Initiating Public/Private Partnerships to Finance Reproductive Health: The Role of Market Segmentation Analysis

by

Ruth Berg

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Abstract

Participants at the 1994 International Conference on Population and Development (ICPD) developed an ambitious agenda, calling for more and better quality reproductive health products and services around the world. This mandate, along with the increased global demand for reproductive health care, poses a financial challenge to both donors and local governments. Recognizing this, the ICPD *Programme of Action* stressed the need for more efficient resource use through stronger public/private partnerships and an expanded private sector role.

Carrying out these recommendations requires improved public/private dialogue and further exploration of opportunities for the public and private sectors to coordinate their efforts. Market segmentation analysis can support this process by highlighting the different reproductive health needs of different population groups and prospects for both sectors to improve resource targeting accordingly.

The purpose of this paper is to familiarize policymakers with market segmentation analysis and its role in supporting more efficient and effective resource use. Specifically, the paper summarizes how market segmentation analysis helped initiate public/private dialogue to guide resource allocation decisions in four countries: Turkey, India, Morocco, and Brazil. In Morocco and Turkey, market segmentation analysis results were central to public/private reproductive health finance discussions and guided public sector decisions to concentrate resources more heavily on the most vulnerable and needy population groups. In Brazil and India, market segmentation analysis findings helped guide reproductive health finance discussions between donors and the private sector that led ultimately to private sector expansion.

Initiating Public/Private Partnerships to Finance Reproductive Health: The Role of Market Segmentation Analysis

Introduction

Participants at the 1994 ICPD developed an ambitious agenda, calling for more and better quality reproductive health services around the world. At the same time, greater numbers of women and men of reproductive age and the growing AIDS epidemic have increased the global demand for reproductive health services. The need to find additional resources to meet the growing demand for reproductive health care is becoming increasingly urgent. Since donors and local governments face resource constraints, the ICPD *Programme of Action* stressed the need for more efficient resource use through stronger public/private partnerships and an expanded private sector role.

Achieving these goals requires information and dialogue. In general, governments are often unaware of how their decisions affect opportunities for private sector expansion because they do not have an established dialogue with the private sector and do not include private sector representatives in policy discussions. Both the public and private sectors typically lack basic market information that would allow them to better coordinate their efforts, including information about the size of each sector's client base, the range of reproductive health needs and preferences, and the ability of clients to pay for goods and services.

Donors, policymakers, and other stakeholders can use market segmentation analysis to facilitate public/private dialogue and collaboration.[1] The analysis divides the reproductive health market into subgroups whose needs, characteristics, or behaviors might require separate service delivery or marketing strategies (Kotler and Armstrong, 1999). By focusing on the distinct needs of different population groups, market segmentation analysis highlights opportunities for each sector to increase its effectiveness and efficiency by using its comparative advantage to meet those needs. The analysis also points out prospects for the public sector to complement (rather than duplicate or crowd out) private sector efforts.

Marketers have long relied on market segmentation analysis to better understand the product and service needs of different groups of consumers. They use the results to guide product development, pricing, distribution, and promotion to the needs of different population segments. This paper demonstrates the relevance of market segmentation analysis beyond marketing. Specifically, the paper shows how policymakers can use this same type of information to better understand the different reproductive health needs of different groups and to think strategically about how they can work with the private sector to more efficiently meet those needs. Using examples for Turkey, India, Morocco, and Brazil, the paper also highlights the role that market segmentation analysis has played in promoting public sector plans to concentrate resources on vulnerable and needy populations (Morocco and Turkey) and supporting private sector expansion (Brazil and India).

[1] Throughout this paper, "public sector" refers to national governments and government donors, whereas "private sector" refers to commercial enterprises and nonprofit organizations.

Why Do Market Segmentation Analysis?

Market segmentation analysis is a useful tool for reproductive health programs that are having to "do more with less." Many governments currently face this challenge because of one or more of the following circumstances:

- *ICPD mandate*. For many governments, adhering to the principles outlined in the ICPD *Programme of Action* requires that they ensure provision of an expanding array of quality reproductive health services.

