Market Segmentation Research

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Acronyms

CYP	Couple Year of Protection
CSC	Contraceptive Security Subcommittee
EC	Emergency contraception
EU	European Union
FC	Female Condom
FP	Family Planning
GNI	Gross National Income
ICPD	International Conference on Population and Development
IPH	Institute for Public Health
IUD	Intra Uterine Device
LMIS	Logistic Management Information System
MICS	Multiple Indicators Cluster Survey
MC	Male Condom
MOH	Ministry of Health
NGO	Nongovernmental Organization
OCP	Oral Contraceptive Pill
PHC	Primary Health Care
RFHI	Republic Fund for Health Insurance
RH	Reproductive Health
STI	Sexually Transmitted Infection
TMA	Total Market Approach
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization

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Executive Summary

This Market Segmentation Research was conducted with the support of UNFPA being one of the recommendations of the evaluation of FP services conducted in 2013. The purpose of the research is to assist the Ministry of Health for ensuring access of the entire population to FP/RH services and contraceptives, with a special attention for vulnerable groups. The study aimed to do an assessment of the existing contraceptive market situation and use, to help defining vulnerable groups and establish a need for free contraceptive products and the initiation of the Total Market Approach in Serbia. The research was carried on by a team of international and national consultants and is bases on secondary analysis of data provided by MICS surveys and national statistics, revision of national documents and interviews with relevant stakeholders. Taking into account that the evaluation of FP services included a large field visit component carried out less than a year ago, we included in the current survey just some interviews with local authorities from Novi Sad and visiting one primary health care clinic.

Background. Serbia is one of the largest countries in the region, considered as an upper middle country, according to the World Bank that started beginning with January 2014 accession talks with the European Union. As all countries in the region, in the past years Serbia has undertaking a health reform and introduced a health insurance system that guaranties a relatively broad package of health services to the entire population, including FP. Women have to register themselves on the list of a gynecologist and can access free FP services, but currently there are contraceptive products free of charge. Primary health care has a good geographical coverage; gynecologists are employed in most primary health care clinics. FP received limited attention in the past years. The process of developing a National Reproductive Health Strategy was initiated with the support of UNFPA and is based on a participatory process currently under implementation. There are few data available in relation to FP. Total fertility rates are varying from 1.6 in the general population to 3.1 in Roma settlements and an early childbearing value of 38.3 among Roma. Contraceptive prevalence rate is low. 41.6 % of women age 15-49 years currently married or in union who are not using any method of contraception, 40% use traditional methods and only 18.4 use a modern method (12.4 use male condoms, 3.3 use pills, 2.2 use IUDs, 0.4 use female sterilization and 0.1 use female condoms) in the general population and 7.2 in Roma women. Abortion data do not capture services provided in private clinics nor medical abortion. The society is polarized from an economical perspective, the 20% richest quintile having a GNI per capita higher the than the 60% of the lowest three quintiles.

Findings. Contraceptive methods. Not all modern methods of contraception are registered in Serbia. There are several brands of pills that are registered, Serbia has its national production of pills as well, but there are effective modern methods missing from the market (injectables, implants, patches, vaginal ring). Beginning with 2015 it seems that no contraceptive methods will be included in the list of drugs subsidized by the health insurance and there are no methods distributed free of charge, with the exception of condoms, provided under the Global Funds Grant, but this programs got to its end. All modern methods, except condoms are available only in pharmacies, there are no significant differences of prices among different pharmacies. There are no social marketing programs operating in Serbia. Cost of Couple Year of Protection (CPR) might vary from 8.46 euro (copper T IUD), 14.4 euro (ROMED condom), 23.4 (Legravan, the local pill and 252 euro (DUREX condom), 189.9 euro (Angeliq pill).

Consumers. Comparing the two MICS, we concluded a decrease of all modern contraceptive prevalence rates. The Method mix of modern contraceptives did not change significantly – 13% using male condoms, 3% pills, 2% IUDs in 2013, but the proportion of women not using any method increased from 39% in 2010 to 42% in 2013. All modern methods except surgical sterilization are used less by Roma women (3% use condoms, 1% use pills and 1% use IUDs). Use of modern contraception has a linear increase with the level of education and wealth status. Use of modern methods vary by regions from 15.3 in Sumadija and Western Serbia to 22.1 in Belgrade. As such Serbia has a high unmet need for modern contraception varying from 55.5% in the poorest quintile of women of reproductive age to 36.7 in the richest quintile. Among Roma the unmet need for modern contraceptive goes up to 67.7%. Affordability of modern methods is one of the explanations for the current situation. Only the wealthiest quintile of the population has the ability to pay for all available methods of modern contraception. For the poorest 10% of the population, there are only three methods with an annual cost below 1% of the annual income, although the cost of Legravan, the pill manufactured in Serbia is near to 1%. It will be important to keep on the market the more expensive brands of methods, because 40% of the population has the ability to pay for all, except the most expensive pill and the regular use of emergency contraceptives and 60% of the population has the ATP for almost all modern methods with exception of two pill brands. The most cost effective method is the IUD (calculated annual cost does not include costs related to insertion and teste required costs). Although the Ministry of Health has already defined some vulnerable groups, these should be revised in order to serve as basis for RH/FP policy development and budgeting.

Providers. Currently, FP services are provided almost exclusively by gynecologist, and there are no strategies to a larger involvement of general practitioners or family doctors in the provision of FP services. Public primary health clinics ensure a good geographic coverage, the private health service delivery sector is currently expanding.

Forecasting contraceptive use and estimating costs was not included as an objective of this survey. The process of developing strategies and policies to increase access of vulnerable population to modern FP methods should be accompanied in parallel by the development of a logistic system and a logistic management information system (LMIS) – currently they are not in place, all contraceptive products are distribute through pharmacies and there are no monitoring mechanism in place for consumption. A rough estimation of costs was done based on population criteria, using a specified set of assumptions, as an example for such calculation undertaken by the Ministry of Health.

Recommendations include the development of a comprehensive, rights based National Reproductive Health Strategy with a special component of Contraceptive Security. This strategy

should be followed by a National FP Program. A coordination Committee should establishes with a special Subcommittee for Contraceptive Security, with a formal secretariat. Vulnerable groups from the perspective of RH/FP should be clearly defined by the Ministry of Health through a participatory process to serve as a basis for quantifying budgets needed and subsequent subsidy strategies. The MoH should initiate the development of facilitation encouraging the private commercial sector by developing a Total Market Approach. Increase of modern contraceptive use should be ensured by increasing access to services as well as intensive health promotion efforts. NGOs should be supported to participate in the entire process, from their active involvement in the development of the National RH Strategy, defining vulnerable groups, developing the National FP program and its implementation and monitoring

Introduction

The goal of Governments in developing and implementing a Reproductive Health (RH) Strategy and Family Planning (FP) Programme is to increase access to contraceptive services in order to better serve women who want to delay or stop childbearing. Doing so, unintended pregnancy will be reduced, women and couples will be helped to attain their desired family size and better time their pregnancies, thus preventing deaths and disabilities related to pregnancy. In addition to these short-term health benefits, increased prevention of unintended pregnancies would have broader, longer-term benefits for women, families and society, ranging from increased education for women and better child health to greater family savings and stronger national economies.

Other priorities in health and frequent political changes in recent years resulted in little attention given to family planning. As result, since 2006 no health surveys and analysis based on statistical analysis were performed with a significant focus on family planning. The most updated data have been collected by the Multiple Cluster Surveys (MICS), performed in 2010 and 2014 by the Statistical Office of the Republic of Serbia in the general population as well as in Roma Settlements and the National Health surveys Serbia 2006 and 2013.

UNFPA supports the Serbian Government in its efforts to ensure sexual and reproductive rights of all citizens, their access to quality RH services and products. One important aspect if this support is the assistance provided to develop a structured framework for further policy and program implementation. Changes in the Government, followed by subsequent changes in the Ministry of Health, delayed this process and a National Reproductive Health/Family Planning strategy has only been initiated, not being yet finalized. FP was included in the latest Health protection plan in Serbia for 2013, a strategic and operational creating a basis for the operation of the Health Insurance Fund, but only with the non-ambitious objective of ensuring that 20% of the female population (aged 15 to 49) will be reached by one "preventative medical exam in relation to family planning". For other areas of FP, only non-quantifiable objectives were set: the need for a more intensified counseling and education work and reach to prevent unnecessary abortions, secondary infertility and Sexually Transmitted Infections.

In November 2013, UNFPA supported the process of assessing FP services in Serbia. The assessment aimed to review quality of care provided by the reproductive health/family planning services at primary care level, review family planning clinical guidelines, protocols and other related documents; rapid; assess the availability of reproductive health/family planning training for health care provider; assess the liaison between programs and quality of care; and assess the

existence of IEC/BCC products and activities. The Final report mentions poorly developed family planning services and widespread prejudices regarding the use of modern contraceptives, both among medical practitioners and the general population in Serbia. It is important to underline that UNFPA provides support for the implementation of these recommendations by assisting the development of the National Programme on Family Planning in Serbia. This comprehensive process has already been initiated and includes support for conducting a situation analysis regarding reproductive health in Serbia, including relevant information on FP, Maternal Health, HIV/ AIDS, STIs etc.; drafting an outline for the National Programmme on Family Planning; conducting a national consultative process and coordination of the Working Group for trainings on FP. During this process, UNFPA Country Office works in a close collaboration with the Ministry of Health / Institute of Public Health "Batut". Another step in supporting the implementation of Evaluation Report is the current market segmentation analysis aimed to ensure access of all categories of population to affordable and effective modern contraceptives, one important pillar of the future RH/FP National Strategy and a subsequent Plan of Action.

