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Financial sustainability of reproductive health services: Understanding costs: An essential skill in reproductive health programs

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Legacy Series:

FINANCIAL SUSTAINABILITY OF REPRODUCTIVE HEALTH SERVICES

Understanding Costs: An Essential Skill in Reproductive Health Programs

Evidence about cost of intervention is critical for program decision-making, because it provides evidence about potential for sustainability. Reproductive health services remain a low priority for most developing country health programs and face continuing reductions in donor funding and competition from other priorities, such as HIV and malaria. It is more important than ever to understand costs of interventions when considering scale-up and sustainability (*Box 1*)—especially comparability of these costs with existing or alternative service delivery strategies. FRONTIERS addressed the need to increase sustainability in two ways: i) routinely monitoring costs of implementing new approaches through operations research; and ii)

Box 1. What Is Financial Sustainability?

Financial sustainability can be considered a state in which a program can cover its costs by some combination of revenue generated from service charges as well as dependable long-term support to cover routine costs. Thus, a program need not necessarily be self-sustaining if sufficient long-term funding is available from other sources.

This paper is part of a series of eight *Legacy Papers* synthesizing major lessons learned through research conducted under the Frontiers in Reproductive Health Program (FRONTIERS).

The full set of *Legacy Papers* includes:

- Capacity Building
- Family Planning
- Female Genital Mutilation/Cutting
- Gender
- Integration of Services
- Sustainability of Services
- Utilization of Research Findings
- Youth Reproductive Health

The complete reports referenced in these papers are available online:

www.popcouncil.org/frontiers

capacity building to enable partner agencies themselves to assess program costs and determine potential economic impact of changes associated with adapting new or revised ways of providing services. FRONTIERS costing studies provide important lessons about ways of measuring the costs and effectiveness of public and non-governmental programs, systematically planning for costing during scale-up, and improving understanding of issues influencing financial sustainability.

Determine Costs Early to Enhance Sustainability

As external support for innovative interventions continues to decline, program managers need to consider long-term usefulness and sustainability of any new or revised interventions being pilot-tested; there is little point in testing interventions that are not affordable. Some strategies programs can use to assess cost of testing and expanding reproductive health projects, as well as ways of assessing potential income-generating strategies, follow.

Consider costs of implementing and scaling up interventions from earliest planning stages. Implementing interventions and institutionalizing effective practices involve costs—including labor, capital, materials, technical assistance, and opportunity costs—all of which need to be borne by government, NGOs, donors, or service users. Thus, when designing a pilot project, planners should attempt to estimate costs of institutionalizing and scaling up interventions before embarking on implementation. Such planning can help to avoid piloting unsustainable interventions. This can be done by identifying and costing resource requirements according to the three main phases of a pilot-test: *planning; introduction of intervention; and ongoing service delivery* (Janowitz et al. 2007). This reduces complexity of costing by breaking project implementation down into component parts and focusing on costs associated with each phase. Scaling-up costs can then be estimated on the basis of the second two phases, which are likely to represent costs of expanding into new sites (introduction of intervention) and sustaining services on a routine basis (ongoing service delivery).

Calculate first-phase and scale-up costs separately. Costs of routinely implementing scaled-up interventions are not simple multipliers of costs of pilot projects, but usually are lower than the pilot project on a per-site basis because of economies of scale, streamlining of activities and substitution of lower-cost resources (Boateng et al. 2006; Birungi et al. 2008). Numerous factors affect the cost of scaling up a successful pilot intervention to multiple service delivery points (SDPs)—including number and size of SDPs, who provides resources and at what prices, and changes in intervention altering cost calculations in scale-up.

Modeling the scale-up of a pilot project to improve FP client-provider interactions in Egyptian clinics shows cost per clinic for implementation would drop significantly from pilot to scale-up, in part because many planning meetings and preparatory activities—about 25 percent of cost of the pilot project—can be reduced, or can cover a larger number of clinics. Economies of scale also reduce cost of other activities, such as training, because larger numbers of providers can be trained together. For example, modeling scale-up from 24 to 567 clinics reduces projected costs of planning from \$1,018 per clinic to \$40 per clinic because little additional work is needed to plan for 567 compared with 24 clinics. By contrast, supervision costs might not change after scale-up as continual supervision is usually necessary to ensure correct implementation of intervention (Janowitz et al. 2007).