- *Increased demand*. The demand for reproductive health services has increased worldwide because of increasing numbers of women and men of reproductive age, rising levels of education, the success of information, education, and communication (IEC) campaigns, and the growing HIV/AIDS epidemic.

- *Donor phaseouts*. Facing their own financial constraints, international donors have phased out or greatly reduced financial support to several developing countries that they judge to be capable of meeting reproductive health service needs with less external support.

- *Budget limitations*. Requests for additional local resources to meet growing reproductive health needs compete with other urgent needs. While some countries have been successful at securing budget line items and budget increases for reproductive health services, many are unable to generate the additional resources needed to meet demand.

In addition to these circumstances, market segmentation analysis is also useful when decision makers are uncertain about where to target limited resources to achieve the greatest impact. It can help determine, for example, where the need for specific reproductive health services is greatest, whether specific population segments have special needs (such as evening hours, low-literacy communication materials, high demand for a specific method, and specific communication messages, among other needs), and what combination of public and private sector services would yield the most efficient use of resources.

What Is Market Segmentation Analysis?

Market segmentation analysis is the process of using statistical techniques, such as cross-tabulation or cluster analysis, to divide diverse populations into smaller subgroups that are similar in characteristics, needs, and likely responses to marketing or service delivery efforts (Weinstein, 1994, 1997; Kotler and Armstrong, 1999). This process could be as simple as dividing the women's reproductive health market[2] into a few distinct demographic groups (such as adolescents, women of prime childbearing age, and women in later childbearing years). Or, depending on the priorities of public and private sector decision makers, it could entail a more complex division based on a variety of demographic, socioeconomic, behavioral, and attitudinal characteristics (for example, urban poor, high-risk youth, or women's status).

[2] In general, the "market" for selected goods and services refers to current and potential consumers for those goods and services. The operationalization of this concept varies across studies. Each of the case studies in this paper specifies how analysts operationalized the family planning market.

Market segments typically have very different socioeconomic, demographic, behavioral, and attitudinal profiles, and these differences provide the basis for strategic thinking about increasing the efficiency of resource allocations and program effectiveness. In particular, market segmentation analysis draws attention to the following considerations:[3]

- *Different needs*. Some segments have a greater need for resources because of their size or because they are more often and more severely affected by a problem. Both the public and private sectors, for example, may achieve greater family planning use per level of expenditure by allocating resources disproportionately in favor of areas where unwanted pregnancy or maternal morbidity is especially high.

- *Different abilities to pay*. Some segments have a greater ability to pay for reproductive health services than others. In many instances, the public sector could make more efficient use of its resources by encouraging better-off clients to use the private sector.

- *Different responsiveness*. Some segments may more readily respond to a given program intervention than others. Thus, reproductive health providers may achieve greater resource efficiency by targeting interventions to more responsive segments, such as those who intend to use a method in the future, rather than on the general population.

- *Different accessibility*. Some segments are more costly to reach than others because of their relative inaccessibility. The commercial sector, for example, may generate more revenue per unit cost by allocating resources primarily to urban and easily accessible rural markets than remote areas.

While market segmentation analysis emphasizes group differences in reproductive health needs, ability to pay, responsiveness to intervention, and accessibility, the analysis is not prescriptive about how the public and private sectors should work together to address these differences. Rather, the analysis is merely one part of the policy process designed to strengthen public/private partnerships. Its main role is to serve as a common source of information that can stimulate and guide public/private dialogue about opportunities for collaboration in the financing of reproductive health goods and services.

When skillfully embedded in the policy process, market segmentation analysis can help public, not-for-profit, and for-profit decision makers coordinate their efforts and use resources more efficiently based on their different, but often complementary, objectives in the provision of goods and services. Commercial organizations generally seek to maximize profits. Thus, market segments that are especially appealing to commercial sector interests are those with the potential to maximize revenue (high levels of need, responsiveness, and ability to pay) and minimize costs (easy accessibility).