The main purpose of this Market Segmentation Research is to identify the most vulnerable groups within the population in order assist the Ministry of Health to provide comprehensive reproductive services including modern contraceptives to those most in need. For increasing the health system performance, five components were recommended: 1) vulnerability, 2) consumption, 3) access and psycho-social determinants of consumption, including willingness to pay, 4) equity-based measures, and 5) source of supply preference.
The objectives of the assignment were to:

- Provide an accurate assessment of the existing market situation in Serbia in regards to contraceptives availability and use;
- Identify the criteria for vulnerable groups' definition so that the public sector is positioned to provide comprehensive reproductive services including modern contraceptives to those most in need;
- Provide a rationale for the Serbian government to consider providing free of charge FP services & products only to the most vulnerable groups in the society;
- Provide a plan of action for engaging all stakeholders for a continuous and uninterrupted supply of commodities;
- Provide a plan of action for implementation of total market approach (TMA);
- Provide specific recommendations for all key players (public sector, commercial sector, social marketing, NGO-s) in implementing the TMA.

As result of findings, recommendations were required regarding program management, data management, quality assurance and quality improvement, evaluation, partnerships, and professional development.

We used for the purpose of this research the following definitions:

Contraceptive Security - A guaranteed long term supply of quality contraceptives for every person who wants them, in accordance with the ICPD goal of universal access to reproductive health services.

Total Market Approach - The total market approach looks at what the public sector, commercial suppliers (for-profit) and non-governmental (not-for-profit) organizations can do to

ensure a reliable supply of reproductive health commodities. It takes into account that not all population groups are able or willing to pay the full market price for such commodities, and foresees subsidies or free supplies for those who cannot afford them. This helps ensuring that the entire population has access to a wider range of affordable quality contraceptives, including marginalized or otherwise under-served groups – UNFPA definition

Family Planning Market - The market for FP includes contraceptive methods, consumers, and providers. Contraceptive methods include both modern and traditional methods. Consumers are defined as women of reproductive age (15-44 years), including those using a modern contraceptive method and those with an unmet need for family planning. Providers are defined as government and private for-profit (commercial sector) and not-for-profit (NGO) entities. The way in which the various components of the FP market fit together is referred to as the FP market structure[1].

Background

Serbia is a large country from the Balkans, with a population of 7,209,764 inhabitants, 1,135,000 living in Belgrade, the capital city and 44.34% living in rural areas[2]. According to the World Bank[3], Serbia is an upper middle country with Gross National Income (GNI) per capita varied from 5600 in 2010, to 5350 in 2012 and to 5730 in 2013. In December 2009 Serbia submitted an application to join the EU, accession talks began in January 2014.

Health care system in Serbia has gone through numerous and continuous changes and reform processes throughout last couple of decades. Public health insurance system, with the Health Insurance Fund at the national level as a key health services purchaser in public health sector, has been in place since 1960s. The health system in structured on three levels, with primary, secondary and tertiary care units. Most primary care centers provide services such as general medicine, pediatrics, obstetrics, gynecology, preventative care and laboratory services in an outpatient setting, but larger clinics may also offer specialty services and public health surveillance. Smaller primary health stations offer services further out into communities in addition to the larger care centers. A wide coverage of primary health care clinics exists around the country.

In the Republic of Serbia, health care is provided both through state and private sectors. The Law on Health Insurance of the Republic of Serbia governs compulsory and voluntary health insurance. The Republic Fund for Health Insurance (RFHI) is in charge of managing and providing the compulsory health insurance while voluntary insurance may be provided by the means of private insurance. Serbia's allocation for health from GDP is above the average of the European Union - 10.4% (9.88% in 2010). Still, in absolute terms Serbia allocates a small amount of funds for health. Social contribution funds represent 69% of the income of the Fund for Health Insurance, while budget transfers from the Ministry of Health make 1.5%. Salaries for employees had the largest percentage in the expense structure - 48%, costs of health care services (energy generating products, vaccines, medications, supplies) –32%, prescription drugs – 13%, sickness benefits and travel costs –2% etc.

[1] Source: Market Segmentation Fact Sheet RH Supplies Coalition
[2] According to http://www.infoplease.com/country/serbia.html, last consulted on October 29th, 2014.
[3] http://data.worldbank.org/country/serbia, last consulted on October 20th, 2014

According to the latest Serbian Population Health Survey Report, conducted by the IPH of Serbia in 2013[4], average out-of-pocket spending for health per capita in Serbia was 31.255 Serbian dinars and approximately the same amount was the spending per capita from the RHFI[5].

One of surveyed areas within the Serbian Population Health Survey was the unmet health care needs as a measure of an access to health care[6]. Every fourth citizen of Serbia (24,8%) stated the lack of financial resources was a key constraint for utilizing health care services. Significantly more women (33,1%) than men reported their unmet health care needs. Also, 18% of population reported their unmet medical care needs due to financial barriers, which is significantly higher compared to European countries and more than eight times higher than average for EU.

Primary health care is provided by 161 primary health care institutions and health infirmaries. Secondary and tertiary health care is available in 42 general hospitals, 15 specialized clinics, 23 independent institutions and clinics, 5 health centers and clinics, 4 clinical centers and 59 other health institutions[7].

Private health sector is developed but not incorporated in the national health system of health insurance. An employee is entitled to health insurance based on temporary or permanent employment; also, retired persons are entitled to health insurance based on the contributions paid during working life. Health insurance is free of charge for unemployed persons registered at the National Employment Service. Beside unemployed persons, the Government covers insurance costs as well for groups not earning any money: retired people, children, persons with disabilities, unemployed persons etc.

The HIF guarantees access to a relatively broad package of health services to the entire population. Scope and content of care are legally defined and include preventive, curative, rehabilitative, inpatient and outpatient specialist care, and primary care including prescription drugs, home care and medical transport. Despite the initial strong emphasis on primary care, the system evolved such that curative services were largely carried out by specialists and in the hospitals.

Access to FP services is included in the primary health care package. Women have to register themselves on the list of a gynecologist and can access free FP services. Some contraceptive pills were included in the list of drugs covered by the health insurance, but it seems that it will no longer be the case in 2015.

FP received limited attention in the past years. The Government does not have a strategy or a Plan of Action in this area. General justifications for not prioritizing FP is related with the opinion that services and products are easily accessible and FP is hard to include in the public agenda due to the constant negative population growth from the past years.

Data are hardly available and limit analysis as well as monitoring and evaluation.

There are significant discrepancies regarding RH related indicators related to Roma population.

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[4] Boricic K et All. Results of Serbian Population Health Survey: Year of 2013. Institute of Public Health of Serbia „Dr Milan Jovanovic Batut“, Official Gazette, Belgrade, 2014, pg. 68

[5] Republic Fund for Health Insurance. Financial Report of the RFHI for 2013. Belgrade, April 2014. Available at http://www.rfzo.rs/download/FINANSIJSKI%20IZVESTAJ%20ZA%202013.pdf

[6] Boricic K et All. Results of Serbian Population Health Survey: Year of 2013. Institute of Public Health of Serbia „Dr Milan Jovanovic Batut“, Official Gazette, Belgrade, 2014, pg. 65-66

[7] HEALTH INSURANCE SYSTEM IN SERBIA - QUALITY, REFORM, FINANCIAL SUSTAINABILITY, Ana Gavrilović and Snežana Trmčić, http://mest.meste.org/MEST_Najava/II_gavrilovic.pdf

Total fertility rate, as showed by the last MICS preliminary results (2014)[8] is of 1,6 in the general population and 3.1 in Roma settlements. Early childbearing registers a value of 1.4 in the general population but of 38.3 in Roma settlements.

Modern contraceptive prevalence rate is very low. 41.6 % of women age 15-49 years currently married or in union who are not using any method of contraception, 40% use traditional methods and only 18.4 use a modern method (12.4 use male condoms, 3.3 use pills, 2.2 use IUDs, 0.4 use female sterilization and 0.1 use female condoms). For modern methods, women from Roma settlements register even lower prevalence rates – 7.2 for all modern methods with lower rates for all modern methods except female sterilization (male condoms – 2.8; female sterilization – 1.8; pills – 1.2 and IUDs – 1.2

Abortions are not registered and reported regularly by the private clinics; therefore official statistics are not providing full overview. The preliminary findings of MICS 5 show a lifetime experience with abortion of 14.6 in the general population and of 30.6 in Roma settlements.

The society is polarized from the perspective of economic status. The 20% richest quintile has a GNI per capital higher than the 60% of the lowest three quintiles.

Methodology

This survey follows at a short time after a comprehensive FP assessment conducted in late 2013, supported by UNFPA. The assessment included focus group discussion with providers and clients, field visits, including in pharmacies. A detailed report was developed by Dr. Mihai Horga, international consultant and Hajrija Mujović-Zornic, PhD from the National Institute of Social Sciences, Belgrade. As result, for the purpose of our study we haven't repeated the field work conducted by them. We interviewed decision makers from most relevant stakeholders, state institutions and NGOs and conducted secondary analysis whenever we have been able to access data. As mentioned, our work was significantly influenced by the lack of strategic and programmatic documents as well as of data.

The methodology used included:

- Review of policy documents, reports and analysis of data – see titles listed under Reference materials – Annex 1
- Meetings with key stakeholders: policy makers, managers, providers, NGOs, clients especially from vulnerable groups, professionals working with vulnerable groups – see Agenda of field visit – Annex 2
- Site visits in Indija and Novi Sad

Findings

The Total Market Approach could respond to the multiple family planning needs in Serbia, by ensuring that all the market of clients–from those who require free services and

[8] Serbia MULTIPLE INDICATOR CLUSTER SURVEY 2014, Serbia Roma Settlements MULTIPLE INDICATOR CLUSTER SURVEY 2014 Key Findings /July 2014/

supplies to those who can and will pay for their services and products –is covered. In an environment constantly confronted with limited public resources it is important to avoid overlapping efforts and inefficient use of resources.

