear ;clinical breast examination	Diagnostic medical and surgical treatment as well as radiation therapy and palliative care	Chemotherapy	NA
Sexual and gender-based violence	General counselling services	Medical treatment and care for victims of violence	Covered	
Infertility	Covered	Covered	Covered	
Menopausal services	Covered	Covered	Covered	

Source: Teerawattananon, Y.; Tangcharoensathien, V. 2004. 'Updated version of Table 3' in "Designing a reproductive health care services package in the universal health insurance scheme in Thailand: match and mismatch of need, demand and supply". Health Policy and Planning Vol. 19, Suppl.1: pp. i36

5. Implications for SRH services of Universal Health Care Coverage

The public health sector in Thailand governed by the Ministry of Public Health has provided comprehensive sexual and reproductive health care services through its network of primary, secondary and tertiary health facilities.

Universal Coverage Scheme has built on this foundation and made access to these services within reach of all those who need it without being encumbered by financial barriers. Thailand adopted its first reproductive health policy in 1997. By 1998, sexual and reproductive health services were organised into ten components: Maternal and Child health; Family Planning; HIV/AIDS and STDs; Sex education; Adolescent reproductive health; Abortion and its consequences; infertility; Breast Cancer and Malignancy of the Reproductive Tract; Post-menopausal and old-age related health care; and Violence Against Women.[65]

For example, sex education and promotion of reproductive health for adolescents was integrated into general health education in health facilities and schools, and other sites through public media and NGOs. Also, essential obstetric care was well integrated within the health care delivery system.

A One Stop Crisis Centres to provide comprehensive hospital services to women experiencing domestic violence started in one provincial hospital in 1999, and there are now provincial hospitals in every region of Thailand providing such services with the support and guidance of the Ministry of Public Health.[66]

5.1 Availability of services

Sexual and reproductive health services constitute a major part of the universal coverage package. Most of the nine ICPD sexual and reproductive health services are part of the benefit package (Table 12).

Although antiretroviral therapy (ART) was not initially a part of the Universal Coverage Package, it was available free of charge through public hospitals to low-income patients since 1992.[67]

The National ART programme was initially under the Disease Control Department of the Ministry of Public Health and in 2004, it was integrated into the benefits package of the SSS. In late 2006, the newly installed Thai government issued a compulsory license for the ARV Efavirenz patented by Merck, which enabled the government to offer ARV to patients at half the price.[68] Cost-containment and civil society movement towards universal ART eventually achieved integration of anti-retroviral therapy into the benefits package of the Universal Healthcare Coverage Scheme.

5.2 Utilisation and equitable access

Major strides have been made in achieving near-universal coverage by maternal health care services. According to Thailand's 2009 Reproductive Health Survey, almost all (98%) pregnant women had received at least one antenatal visit while 74% had received the required norm of at least four antenatal visits.[69]

Particularly noteworthy is the fact that Thailand has been able to increase its already high rates of skilled birth attendance from 85% in 1990-1999 to 99% in 2000-2008.[70] More than 90% of all institutional

Table 13: Odds ratios of MCH service coverage of richest to poorest quintiles and urban to rural areas, Thailand, 2005-06

MCH Coverage Indicator	Average coverage (%)	Relative Risk (Quintile 5: Quintile 1)	Relative Risk (Urban: Rural)
Family Planning	72.6	0.99	1.10
Prenatal care by skilled health workers	97.8	1.05	1.10
Delivery by skilled health worker	97.3	1.10	1.23
Delivery in a health facility	---	1.10	1.28

Source: Limwattananon, S.; Tangchroensathien, V.; Prakongsai, P. 2010. "Equity in maternal and child health in Thailand". Bulletin of the World Health Organization Vol. /No. 88: pp. 420 – 427.

deliveries took place in a government facility, and only 8.5% took place in a private health facility.[71]

Contraceptive prevalence rate was over 80% in 2000-2008, and total fertility rate in 2008 was a low 1.8.[72] Breast and cervical cancer screening is available through the public sector in health, and the 2009 Reproductive Health Survey reported that 55-60% of women aged 30-59 years had been screened for each of these reproductive cancers.[73] Coverage by antiretroviral therapy was as high as 61% in 2009, as compared to the global average of 36% for low and middle income countries.[74]

Studies on the impact of equity specifically related to sexual and reproductive health services were not found, barring one on maternal and child health. This study, carried out in 2005-06, covering 40,000 women of reproductive age across Thailand, found that there were virtually no rich-poor gaps in access to maternal health care and family planning services.[75]

6. Concluding remarks

Thailand presents an interesting case study of privatisation in the health sector. Private financing was the principal mode of financing health expenditures in Thailand throughout the 1960s and 1970s, and even up to the mid 1990s.