By contrast, nonprofit organizations typically aim to maximize equitable access to health care within the constraints imposed by the need to remain sustainable. As a result, many of these organizations may place greater emphasis on a segment's level of need in order to meet equity objectives, and place only enough emphasis on a segment's responsiveness, ability to pay, and accessibility to maintain sustainability.

[3] Adapted from Andreasen (1995) and Weinstein (1994).

Like nonprofit organizations, the public sector generally seeks to maximize equity. In contrast to nonprofits, however, the public sector does not depend on client payments for survival. As a result, the public sector is in a better position than either the not-for-profit or the for-profit sectors to focus on those population segments with high service needs and low accessibility, regardless of segment responsiveness or ability to pay.

In addition, the public sector can use these different objectives to its advantage to ensure universal access to quality reproductive health services with limited public resources. By encouraging the use of the private sector among public sector clients who have financial and physical access to private sources, for example, the public sector succeeds in (1) promoting private sector expansion, (2) maintaining access to reproductive health services, and (3) making more public resources available to improve or expand services for the most vulnerable population groups.

Market Segmentation Analysis in Practice

This section reviews the experiences of Turkey, India, Morocco, and Brazil—countries that have used market segmentation analysis to think strategically about public and private sector roles in the market. In particular, the section highlights how decision makers used information about the different needs, abilities, responsiveness, and accessibility of various population groups to reorient resource allocation decisions.

Turkey

In 1994, USAID entered into an agreement with the government of Turkey to phase out all donated contraceptives by the year 2000. During the following year, as it became increasingly clear that the General Directorate of Maternal and Child Health and Family Planning (MCH/FP) would not be able to secure a budget increase to compensate for the loss in donated products, the directorate began to consider restricting free services to priority groups. Some MCH/FP staff viewed this proposal as a solution to growing financial constraints, while other staff firmly believed that the government was both ethically and legally obligated to provide free services to all who requested them.

MCH/FP leadership explored the issue by holding a series of workshops in 1995 and 1996 and by conducting a market segmentation analysis with technical assistance from USAID's OPTIONS II and POLICY projects. The goal of the analysis was to generate dialogue within the directorate and across public, nongovernmental organization (NGO), and commercial service sectors about the following:

1. The extent to which the current family planning market was "well-segmented"; that is, whether source use and method use among different groups were consistent with an efficient use of available public and private resources.

2. Whether the current market structure—the source mix and method mix—could be improved to optimize the use of public and private sector resources.

3. Whether the current market structure was consistent with national family planning goals and needs (Cakir and Sine, 1997).

Using data from the 1993 Turkey Demographic and Health Survey (DHS) and the 1987 Household Income and Expenditures Survey, the market segmentation analysis uncovered seven distinct market segments (see Figure 1).[4] The analysis also indicated that the segments varied substantially in their reproductive health needs and abilities to pay, which stimulated public/private dialogue about the corresponding resource allocation implications.

Figure 1. Market Segments: Turkey 1993

Segment	Market Share	Description
High Risk*–Older Poor	5.4%	High unmet need, poor/lower income, rural, farmers/ unskilled labor, low women's status, high parity, late-30s to early-40s, limited health insurance coverage.
High Risk–Young Unskilled	11.1%	Lower middle income, rural/urban, high unmet need, low parity, early-20s, limited health insurance coverage, medium women's status, farmers/unskilled labor.
High Risk–Young Skilled	6.6%	Lower middle income, urban, high unmet need, low parity, late teens to early-20s, limited health insurance coverage, medium women's status, sales/services, and skilled labor.
High Risk–Family Building	25.3%	Lower middle income, rural/urban, medium unmet need, medium parity, mid-20s to mid-30s, limited health insurance coverage, medium women's status, farmers/unskilled labor.
Medium Risk–Older Unskilled	18.7%	Upper middle/lower middle income, rural/urban, low unmet need, late-30s to late-40s, moderate health insurance coverage, medium women's status, farmers/unskilled labor.
Medium Risk–Young Skilled	12.4%	Upper middle/lower middle income, urban, medium unmet need, mid- to late-20s, moderate health insurance coverage, medium women's status, services/sales/skilled labor.
Low Risk–Better Off	20.5%	High/upper middle income, rural/urban, low unmet need, mid-30s to early-40s, high health insurance coverage, high women's status, professionals/service/clerical labor.