FP market structure

The FP market structure includes contraceptive methods, consumers and providers.

Contraceptive methods

Contraceptive methods include both modern and traditional methods.

Modern contraceptive methods

In Serbia there are a significant number of modern contraceptives registered, although they are not covering the entire spectrum of available modern methods.

Table 1 Modern contraceptive methods registered in Serbia

Type of method	**Brand**
Combined oral contraceptives	Legravan, Angeliq, Jeanine, Lindynette, Midiana, Microgynon, Novinette, Qlaira, Yasmin, Yazz, Diane 35
Progestagen only pills	Not registered
Injectable contraceptives	Not registered
Non medicated IUDs	Mona Liza (Cu) 350
Hormonal Intrauterin Systems	Mirena
Implants	Not registered
Contraceptive patch	Not registered
Medicated vaginal ring	Not registered
Spermicides	Pharmatex vag tbl
Emergency Contraceptives	Escapelle, Postinor
Condoms	Durex, Romed

As seen from the above table, in the absence of a TMA, pharmaceutical companies prefer to register products with high margins of profit, dropping from lists products that are of low costs.

Modern contraceptive methods are available from one source: from pharmacies, without subsidized prices with the exception of condoms that are available for free in the projects under the Global Fund, but programs have ended and there are no future perspectives for new grants. No free of charge contraceptives are available for any population group (as mentioned, with the exception of condoms) and no social marketing program operates in Serbia. Data in this an analysis are based only on available MICS surveys, data from private sales could not be collected.

Prices of products are not differing with more than +/- 2 or 3%. We found the following values for contraceptives in pharmacies:

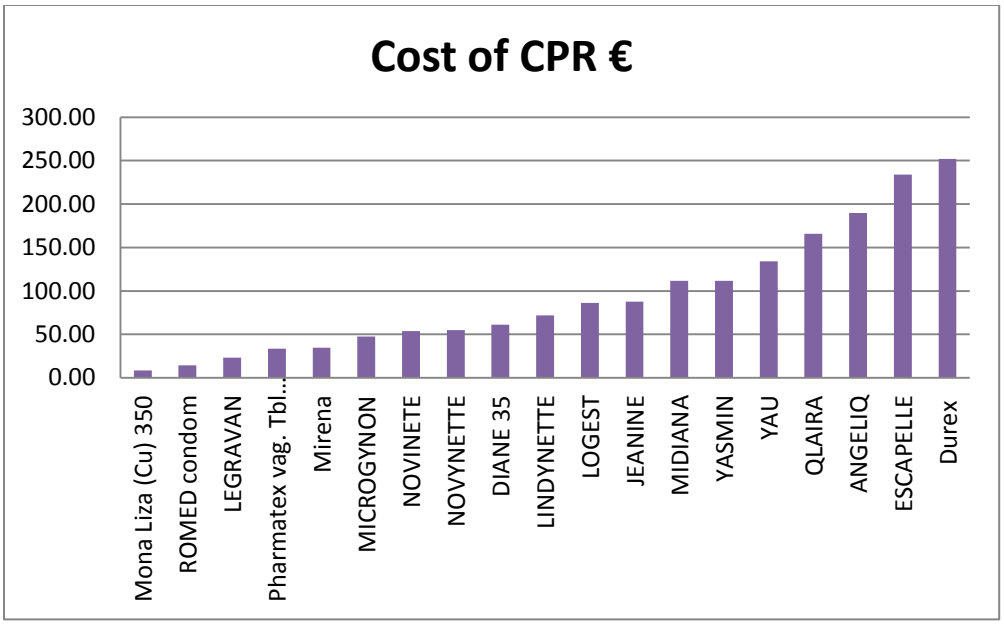
Table 2 Costs of modern contraceptive methods and CPR

Product	Unit Price RSD	Unit Price Euro	Cost of CPR - RSD	Cost of CPR Euro
Pills				
DIANE 35	487,50	4,09	7312.5	61.35
LEGRAVAN	185,79	1,56	2786.85	23.4
ANGELIQ	1507,11	12,66	22606.65	189.9
JEANINE	694,97	5,84	10424.55	87.6
LINDYNETTE	571,15	4,79	8567.25	71.85
LOGEST	685,11	5,75	10276.65	86.25
MIDIANA	887,54	7,45	13313.1	111.75
MICROGYNON	377,25	3,17	5658.75	47.55
NOVYNETTE	434,90	3,65	6523.5	54.75
QLAIRA	1315,16	11,05	19727.4	165.75
YASMIN	887,54	7,45	13313.1	111.75
YAU	1065,19	8,95	15977.85	134.25
NOVINETE	427	3,58	6405	53.7
IUD				
Mona Liza (Cu) 350	3525	29,62	1007.14	8.46
Mirena	14490	121.56	4140	34.73
Condoms				
ROMED	15	0,12	1800	14.4
Durex 3 pc (classic, extra, safe…)	250	2,10	10000	252
Spermicides				
Pharmatex vag. Tbl (12)	400,77	3,36	4007.7	33.6
Emergency contraception				
ESCAPELLE	1392,16	11,69	27843.2	233.8

For calculating the annual cost of using a method the standard consumption units were utilized[9]. CYP factors used for the analysis were 120 condoms per year, 15 cycles of pills, 3.5 years per IUD, and for emergency contraceptive pills 20 doses per CYP.

Figure 1. Cost of CPR in EURO

[9] MEASURE Evaluation PRH. Family Planning and Reproductive Health Indicators Database. Couple-years of protection (CYP). http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp/cyp accessed 11.11.2014



. The market has various products, with a large variation of prices.

Injectables

No injectables are currently on the market. Companies are not interested to register or re- register products with very small profit margins in a very small market determined by the extremely low modern contraceptive prevalence rate. Still, there are mechanisms in place that would allow importing them with a special waver from the Agency for Registration of Drugs, if the Ministry of Health, in consultation with other stakeholders, would consider that their high effectiveness, low cost and easiness to use make them useful for certain categories of consumers.

Implants

Implants are not registered. Registration fees for a new product determine the lack of interest of producers to register their products in a very small market.

Emergency contraception

Emergency contraceptive pills (EC) are accessible only in pharmacies, the registered product is over the counter, not needing a prescription for buying it. Regulations are not very clear regarding adolescents access to emergency contraceptives, current practices are hard to evaluate. Providers have negative attitudes regarding the OTC status of emergency contraceptives and would like to see them distributed only on prescriptions issued by gynecologists.

IUDs

IUDs are registered as “other medical products” except the Mirena IUD produced

by Bayern that has a hormonal content and registered as a "drug". IUDs by law have to be inserted only by gynecologists. We couldn't gather data related to sales of Copper IUDs. Bayer, the manufacturer of Mirena has a high interest in promoting the product and has applied for its 50% reimbursement by the health insurance. As other modern contraceptives, prevalence of use decreased compared with 2010. A new intrauterine system is prepared to be launched on the market in the next future. Having a smaller size, the producer recommends its use primarily at nulliparous women. Insertion of IUD faces barriers of providers, who are requesting several investigations prior to inserting an IUD, some investigation not being covered by the health insurance are raising the overall cost of the method. Although on a medium and long term copper IUDs are the most cost effective methods, the fact that women have to cover the entire cost in the moment of insertion might discourage the use of this method.

Condoms

Condoms are the modern method with the highest prevalence rate among all categories of users, except women with more than four children who prefer IUDs. They are as well the only method that has been distributed for free during the implementation of the Global Fund projects. They are widely accessible, in pharmacies as well as in general store, petrol stations etc.

Surgical sterilization

Surgical sterilization is accessible only in hospitals. There are no information regarding vasectomy. Concerning surgical sterilization for women, although not documented, general opinions are mentioning that most often it is performed during caesarian operations, often as result of a "medical indication", taken into consideration that the legislation is not clear about performing at request. There are no data concerning this method, except those collected by the MICS surveys.

Traditional methods

Traditional methods are the most predominant contraceptive methods used in Serbia. It is important to mention that even traditional methods are increasing prevalence by educational and economic status.

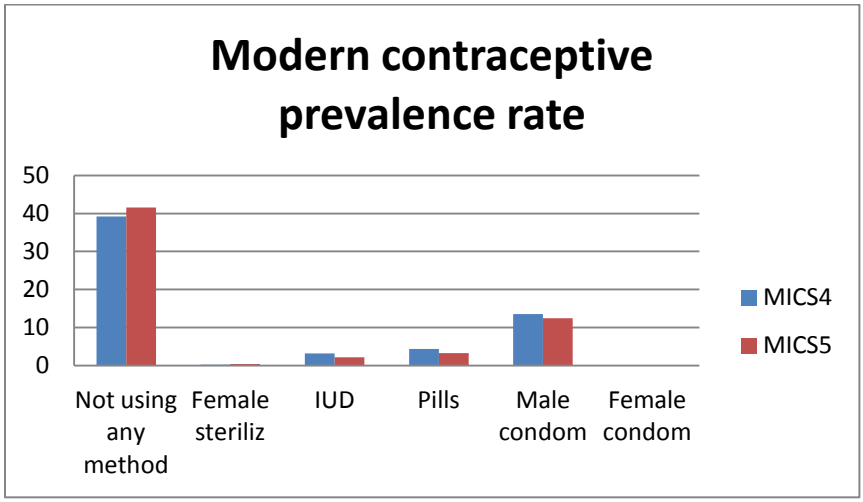
Consumers

Consumers are defined as women of reproductive age (15 to 44 years), including those using a modern contraceptive method and those with an unmet need for family planning. Before having access to detailed data from MICS 5 we could not perform a trend analysis for the past years.