Use existing institutions to pilot-test activities that could be scaled up. In Kenya and Senegal, multisectoral approaches for improving youth reproductive health were introduced through public-sector ministries because existing structures are sustainable and already reach the vast population majority. Staff from three ministries in each country planned and implemented interventions; community leaders and existing youth organizations participated in planning and played major roles in outreach and education. This approach not only contained costs pilot-testing donors through enormous resource contributions of ministry staff time, infrastructure and facilities, but also enabled expansion and scale-up costs to be institutionalized within annual budgets and ministry workplans (Joyce et al. 2008).

Capacity Building to Help NGOs Achieve Financial Sustainability

It is difficult to find trained professionals in nongovernmental organizations (NGOs) with experience collecting and analyzing information on service delivery costs. Moreover, few health NGOs possess essential business skills in costing, break-even analysis and market research, skills necessary for planning and evaluating interventions to control costs and increase income. FRONTIERS partner, Family Health International, implemented the “Financial Sustainability Capacity Building Initiative” (FSCBI) from 1999 to 2008 to build skills in economic analysis to help NGOs improve sustainability. Staff and managers from participating NGOs in Africa, Asia, and Latin America attended week-long regional workshops combining training on economic analyses with research proposal development (*Box 2*); those whose proposals were accepted received financial and technical assistance to conduct capacity building and research (Bratt, Janowitz, Homan, and Foreit 2008).

Box 2. Four Types of Cost Studies Undertaken During FSCBI

Cost diagnostic studies focused on measuring the average costs of services provided through clinics and hospitals; **sustainability diagnostic** studies looked at costs and also collected information on competing providers and measured a client’s willingness to pay; **break-even analysis** examined the question of how many units of service or product needed to be sold in order to cover fixed and variable costs; and **income generation** studies measured the impact on revenues and costs of a variety of interventions designed to improve financial sustainability.

One-week workshops combining didactic training in economics-related operations research with proposal development and subsequent technical support can build economics capacity in NGOs. Institutionalization of skills learned in workshops requires repeated practice through subsequent applications. Practice requires not only resources, but also commitment from senior managers who must be convinced conducting OR to develop and test ways of improving financial sustainability is appropriate use of scarce resources. A supportive environment is essential to nurture newly-formed technical capacity built in a week-long workshop; this environment is more likely when an NGO has strong and supportive leadership and minimal staff turnover. Only two FSCBI participants (Prosalud in Bolivia and CHAG in Ghana) moved beyond the first round to carry out second-generation projects. In both cases, substantial technical and financial assistance was still required to develop and implement these studies. This suggests need for long-term commitment to financial capacity building initiatives (Boateng et al. 2006; Merida et al. 2006).

Management support and commitment are critical. Ultimately, organizational capacity resides in individuals free to leave for better opportunities. Thus it is critical NGO managers participate in and support financial analysis capacity building so when trained staff leave, skills are retained. Some NGOs in FSCBI lost key staff during implementation, which stopped projects or reduced likelihood of result use. In Bolivia, Prosalud's champion of testing alternative marketing plans left and was replaced by staff who assigned lower priority to developing new marketing strategies. As a result, one of two second-generation OR projects was dropped, and another was completed with little direct involvement of Prosalud senior management (Merida et al. 2006; Bratt, Janowitz, Homan, and Foreit 2008).

NGOs attempting to generate additional income had little success. Cost control and income generation are the two main paths to financial sustainability available to NGOs. Organizations working with FSCBI tended to show more interest in generating income than controlling costs, but income-generation interventions failed to produce much additional revenue from RH services. ASHONPLAFA instituted systematic screening¹ in Honduras, for example, but identified only small demand for additional family planning and RH services; income-generation efforts should focus on other types of services, such as dental care, optometry services, and internal medicine. In studies with Child In Need Institute (CINI) and Chhetrapati Family Welfare Center (CFWC) NGOs in India and Nepal respectively, additions to revenue were very small, indicating large increases in volume would be needed to make substantial impact on sustainability (Das et al. 2007; Shrestha et al. 2007).

Donor expectations for NGO financial sustainability are not always realistic. Donors encourage financial sustainability while simultaneously expecting increased number of services to the poor. However, serving the poor may inhibit an NGO's self-sustaining efforts, because the poor are often unable to contribute to costs of services. Consequently, NGOs need to cross-subsidize some services for the poor through revenues earned from profitable services or from external donor support. Organizations attending FSCBI workshops from Bangladesh, Ghana and Nepal were severely constrained by government and donor requirements they reduce dependence on external grants while keeping fees low and/or increasing number of services provided to the poor (Bratt, Janowitz, Homan, and Foreit 2008).