* For purposes of the Turkey study, "risk" refers to the estimated likelihood that women in a given segment would forgo reproductive health service if free services were no longer available. Stakeholders estimated these risk levels based on the characteristics of each segment.

The analysis revealed four market segments at "high risk" of losing needed reproductive health services if access to free services were no longer available (as indicated by low socioeconomic status and limited health insurance coverage). Each of these segments also had relatively high levels of unmet need. Taken together, the four high-risk segments make up almost one-half of the family planning market, suggesting that a greater concentration of public

[4] The analysts defined the "market" in Turkey as current users of modern contraceptive methods, women with an unmet need for family planning, women with unwanted pregnancies, and women who became pregnant because of method failure.

(and possibly NGO) resources for these segments could have a significant impact on family planning use.

Two findings suggested opportunities for the public sector to allocate resources more efficiently. First, the data showed that *insured* women in the wealthiest segment (Low Risk–Better Off) and *uninsured* women in the poorest segment (High Risk–Poor) used public sector services for supply methods in nearly identical proportions. Second, the analysis found that fully two-thirds of insured members of the Low Risk–Better Off segment relied on the public sector for their method. These findings prompted MCH/FP staff to question whether, given the directorate's growing resource constraints, it made strategic sense to provide free services to better-off clients with health insurance coverage that includes family planning.

To stimulate intersectoral dialogue about reproductive health finance issues, USAID sponsored a Public/Private Partnership Workshop in 1996. The workshop included representatives of both the public and private sectors: senior MCH/FP staff, NGO members, pharmaceutical distributors, and private sector physicians. After reviewing the results of the market segmentation analysis, participants generally agreed that each sector could increase resource efficiency by improving the targeting of its resources. The question of whether free public services should be targeted to selected population groups, however, unleashed a series of heated debates between representatives of the private and public sector and within the Ministry of Health (MOH) itself. To help resolve this issue, a group of workshop participants formed a working group, which, after intensive discussions, identified a specific set of socio-demographic and economic characteristics that it believed described those people most in need of free services. A senior MCH/FP official in the working group presented the results in the plenary session, an event that marked the first time the MOH openly specified what it considered to be priority groups for free public services.

Building on the momentum generated by the workshop, an advisory committee comprising primarily members of the General Directorate of MCH/FP consulted with the directorates of Primary Heath Care and Curative Medicine and developed and endorsed a targeting strategy, labeled the Insurance/Ability to Pay Model. According to the strategy, anyone who is a beneficiary of social health insurance is entitled to free service; however, the cost of the contraceptive methods themselves must be reimbursed by the social health insurance organization. The extent to which uninsured clients receive free services would depend on the consumer's income or "ability to pay." The poor and near-poor would receive free services and products, while all other uninsured clients would be requested to make a recommended donation for the service. Turkey is currently building broader institutional support for the Insurance/Ability to Pay Model and developing plans for its implementation.

India

In 1992, the government of India and USAID signed a 10-year, $325 million bilateral agreement to expand dramatically the demand for and use of contraception in the impoverished state of Uttar Pradesh. The agreement, called the Innovations in Family Planning Services (IFPS) Project, placed special emphasis on increasing the use of contraceptive methods to space pregnancies. The project allocated $42 million for an unspecified social marketing program. However, differences between USAID and the Indian government about how to manage this program significantly slowed its implementation.