From the preliminary findings of MICS 5 we can conclude that compared with MICS4,

MICS 5 shows that contraceptive prevalence rate of all modern methods decreased.

Figure 2. Modern contraceptive prevalence rate



Modern methods mix did not encounter any significant change between 2010 and 2013, with the exception of the fact that the percentage of women not using any method, increased, as shown by the results of the MICS surveys

Figure 3. Use of contraception, percentage of women aged 15 to 49 years, 2010

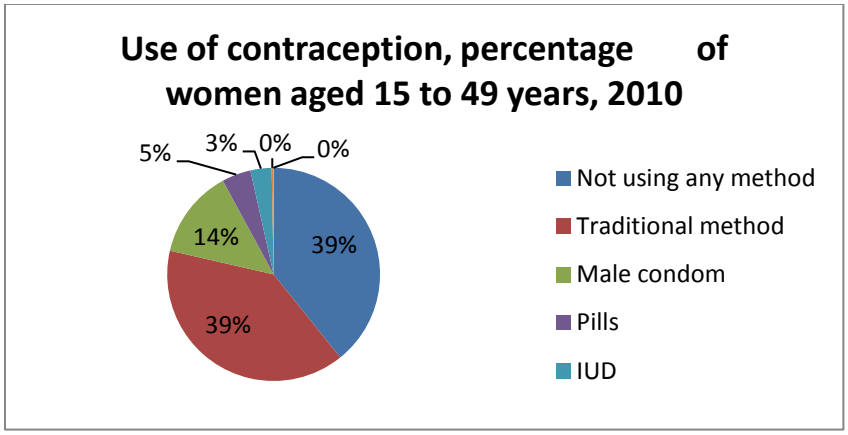


Figure 4. Use of contraception, percentage of women aged 15 to 49 years, 2013

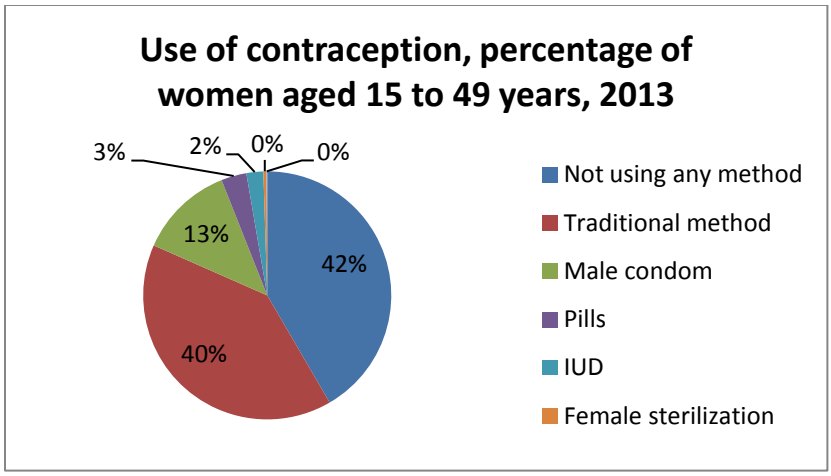


Figure 5. Use of contraception, percentage of Roma women aged 15 to 49 years, 2010

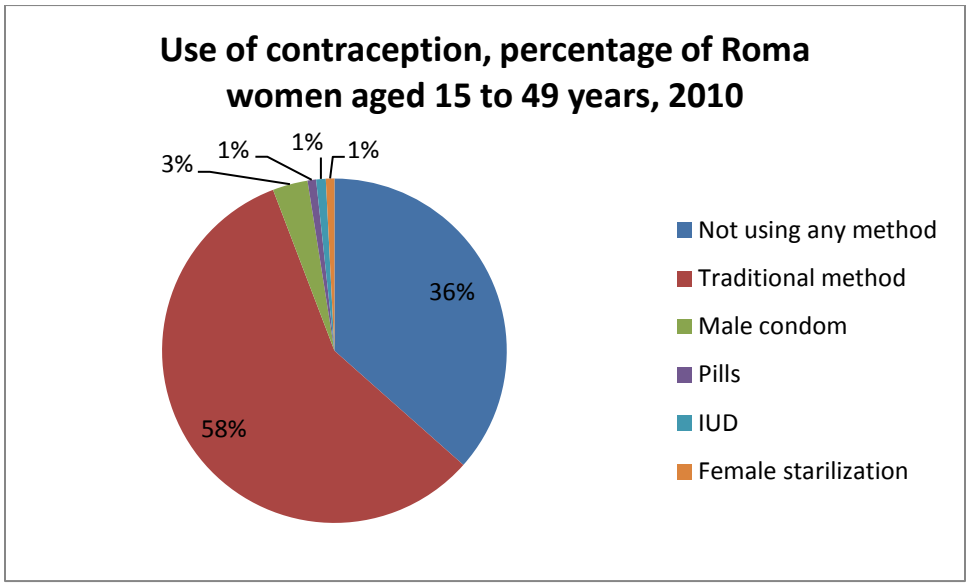
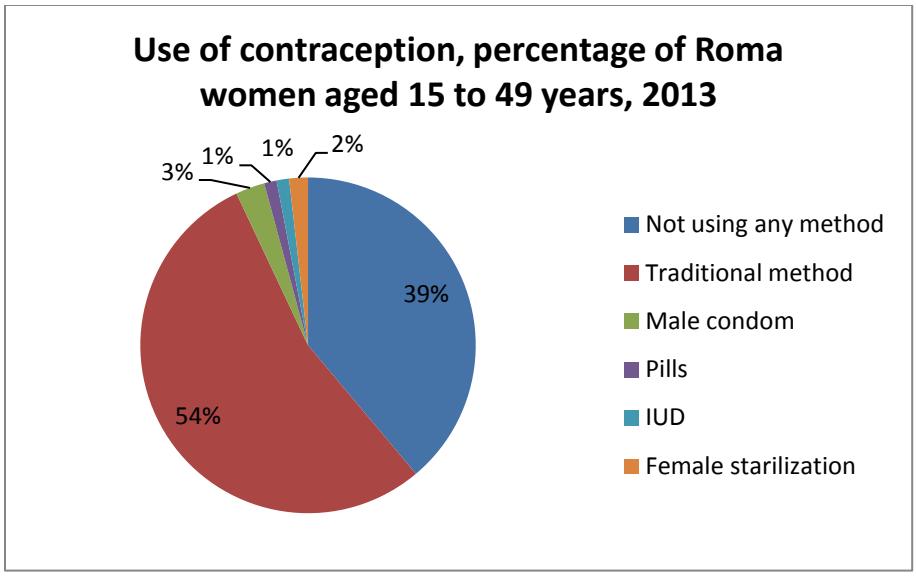


Figure 6. Use of contraception, percentage of Roma women aged 15 to 49 years, 2013



From the analysis of MICS4 we can conclude that except surgical sterilization, all modern methods are used more by women with higher education and increasing economic status