NGOs may continue to support ineffective interventions despite negative findings. It is commonly assumed utilization follows naturally from successful intervention, but in FSCBI, this was not always the case. In one NGO, complementary (paired) products sales did not increase revenues, but training was continued because it could without cost, and senior management continued to believe in it, despite negative results (Bruce et al. 2006). A systematic screening in Honduras was scaled up although only 11 percent of clients were screened (Vernon et al. 2005). Training in financial research and analysis cannot result in sustainability unless senior managers have strong understanding of their purpose and value.

¹ Systematic screening is a technique for identifying and meeting unmet client need for health care services. Providers use a standardized instrument, generally a checklist or set of questions to determine whether a client needs services other than the one for which she came—such as reproductive health services, immunization, or other services. Providers then offer additional services during the same visit or make an appointment or referral for services that cannot be provided immediately (Foreit 2006, online at www.popcouncil.org/pdfs/frontiers/pbriefs/Sys_Scrn_brf.pdf).

NGOs should be alert for opportunities arising from changing government health care strategies. Organizations can take advantage of sector wide approaches (SWAp) and decentralization processes to enhance financial sustainability, but they need to recognize opportunities in public-private partnerships and become more entrepreneurial in nature. A survey of 16 RH NGOs in Uganda analyzed their ability to survive in the context of the Ministry of Health's SWAp. NGOs have many opportunities offered by the SWAp to enhance sustainability and effectiveness by reducing current dependency on donor funding if they address systemic weaknesses, such as not having strategic plans or by translating plans into concrete ways of improving financial sustainability (Mugisha, Birungi, and Askew 2005).

Classifying NGOs on a four-category continuum of preparedness for active engagement in the SWAp ("limping," "surviving," "transitory," and "thriving") showed none of 16 NGOs could qualify as "thriving" (*Box 3*), showing need for considerable capacity building in NGOs as they make the transition from donor dependency to becoming integral components of the overall health sector (Mugisha, Birungi, and Askew 2005).

In Ghana an assessment on RH priority setting in health sector reforms at the district level highlighted a comparative advantage many NGOs have delivering certain RH components at district levels, a factor NGOs could take advantage of in strengthening sustainability (Birungi et al. 2008).

Box 3. Factors influencing Potential NGO Success

To compete in the changing health care environment, an NGO should have the following characteristics:

- A strategic plan and ability to implement the plan;
- A manageable human resource development plan and management information systems plus other institutional management systems;
- A marketing strategy based on analysis of its potential to offer or sell services to specific clientele;
- A customer oriented and participatory philosophy;
- Ability to combine goal of serving poor with schemes to serve wealthier customers for cross-subsidization;
- A strategy enabling transition from existing donor relationships into other approaches of generating income; and
- Capacity to generate funds from a variety of sources.

Mugisha, Birungi, and Askew 2005

Does integration of services lead to cost benefits? The evidence is still unclear.

Integration of services is promoted based on two assumptions: First, it will improve health status, and second, it may reduce average costs and increase income. Client benefits are clear. When providers in Bolivia, Honduras, India, and Senegal integrated systematic screening for multiple client needs, services per client increased by 9 to 35 percent (Foreit 2006). Integration of HIV information and services into FP in Kenya and South Africa resulted in improved quality of care and increased access to and use of HIV counseling and testing (Mullick et al. 2008; Liambila et al. 2008). The Kenya study showed integration incurred an incremental yet affordable cost for additional provider time for both. A projection of costs for national scale-up of this integration model showed incremental costs for integrating onsite HIV testing into FP ranged from \$5.60 (for hospitals) to \$9.53 (for dispensaries) per client; this compares favorably with estimated \$27 per client for VCT services offered by stand-alone testing centers (Liambila et al. 2008; Sweat et al. 2000). In another study, in India, integrating RH with HIV testing, provision of RH services increased from 12 to 25 services per day and from 4 to 22 for VCT. When income from service fees were compared to provision costs, a small positive margin was earned (US\$0.07), indicating provision of integrated services added more to program revenues than to costs (Das et al. 2007).