Based on a 1997 project assessment recommendation, USAID requested that the POLICY Project conduct a series of market studies, including a market segmentation analysis. The purpose of the market segmentation study was to highlight opportunities to expand subsidized sales of oral contraceptives and condoms to complement the distribution of both free and fully commercial products. The assessment team specified that the analysis should focus on the following question: "What are the relative roles of free distribution, subsidized sales, and commercial marketing in serving clients with different income levels in the most cost-effective way?" (Sewell et al., 1997:54).

Using data from the 1992-93 National Family Health Survey and the 1995 PERFORM Survey, the market segmentation analysis was conducted in two stages. The first stage divided the family planning market into numerous segments and subsegments based on different types of contraceptive use, nonuse, and future intentions (The Futures Group International, 1998).[5] The second stage focused on those segments most likely to respond to social marketing efforts: current condom and pill users (users) and women intending to use condoms or pills in the future (intenders). Differences among these segments in terms of their needs and abilities to pay helped decision makers reach consensus about where to target the social marketing initiative.

Results showed that in rural areas roughly 1.6 million women reported that they intended to use oral contraceptives in the future, a figure that was more than five times the number of current rural pill users (see Figure 2). Furthermore, the majority of both current pill users and pill "intenders" came from the poorest socioeconomic segments in the rural sector, suggesting a limited ability to pay for the method. Thus, the analysis suggested a large potential market for free or low-priced (subsidized) oral contraceptives in rural Uttar Pradesh.

In urban areas, the number of pill intenders was also larger than the number of pill users (see Figure 3), and most pill intenders planned to use the private sector as their source, regardless of their socioeconomic class. This finding suggested that the need for subsidized pills was not as acute in the urban sector as the rural sector, thus pointing to opportunities for commercial sector expansion to meet the needs of urban pill intenders.

The analysis revealed little potential for further growth of the urban market (as indicated by high levels of current use and low levels of intended use in the future). By contrast, the low levels of both current and intended condom use in rural areas suggested a role for demand-generation activities in rural areas. As with the pill, socioeconomic information indicated that rural marketing efforts would need to support low-priced condom brands.

[5] The analysts defined the "market" in India as current users of modern contraceptive methods, women with an unmet need for family planning, women with unwanted pregnancies, women who became pregnant because of method failure, and women who intended to use family planning in the future.