Figure 7. Prevalence according to certain characteristics

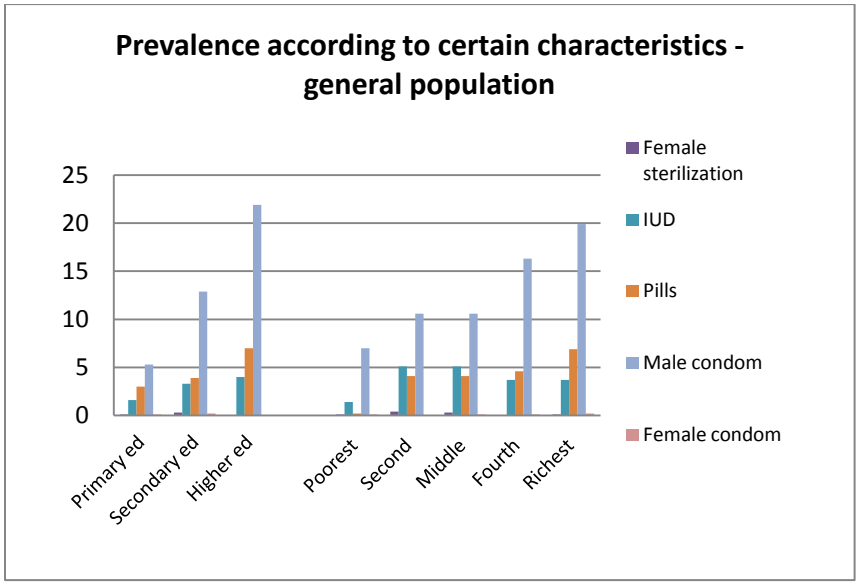


Figure 8. Prevalence according to certain characteristics - Roma women

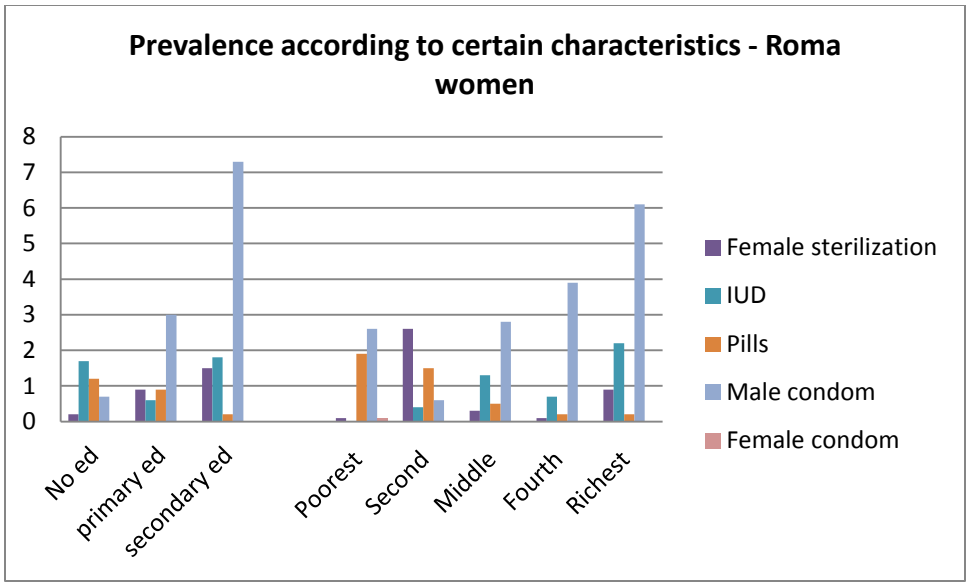
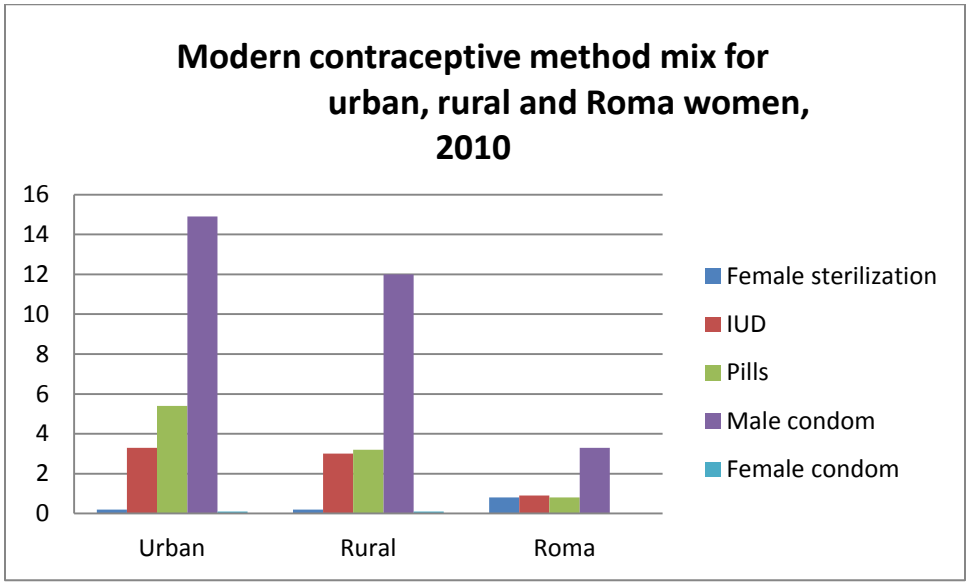


Figure 9. Modern contraceptive method mix for urban, rural and Roma women, 2010



As known, use of modern contraceptives is influenced by the level of education and the wealth status. Comparing modern methods prevalence rates in the general population with the situation among Roma women, we can conclude that in the general population, the increase in prevalence is linear and depends on the level of education and wealth status while among Roma women, differences are less significant and have an irregular trend. As we can observe, for most categories, condoms are by far the most used modern contraceptive method.

Figure 10. Prevalence according to certain characteristics - general population

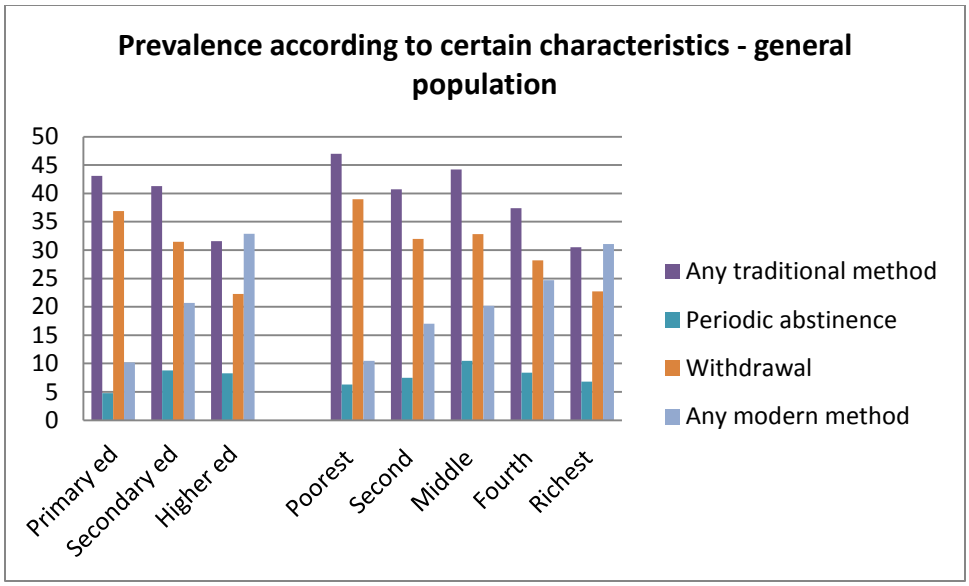
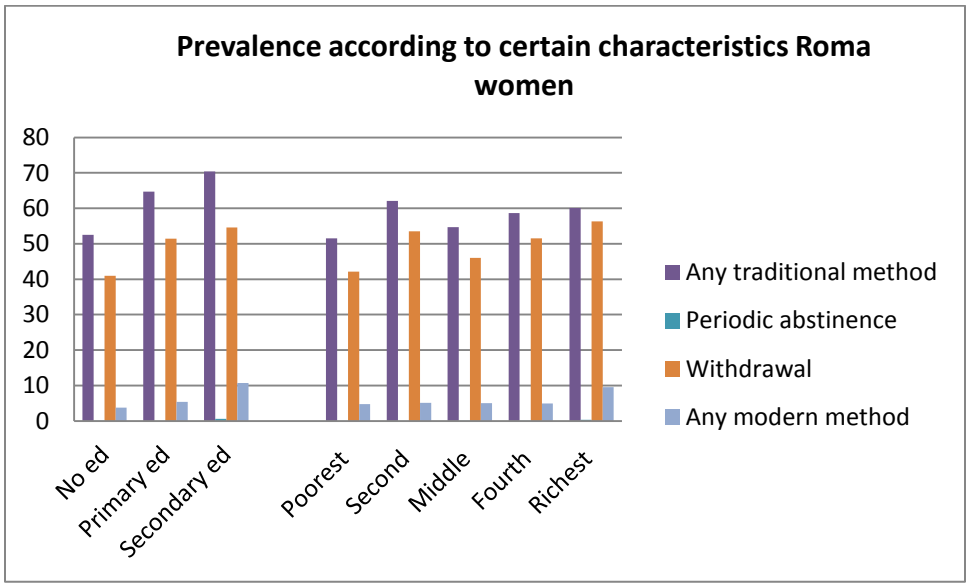


Figure 11. Figure 11. Prevalence according to certain characteristics Roma women



Use of traditional methods is influenced as well by the educational level and wealth status, but a lesser extent than for modern methods.

Figure 12. Use of modern contraception by residence, 2010

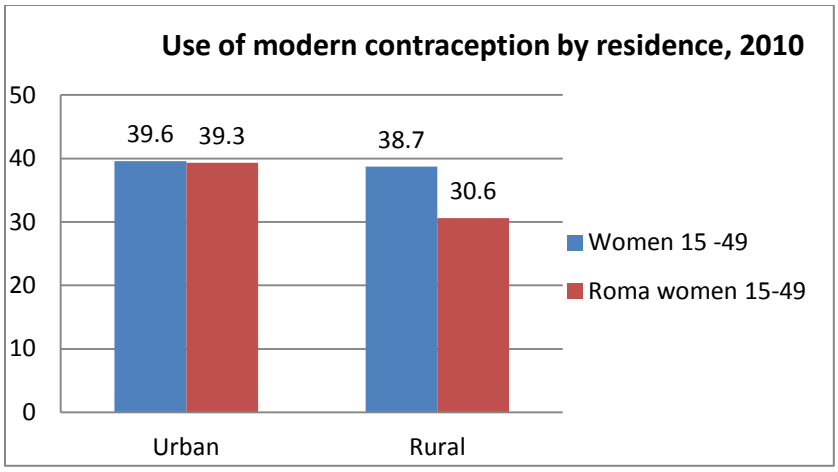
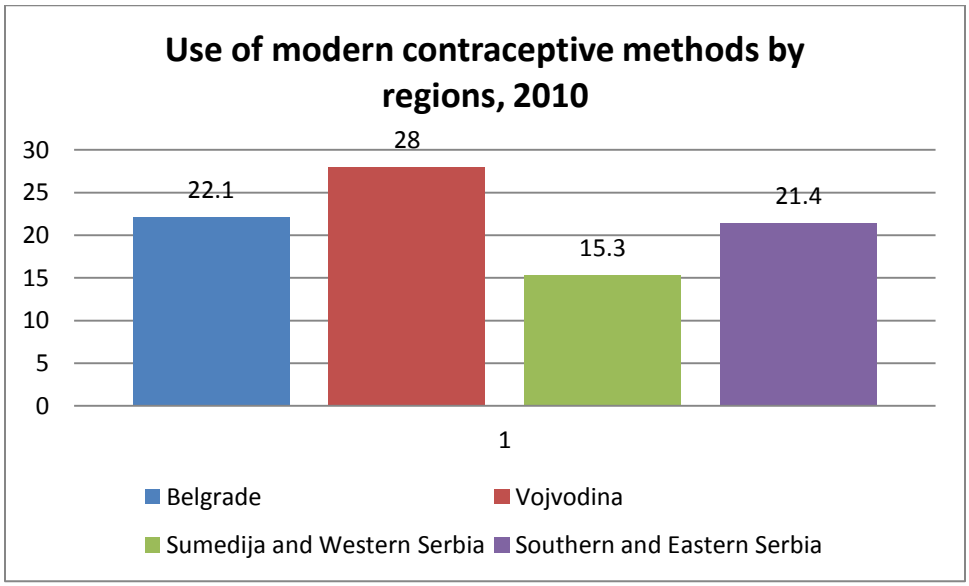


Figure 13. Use of modern contraceptive methods by regions, 2010



Urban/rural Residence does not have an impact of the use of modern contraceptives, with a slight difference for Roma women. But in some regions modern contraceptives are more prevalent than in others.