In a period during which public expenditures on health were cut in most developing countries and a shift occurred towards limiting state involvement in the health sector, Thailand chose to swim against the tide. In the period following the economic crisis of 1997, public expenditure on health in Thailand increased steadily in actual terms and also as a proportion of total expenditure.

At the same time as the public investment in health substantively increased, Thailand also encouraged the growth of the private sector in health. While there was always a private health sector in the country, it was during the economic boom of the 1980s that the numbers of private health facilities grew rapidly. This was because of the emerging demand for high quality services by the well-to-do within the Thai population whose income had grown during the boom.

The government was and continues to be a purchaser of services provided by the private sector. Services of the private hospitals are contracted by the government for the Social Security Scheme and by the NHSO for the Universal Coverage Scheme, both of which are financed by general tax revenue. To some extent, then, the private sector in health is being effectively harnessed to achieve the country's public health goals.

The economic crisis of 1997 caused low demands for high-cost private health care from the Thai population. A section of the private health facilities decided to tap the global market for low-cost health care by promoting medical tourism. This received active policy support.

The compatibility of two seemingly contradictory policies – of universal coverage and privatisation, especially the promotion of Thailand as an Asian medical hub – has been the subject of much public debate and discussion in Thailand. It was the subject of a panel in the National Health Assembly (NHA) 2006. One position was that these were "*two different ideas, two different forces, which resulted in two public policies for two distinct groups, groups with two different statuses".*[76]

Both policies had contributed to a greater demand for health services and resources with adverse consequences for national health. The NHA panel, which consisted of speakers from the academic, public, and private sectors, recommended that there should be some kind of moderation and rationality. It suggested that a ceiling be set on the numbers of international patients who would receive health care in Thailand and the number be decided in such a way that medical tourism does not affect health care for Thais. Another recommendation was to establish an independent mechanism to monitor and audit policy implementation to ensure rights and safety of the general public are protected.

Application of the "Sufficiency Economy" principle to the health sector has prompted a fine balance between equity and social justice on the one hand and profitability and economic survival on the other. Whether this experiment will succeed depends on how the country deals with the human resources crisis caused by the internal brain drain from the public to the private sector.

The success thus far of the Universal Healthcare Coverage Scheme is attributed to some essential preconditions. One important precondition is the existence of a wide network of primary health care centres and personnel catering to the rural population. Without this, Universal Coverage would have remained an aspiration and not translated into real access for the poor and rural populations. Second is the existence of an adequate tax base to enable general tax-based financing of Universal Healthcare Coverage Scheme. Of course, the decision to allocate substantial sums for universal coverage indicates strong political will and support, but many countries with political will may not have the means to invest on such a comprehensive benefit package covering 75% of the population.

This middle path has meant universal access to a wide range of sexual and reproductive health services financed by tax revenue. The Thai government has not hesitated to take on the mighty transnational pharmaceutical companies by issuing compulsory licenses for HIV drugs so that a majority of PHA can be provided free or subsidised treatment. The only major lacuna is in the provision of safe abortion services, for which a struggle is on for legislative change.

One lesson to be learnt is that the struggle for affordable and comprehensive sexual and reproductive health services is inextricably linked to that for universal health care coverage. The challenge would be to ensure that SRH services do not drop under the radar or get only lip service in the benefits package for Universal Health Care. This would require a critical mass of SRH advocates to make this a priority within their countries and internationally.

Therefore, to all advocates for universal access to comprehensive SRH services, Thailand's experiment in pursuing universal coverage without completely clamping down on privatisation is one worth keeping track of and drawing lessons from.

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