Figure 2. Use and Intended Use of Spacing Methods in Rural Uttar Pradesh, 1995

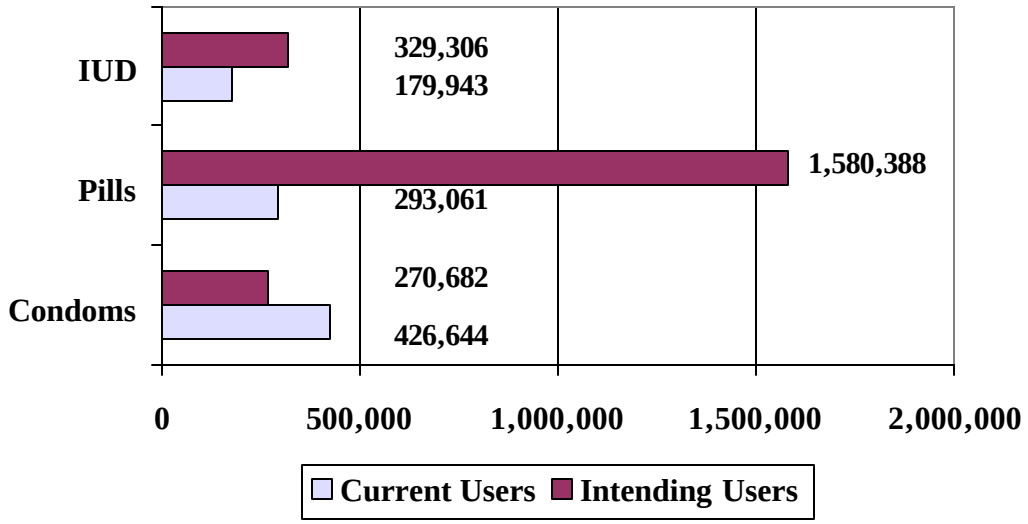
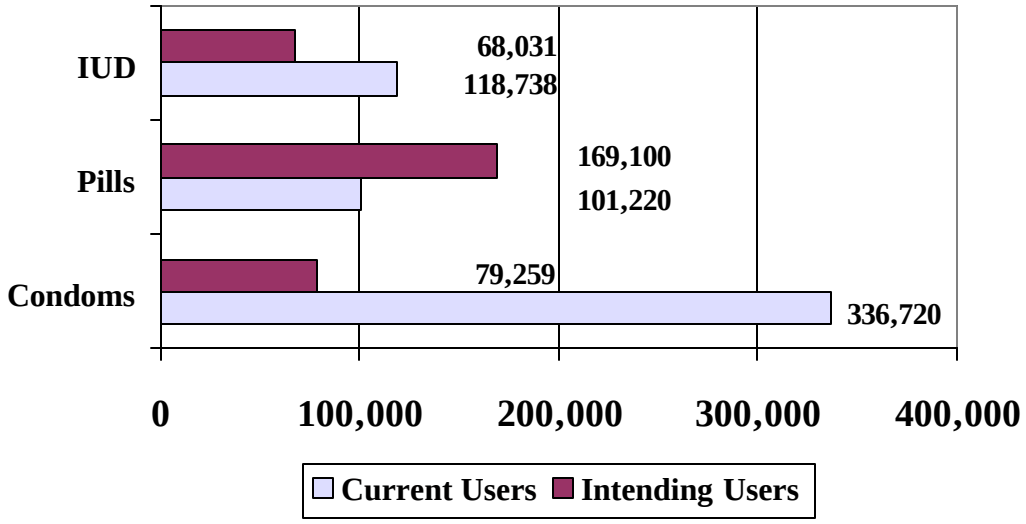


Figure 3. Use and Intended Use of Spacing Methods in Urban Uttar Pradesh, 1995



Upon completion of the market segmentation analysis and associated studies, USAID and the State Innovations in Family Planning Services Agency (SIFPSA)[6] convened a team to develop a market action plan that would incorporate results from the analyses and lay out a marketing strategy for condoms and pills in rural and urban areas. Elements of the plan's strategy that draw directly on the results of the market segmentation analysis include the following:

- Promote subsidized pill brands in the rural sector, particularly the market-leading government brand;
- Focus on market-building activities for condoms in the rural sector; and
- Explore the possibility of investing resources in a pilot project with commercial firms to service rural areas with low-priced, commercially sustainable products.

The market action plan proposed to channel the majority of funding through SIFPSA; in turn, SIFPSA, in collaboration with USAID, would design and manage specific social marketing programs. The Indian government and USAID approved the marketing action plan in 1998. Thus, for the first time in USAID's history in India, it was able to reach a formal agreement with the government on a major contraceptive social marketing effort. In 1999, SIFPSA initiated a procurement process to implement the statewide program. The competitive bid was awarded to Hindustan Latex Limited (HLL) to market oral contraceptives and condoms in rural Uttar Pradesh. SIFPSA's Project Appraisal Committee and Governing Body approved the final agreement with HLL in early 2000. Implementation of the $3.5 million contract began in April 2000.

Morocco

In the mid-1990s, USAID decided to phase out contraceptive donations to the government of Morocco by 2000. To ensure the sustainability of family planning services, USAID proposed a new strategy of cooperation that emphasized greater private sector participation. In an effort to address public sector concerns that private sector expansion might supplant needed public sector services, USAID requested that the POLICY Project conduct a market segmentation analysis in 1998. The two main objectives of the analysis were to (1) promote dialogue between the public and private sectors about how to most effectively coordinate their efforts and (2) identify public and private sector market opportunities that would support the goal of sustainability.