As might be expected unmet need for contraception is highest among poor women, women living in rural areas and Roma women. If we analyze the unmet need for modern contraception, by adding those who use traditional methods, we can conclude on the real needs regarding the development and implementation of national strategies and programs.

Figure 14. Unmet need for contraceptives for spacing and limiting pregnancies and use of traditional methods by wealth, 2010

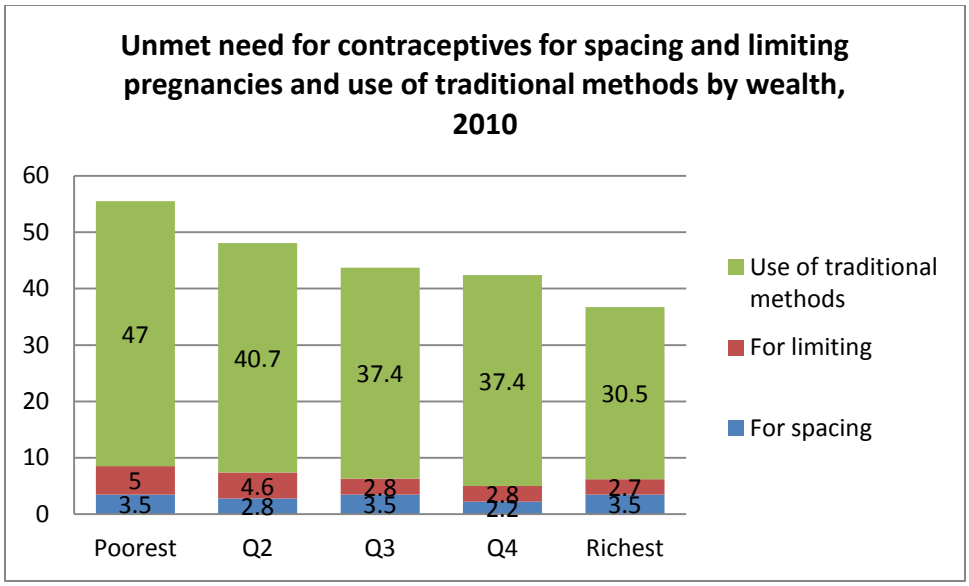
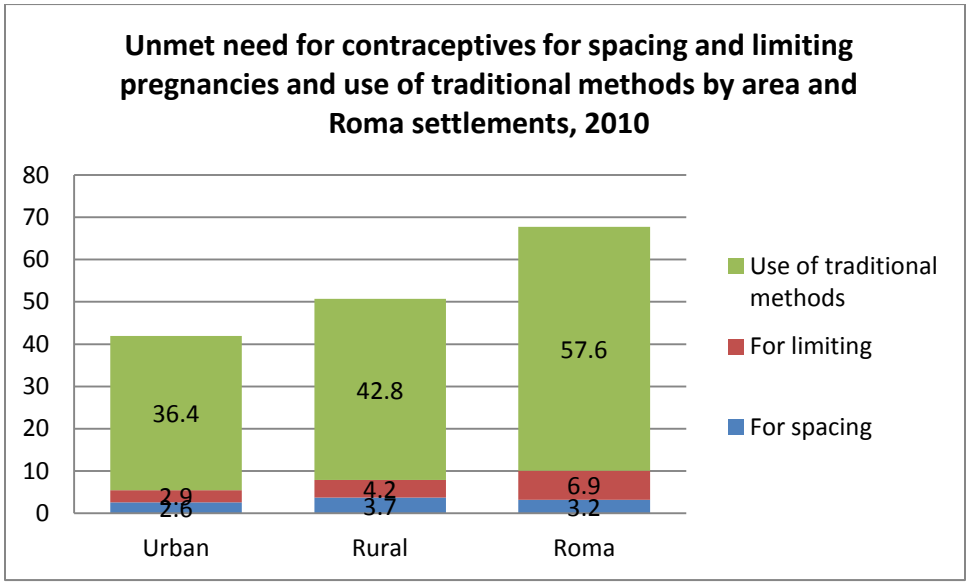


Figure 15. Unmet need for contraceptives for spacing and limiting pregnancies and use of traditional methods by area and Roma settlements, 2010



Affordability of modern contraceptives is a key element influencing the prevalence rates. For the purpose of our study it is important to measure the ability to pay (ATP) of consumers. Ability to pay measure the possibility to find the necessary money to cover the costs of using a modern contraceptive method. Our analysis is based on the assumption that lower the relative cost of contraceptives, in relation to income, the greater the ability of users to pay for them.

For our calculations we used figures from World Bank data regarding gross national income by quintiles, compared to costs of annual use of available contraceptive methods as

calculated for CYP. Most international recommendations suggest that costs of contraception should not exceed 1% of the annual income of a couple, when measuring ATP[10].

Table 3 Cost of contraceptives as a percentage of annual income for couples

	Q1 Richest					Q5 Poorest	
	Richest 10%	Lower 10%	Q2	Q3	Q4	First 10	Poorest 10%
GNI per capita us$	35385	17987	12638	9861	7594	3386	2217
GNI per capita RSD	3012679	1531413	1075999	839566	646553	288284	188755
Condoms							
ROMED condom	0.03	0.06	0.08	0.11	0.14	0.31	0.48
Durex	0.17	0.33	0.46	0.60	0.77	1.73	2.65
Pills							
DIANE 35	0.12	0.24	0.34	0.44	0.57	1.27	1.94
LEGRAVAN	0.05	0.09	0.13	0.17	0.22	0.48	0.74
ANGELIQ	0.38	0.74	1.05	1.35	1.75	3.92	5.99
JEANINE	0.17	0.34	0.48	0.62	0.81	1.81	2.76
LINDYNETTE	0.14	0.28	0.40	0.51	0.66	1.49	2.27
LOGEST	0.17	0.34	0.48	0.61	0.79	1.78	2.72
MIDIANA	0.22	0.43	0.62	0.79	1.03	2.31	3.53
MICROGYNON	0.09	0.18	0.26	0.34	0.44	0.98	1.50
NOVYNETTE	0.11	0.21	0.30	0.39	0.50	1.13	1.73
QLAIRA	0.33	0.64	0.92	1.17	1.53	3.42	5.23
YASMIN	0.22	0.43	0.62	0.79	1.03	2.31	3.53
YAU	0.27	0.52	0.74	0.95	1.24	2.77	4.23
NOVINETE	0.11	0.21	0.30	0.38	0.50	1.11	1.70
DIU							
Mona Liza (Cu) 350	0.02	0.03	0.05	0.06	0.08	0.17	0.27
Mirena	0.02	0.14	0.19	0.25	0.32	0.72	1.10
Spermicides							
Pharmatex vag. Tbl (12)	0.07	0.13	0.19	0.24	0.31	0.70	1.06
Emergency contraception							
ESCAPELLE	0.46	0.91	1.29	1.66	2.15	4.83	7.38

As seen from the above table, only the wealthiest quintile of the population has the ability to pay for all available methods of modern contraception. It should be mentioned that even for the poorest 10% of the population, there are three methods

[10] Singh S, Darroch JE, Ashford LS, Vlassoff M. Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health. New York: UNFPA and the Guttmacher Institute, 2009; Singh S, Darroch JE. Adding It Up: Costs and Benefits of Contraceptive Services Estimates for 2012. New York: UNFPA and the Guttmacher Institute, 2012

with an annual cost below 1% of the annual income, although the cost of Legravan, the pill manufactured in Serbia is near to 1%. It will be important to keep on the market the more expensive brands of methods, because 40% of the population has the ability to pay for all, except the most expensive pill and the regular use of emergency contraceptives and 60% of the population has the ATP for almost all modern methods with exception of two pill brands. The most cost effective method is the IUD (calculated annual cost does not include costs related to insertion and teste required costs)

The ATP analysis has been done in order to demonstrate the type of data provided. It is important to mention that calculations were made based on data from 2010 (the data we could access from the internet[11]. Such analysis should be done on a regular base, using updated figures provided by the relevant state institutions.

Ability to pay is different from willingness to pay that is related with the value placed by the consumer on a specific method and brand. Sales of different products show that there are women who are prepared to invest much more than 1% in modern contraceptives which the market open to new and more expensive products. Serbia is in the process of entering the EU, it is foreseeable that the country will have an economic growth in the near future, GNI will change and similar ATP surveys will be needed in order to modulate the investment from public funds for satisfying need of modern contraception of all population segments.

One important objective of our assignment was to identify criteria for vulnerable groups' definition so that the public sector is positioned to provide comprehensive reproductive health services including modern contraceptives to those most in need during the forthcoming period. Although the word "'vulnerable" is no widely used in health and social care, its precise definition remains elusive. Thus the concept of "vulnerable" is relative and open to interpretation as well as the one of "vulnerable groups". In many countries different areas use different criteria for defining groups in need of special attention. The Ministry of Health has already addressed the issue of vulnerable groups in other contexts of health and will need to adjust these definitions in the context of FP and RH. Generally, vulnerable groups include those groups in the society who are more likely to be vulnerable to ill health, in our particular situation to FP, as the very young (girls and boys), women from ethnic minorities, those who have little social support, those with little education, those who earn a low income and those who are unemployed. It will be important to take into consideration the following accepted definitions:

- **Poor:** people living below the national poverty line
- **Marginalized / Socially-excluded:** people who are wholly or partially excluded from full participation in the society in which they live, for reasons of culture, language, religion, gender, education, migrant status, disability or otherwise, have not benefitted from health, education and employment opportunities and whose sexual and reproductive health needs remain largely unsatisfied.
- **Under-served:** people who are not normally or adequately served by established sexual and reproductive health service delivery programs due to a lack of capacity

[11] http://data.worldbank.org/country/serbia

and/or political will; for example, people living in rural/remote areas, internally displaced people or young unmarried people. In most countries across the world, young people have higher unmet need for sexual and reproductive health services compared to adults, and therefore are categorized as under-served.

A variety of criteria have been used in the construction of groups as being "vulnerable". These are based on the ways in which they are marginalized, socially excluded, have limited opportunities and income, and suffer abuse (physical, sexual, psychological and financial), prejudice and discrimination. From the perspective of RH/FP, such groups include persons living in remote rural areas, persons with no health insurance, adolescents and young person etc. Groups like people with disabilities, ethnic minority groups, those living with a mental illness, the homeless, and asylum seekers and refugees should not be omitted to the specials characteristic of programs addressing these target groups. Based on suggestions from interviewed persons we constructed an initial set of criteria that could be used and further developed by the Ministry of Health.

Table 4 Matrix for vulnerability index

Criterion	**Poor**	**Marginalized /Socially excluded**	**Underserved**
Poverty			
Culture			
Religion			
Gender			
Education			
Employment			
Migrant status			
Residence			
Age			
Marital status			
Prior service use			
Health insurance status			

Based on the three characteristics listed above: Poor, Marginalized and Underserved, a Vulnerability Index can be established. It is important to ensure sensitivity of vulnerability attributes. This attributes should be established through a consultative process with the relevant stakeholders.

Below are examples of attributes to be considered for further discussions

Table 5 Attributes for vulnerability

Dimension	**Attribute**	**Vulnerable**

Marginalized	Primary Language spoken	Roma, other
	Level of completed education	Has not completed primary/ secondary/ Basic education
	Ethnicity	Roma, other
	Migrant status	No registration
	Domestic/violence abuse	Yes
	HIV status	Positive
Under-served	Place of residence	Rural
	Prior service use	No
	Special needs for comprehension or access	Learning disabilities + other disabilities
	Social medical insurance	No

They might be governmental institutions or NGOs familiar with the concept of Vulnerability Index. Their expertise might be used by the MoH for defining a scale of "vulnerability" that would offer criteria for consideration of differential rates of subsidies for different groups and different program approaches for increasing access.

Table 6 Vulnerability Index

Vulnerability	**%**
Not vulnerable	
Only Poor	
Only Marginalized	
Only Underserved	
Poor & Marginalized	
Poor & Underserved	
Marginalized & Underserved	
Poor, Marginalized & Underserved	

Providers

Providers are defined as government and private for-profit (commercial sector) and not-for-profit (NGO) entities.

Public sector

As mentioned previously, primary health care is provided by 161 primary health care institutions and health infirmaries. Secondary and tertiary health care is available in 42 general hospitals, 15 specialized clinics, 23 independent institutions and clinics, 5 health centers and clinics, 4 clinical centers and 59 other health institutions[12].

Only gynecologists provide FP services. They are working on primary as well as in secondary and tertiary care institutions. In Serbia there are a large number of gynecologists in the Primary Health Care centers, therefore services are highly accessible to anyone. All PHCs have gynecologists, , so GPs do not focus on FP. According to the "Assessment of the Family Planning Services in the Republic of Serbia"[13], there are more than 7,500 gynecologists in the Primary Health Care Centers, and one primary health care gynecologist covers approximately 6,500 women. According to the same study, there are no strategies or intentions to change that and to confer a role to general practitioners in family-planning.

Private for-profit (commercial sector)

The private for profit sector is represented by private pharmacies and private health clinics. From discussions with different institutions and providers it was concluded that the number of private clinics and hospitals is increasing, but there are incomplete data regarding the services provided by them. Pharmacies are also ensuring a good coverage across the country, but, for economic reasons, due to very low demand their interest to immobilize funds in stocks of contraceptives is low, thus, pharmacies located in other places than larger cities have a small variety of modern contraceptives, making access difficult even for people willing to pay for them.

Private not -for-profit

NGOs and Social marketing

There are no social marketing programs, they have not been taken into consideration. There are no NGOs providing FP services.

Forecasting contraceptive use and estimating costs

[12] http://mest.meste.org/MEST_Najava/II_gavrilovic.pdf
[13] Assessment of the Family Planning Services in the Republic of Serbia", Report of a mission conducted by Dr. Mihai Horga, East European Institute for Reproductive Health and Hajrija Mujović-Zornic, PhD, National Institute of Social Sciences, Belgrade November 2013, pdf

Forecasting contraceptive use and estimating costs were not included specifically in the ToR for this survey, but during the discussions with officials from the MoH it became evident that they would welcome some general estimations. Calculations are difficult to make due to several reasons: The most accurate forecasting takes into consideration consumption data that allow not just calculating yearly consumption but also to see trends of consumptions. Such consumption data are delivered by an LMIS and Serbia does not have yet such a system. A second difficulty is related with the fact that there are no documented plans for the future: in the absence of a RH/FP Strategy, a Contraceptive Security Strategy or Plan of Action is hard to predict if and which groups of population will be considered to benefit of subsidized contraceptive products. Contraceptives were not considered so far to be included under central procurement mechanisms. For now, FP providers issue prescriptions for modern contraceptives (except condoms) and clients use pharmacies to procure their products. The final results of MICS 5 not being yet published we haven't been able to make any detailed trend analysis regarding method mix.

A second way of making calculations for forecasting purposes takes into consideration demographic based data. For this purpose Futures Group International developed a software program called *Spectrum11* that performs the forecasting calculations and takes into account the impact of projected mortality, women of reproductive age (WRA) and other variables to produce forecasts. The application can be accessed at http://futuresgroup.com/resources/software_models/spectrum.

In this circumstance, we did just a simple forecasting exercise based on several assumptions. We used as baseline the data provided by MICS 4 and prices from ACCESS RH of UNFPA. If the MoH will decide to use centralized procurement, UNFPA can provide support to procure contraceptives from ACCESS RH, a specialized UNFPA-managed reproductive health procurement and information service that aims to improve access to quality, affordable sexual and reproductive health (RH) commodities. As shown in the table and in the figure from below, prices of contraceptives are very different.

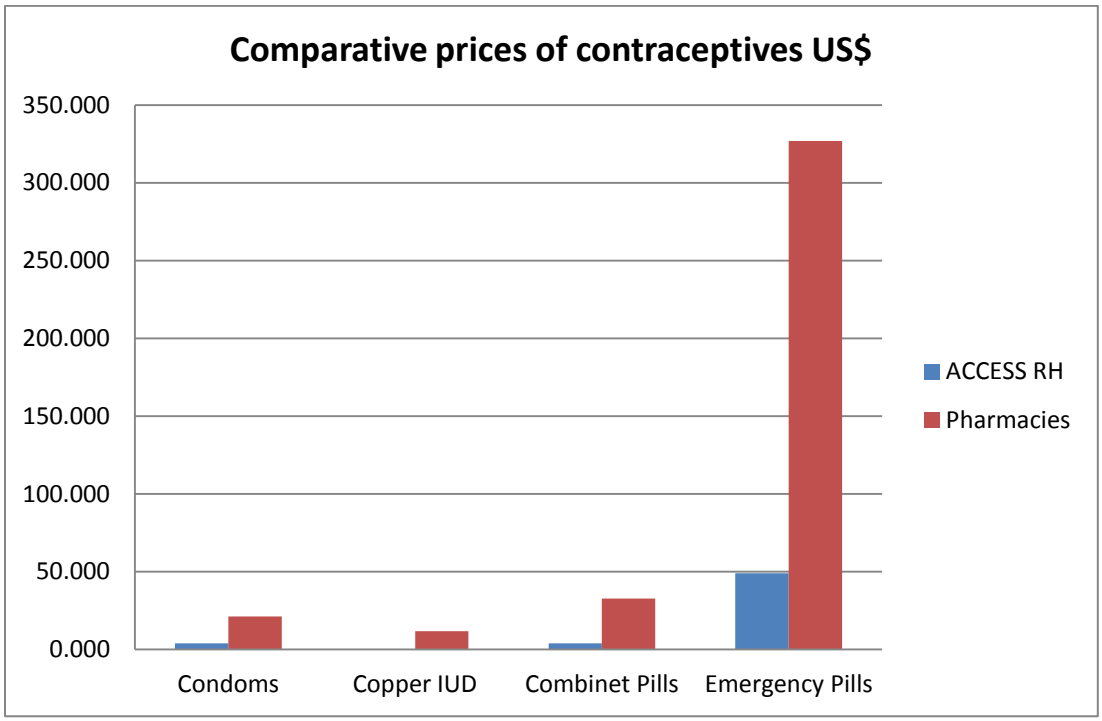
Table 7 Indicative international prices for procuring a range of modern contraceptives, 2014[14]

Contraceptive method	Unit	Average cost per unit US$	Quantity required per couple year of protection (CYP)	Cost per CYP
Male condom	Gross	4.645	120 items	3.87
IUD CopperT	Set	0.35	3.5 CYP per IUD inserted	0.10
Progestagen only pill	Cycle	0.4133	15 cycles	6.20
Combined low dose pill	Cycle	0.27	15 cycles	4.05
Emergency	Pack	2.45	20 doses	49.00

[14] ACCESS RH Product catalog, http://www.myaccessrh.org/products, accessed 18.11.2014

pill				
Injectable contraceptive	Vial	1.1	4 doses	4.40
Subdermal implants	Set	16.5	3.8 CYP per implant	4.34

Figure 16. Comparative prices of contraceptives US$



An example of calculation of cost is presented below. It is based on population data calculating the costs of modern contraceptives for the poorest 40% of the population, with CPR for modern contraception of 17% (as the CPR for the second poorest quintile from MICS4). As for method mix, the calculation is based on the assumption that with an easier access to modern methods (including affordability), the method mix will change with an increase of 10% for pills and IUDs compared to 2004 and a decrease of condoms use (as result of the end of the Global Fund condoms). In this scenario, total costs for procuring contraceptives from ACCESS RH would be of 327989.48 US$.