Using data from the 1992 DHS and 1995 DHS Panel Survey on Population and Health, the market segmentation analysis divided the family planning market into five distinct groups (Cakir, 1998).[7] Figure 4 summarizes the defining characteristics of these segments. The results highlighted opportunities for public and private sector coordination based on the different accessibility and needs of different segments.

[6] SIFSPA is an autonomous body constituted by the government of India, the government of Uttar Pradesh, and USAID, to implement the USAID-funded IFPS Project in Uttar Pradesh.

[7] Note that the "market" in this analysis refers to current users of modern contraceptive methods, women with an unmet need for family planning, women with unwanted pregnancies, and women who became pregnant because of method failure.

Figure 4. Market Segments: Morocco 1995

Segment	Market Share	Description
Older City Dwellers	18%	Older, urban, affluent, many are educated, medium parity, limiters, family planning users.
Young City Dwellers	20%	Young, urban, middle-class, more than one-half are educated, low parity, spacers, family planning users.
Older Working Class	34%	Older, rural and urban, working class, few are educated, high parity, limiters, family planning users.
Poor	18%	Around 30-years old, poor, rural, few are educated, limiters, family planning users.
Traditionalists	10%	All ages, rural, poor, all regions, few are educated, high parity, nonusers of family planning, most prefer to limit.

The analysis found a substantial mismatch between older women's family planning intentions and method use. Specifically, while the majority of Older City Dwellers and Older Working Class women wanted no more children, fewer than 20 percent in either segment used a long-term method (female sterilization or IUD). This finding, combined with the medium to high socioeconomic status and size of these two market segments, suggested an opportunity for the private sector to play a greater role in the provision of long-term methods in Morocco.

The Traditionalists segment, representing approximately 225,000 couples, was composed entirely of women with an unmet need for family planning. Traditionalists are poor and rural for the most part, and 72 percent wanted no more children. The finding indicates a clear need for public sector expansion in rural areas, as this sector is difficult for the private sector to adequately reach without compromising profits or sustainability.

The MOH presented the results of the market segmentation analysis at a 1998 workshop, entitled "Strategies to Consolidate RH Programs: The FP Element," which included participants from the public sector, private commercial sector, and voluntary agencies. Results helped participants reach consensus on the need to diversify the method mix to make long-term methods more widely available. Moreover, the public sector stated the importance of supporting the private sector, particularly in urban areas, in order to increase access to long-term methods. Participants agreed that the national FP/RH objectives would be to increase the share of long-term methods and injectables in the method mix and to balance the public/private mix to 50/50 by 2005. As a result of the analysis, the MOH also requested an assessment of unmet need in rural areas to explore the need for public sector expansion there.

Brazil

Brazil is often referred to as a "two-method" country because most contraceptive users rely on either female sterilization (52% of reproductive age) or oral contraceptives (27%) (Badiani et al., 1997). Thus, when Pharmacia & Upjohn/Brazil (P&U) registered the three-

month injectable Depo-Provera in 1997, USAID welcomed the opportunity to broaden the contraceptive method mix. Preliminary discussions with P&U, however, found that the company intended to market Depo-Provera to physicians who, in turn, planned to target it primarily to breastfeeding women. By originally focusing on a relatively small and narrow segment of the market, P&U planned to charge a relatively high price (US$20) per dose. As part of an effort to persuade P&U that it could profitably market Depo-Provera to a much broader segment at a substantially lower price, USAID supported a market segmentation analysis conducted by the SOMARC III Project.

Using the 1996 Brazil DHS, the market segmentation analysis divided the market into five segments: (1) women under 30 with no children; (2) women under 30 with one child; (3) women with more than one child who wanted to space future births; (4) unsterilized women who wanted no more children; and (5) all other women of reproductive age.[8] The analysis highlighted differences in the likely responsiveness among the different segments in order to identify private sector opportunities.

To determine which of the five segments would be most likely to respond favorably to a campaign promoting Depo-Provera, the analysis examined the characteristics of current users of one-month injectables in relation to the characteristics of the five segments.[9] The analysis found that more than 75 percent of current injectable users had previously used the pill, had one or more children, and wanted to space another birth or limit childbearing. Segments 2, 3, and 4 matched these characteristics the most. Moreover, segments 2, 3, and 4 were also more likely than other segments to contain past users not only of oral contraceptives but also of the one-month injectable, indicating a relatively strong interest in hormonals. Women from these segments who matched the characteristics of one-month injectable users composed 19 percent of the entire family planning market, suggesting a potential market for injectables of 8.4 million users compared to approximately 330,000 current users (Allman, 1998; Allman et al., 1998).

Based on this analysis and supporting sales projections, USAID proposed that P&U change its marketing strategy from one that targeted a narrow market of upper-income breastfeeding women and a high price to one that focused on a broader market and a lower price. In exchange, USAID would support P&U's medical detailing efforts with a consumer marketing program and forge strategic partnerships with key groups, such as the MOH, leading medical groups, and family planning associations in Brazil. After extensive and intense negotiations, P&U agreed to introduce Depo-Provera at $10 per dose (one-half the originally planned price). Within less than one year of the new strategy's implementation, sales of Depo-Provera exceeded P&U's original sales projections by more than 30 percent (Allman, 1998).

[8] The "market" in the analysis for Brazil refers to all women in union of reproductive age (15–49).

[9] The injectable market, which constitutes 1.2 percent of the method mix, is dominated by Perlutan, a one-month injectable produced by Boehringer Ingelheim. Perlutan currently accounts for 76 percent of injectable unit sales in Brazil. Schering AG recently introduced Mesigyna, a premium-priced, one-month injectable that contains one-half the hormonal content of Perlutan. In the two years that it has been on the market, it has captured a 7 percent market share. Since 1993, the injectable market has grown at an average rate of 23 percent per year (Allman et al., 1998).

Conclusion

The question of who will pay for reproductive health services has become more pressing as the need for these services continues to grow in the face of limited resources. Many observers have pointed to the need for stronger public/private partnerships and private sector expansion to alleviate current resource constraints (Cross, 1993; Catino, 1999; Rosen and Conly, 1999; Hardee and Smith, 2000).

As the country examples in this paper demonstrate, market segmentation analysis can play an important role in supporting such partnerships by identifying prospects to improve resource targeting in both the public and private sectors. In all four country examples, market segmentation analysis provided timely and relevant information about the reproductive health market that stimulated meaningful public/private dialogue about reproductive health financing options and partnership opportunities. These discussions also led to specific financing actions. In Turkey, for example, the MOH developed a new model that will shift public resources away from clients who can afford to pay for reproductive health goods and services toward more vulnerable population segments. In Brazil, market segmentation analysis results helped persuade private sector decision makers to broaden the target market for Depo-Provera.

As Turkey's experience showed, there does not need to be an exact match between the segments that public and private decision makers decide to target and the segments in the analysis. Public/private discussions of market segmentation results produce their own dynamics and may lead to the creation of targeting strategies that do not directly correspond with the market segmentation analysis, but that are nevertheless appropriate.

It is also important to recognize that the different strategic objectives of the public and private sectors translate to different information needs. Fundamental pieces of information that commercial sector decision makers need to target population segments that will support profit objectives are consumer income and demand for their specific product brands. By contrast, public sector objectives to ensure quality and access require information about population needs for all reproductive health methods (as opposed to needs for specific brands), regardless of income. Thus, in order to be relevant and persuasive, market segmentation analysis needs to adequately address the concerns of each sector. The best way to ensure this is to involve both public and private sector decision makers in identifying policy and marketing questions that the market segmentation analysis can help answer.

Finally, although market segmentation analysis highlights opportunities for public and private sector decision makers to use resources more efficiently and coordinate their efforts to meet reproductive health needs, the analysis does not specify actions that either sector should take. This is the domain of policy dialogue and negotiation with support from market segmentation analysis and other sources of information.

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