Table 8 Costs in US$ of contraceptive commodities

	Numbers of women 15-49 years, (total 1,616,593)	CPR estimate	Method mix	Indicative costs US$ with procurement from ACCESS RH for 1 year

Lowest 40% of the population – the poorest	646637.2	17%	COC 31%, IUD 25%, condoms 44%	327989.48

The purpose of this example was to offer a model of calculations. The actual calculations will be done after establishing parameters related to vulnerable groups, level of subsidies etc.

Recommendations

The Government and the MOH will need to strengthen its commitment for FP. Justification for placing more emphasis on FP comes not just from all the international commitments but from the long term benefits of FP as well. Decrease of maternal and infant mortality and morbidity along with ensuring human rights and social equity as well as economical long term economic gains are important factors to justify this new attitude. For the entire process a strong political will ensured by the Government will be necessary.

1. **Development of a comprehensive, rights based National Reproductive Health Strategy and Plan of Action**

This recommendation was formulated by the FP assessment conducted last year as well. It was very well justified, we are sustaining the opinions expressed by the authors. We would like to underline the following important components to be taken into consideration:

- The National Reproductive Health Strategy should include a component regarding Contraceptive Security. Contraceptive Security is a long term goal requiring constant monitoring of changes at social and economic levels of the society and identification of solutions necessary to ensure all Serbian citizens sexual and reproductive rights, in an environment with high needs and limited resources. Public/private partnership and coordination are key elements for the success of this process.
- The National Reproductive Health Strategy should have a clear implementation plan either under the form of a National Program or a National Plan of Action.
- A Reproductive Health Committee should be established involving all relevant stakeholders, NGOs as well as representatives of the private sector.
- The Reproductive Health Committee should have a Contraceptive Security Subcommittee (CSS) coordinated by the Ministry of Health. The CSS should ensure a forum for discussions for private and public institutions and should act as a consultative body ensuring participation of all major stakeholders. It should act as the major coordination unit for the Total Market Approach in Serbia. Although different initiatives regarding coordinating groups might already exist, without a special body with specific responsibilities in the area of Contraceptive Security it will be difficult to ensure consistent steps towards TMA. The CSS should have a more active role during the set-up of the entire system afterword keeping responsibilities of monitoring and supervising regular forecasting and budgeting.

Role of CSS:

- Analyze coverage with FP services and contraceptives nationwide including all sectors
- Ensure the availability of CC at all level of the public system
- Offer to the MOH a negotiation space/forum with other ministries and with the private sector, as part of the TMA
- Monitor and evaluate implementation of measures defined to implement the Total Market Strategy
- Develop an Implementation Plan

Membership: technical level, combining different technical expertise – it is recommended to have different institutions as members of the CSS and each institution to nominate a technical level person that can effectively participate in conducting monitoring, analysis, technical solutions etc., taking into account also the need for availability in meetings.

Frequency of meetings: four times per year, eventually more frequent in the beginning

Secretariat of this Committee – the CSS should have a Secretariat including a part time person (at least 1-3 days/month) with contractual obligations to fulfill these responsibilities, an e-mail address. The MoH should run consultation with potential partners and donors to identify the necessary resources and location of the Secretariat. The CSS could be part of the Institute for Public Health where there are human capacities to undertake such responsibilities.

2. Identification of vulnerable groups

This is a complex process taking into account the existing situation of the prevalence of modern contraceptives in Serbia. An important question to answer is if women exposed to the risks of repeated abortion are included under vulnerable groups. The MoH should give a new consideration to its political support to family planning and reconsider accordingly its strategy and priorities.

Round table or seminar involving key stakeholders to define vulnerable groups would help defining criteria and would support the MoH in defining its future program approaches and subsequent budgetary allocations. Allocation of funds to vulnerable groups should take into consideration existing health insurance coverage.

3. Facilitations encouraging commercial sector

Facilities encouraging the commercial sector should be discussed formally in CSS and then followed by the MOH. Some suggestions came up during the interviews. We just list them because it is important to have them discussed formally in the CSC:

- Decrease/eliminate VAT for condoms
- Eliminate re-registration of contraceptives
- Consideration of reimbursement schemes for contraceptives, including IUDs

5. Increasing access to public services

Existing data clearly show that provision of FP services integrated in primary care is an effective strategy. Efforts should continue in this respect to expand services not only in all health centers but also in communities were only health posts are operating starting from the most remote areas towards urban areas.

A survey aiming to identify barriers other that misinformation and myths regarding modern contraceptives should be conducted among vulnerable groups. According to the results, a restructuring of FP service provision might be needed

6. Increase modern contraceptive utilization

Investment in efforts to increase modern contraceptive utilization is a political decision that will need to be considered under the Reproductive Health Strategy. Meanwhile, bringing together major stakeholders will allow exploring as well their ideas in this respect. Some options to be considered might be:

- Post-abortion Contraception including after medical abortion.
- Develop and disseminate guidelines and protocols for contraception after medical abortion (first develop regulation regarding medical abortion)
- Immediate Postpartum Contraception.
- Integration of positive messages regarding modern methods of contraception in primary health care

7. Health promotion – promotion of FP and modern contraceptive methods

The reform of the health system raised important challenges in the past years. In this complicated context, health promotion was not a priority, thus budgets were not sufficient in the past years. This might be one of the reasons for the decrease of modern contraceptives prevalence rates.

Taking into consideration the low modern contraceptive prevalence rate, it will be important to link and coordinate health promotion and the contraceptive security strategy with the objectives of the future Reproductive Health Strategy. The following elements should receive further consideration:

- Targeted health promotion interventions for:
  - Ensuring that FP is included as a priority in all strategies impacting youth, health, education, social protection programs etc.
  - Dissemination of information regarding access to services of vulnerable groups
  - Behavior Change Communication interventions using community approach (especially to correct misinformation and misbelieves regarding hormonal contraceptives)
  - Agreement between the MOH/IPH and the National Public TV for promoting modern contraception and access to FP services based on a well-designed communication strategy

UNFPA should continue to support NGOs to take an active part in all aspects related to RH/FP, from the development of strategies and programs to direct projects implementation.

Annex 1

List of Reference Materials

- Women and Man in Republic of Serbia, Statistical Office of the Republic of Serbia, Belgrade, 2011
- Strategy for Youth Development and Health in the Republic of Serbia, Ministry of Health Republic of Republic of Serbia
- Serbia National Youth Strategy
- Salaries and wages per employee by activities paid in September 2014, Statistical Office of the Republic of Serbia
- Health Statistical Yearbook of Republic of Serbia, 2012, Institute of Public Health of Serbia "Dr Milan Jovanovic Batut"
- Health Statistical Yearbook of Republic of Serbia, 2013, Institute of Public Health of Serbia "Dr Milan Jovanovic Batut"
- National Health Survey Key Findings, 2006, Ministry of Health Republic of Republic of Serbia
- *2014 Serbia Multiple Indicator Cluster Survey* and *2014 Serbia Roma Settlements Multiple Indicator Cluster Survey, Key Findings*. Belgrade, Serbia: Statistical Office of the Republic of Serbia and UNICEF
- *Multiple Indicator Cluster Survey 2010* and *Serbia Roma Settlements Multiple Indicator Cluster Survey, 2010,*: Statistical Office of the Republic of Serbia and UNICEF
- Health Insurance sistem in Serbia –quality, reform, financial sustainability, by Ana Gavrilović and Snežana Trmčić
- "Strengthening the national response to HIV / AIDS decentralization of key health services" funded Global Fund to Fight AIDS, Tuberculosis and Malaria RESEARCH AMONG POPULATIONS UNDER Increased risk of HIV, The basic results, 2012, September, 2012.
- Assessment of FP services in the Republic of Serbia, Mihai Horga, Eastern Institute for Reproductive Health and Hajrija Mujović-Zornic, PhD, National Institute of Social Sciences, Belgrade, November 2013
- An in-depth analysis of family planning and reproductive health contraceptive security in seven middle-income countries in Eastern Europe and Central Asia (Armenia, Bosnia-Hercegovina, Bulgaria, Macedonia, Serbia, Azerbaijan and Kazakhstan). UNFPA, 2012
- Report of a High-Level Consultative Meeting on "Promoting national ownership on Reproductive Health Commodity Security (RHCS) using evidence based advocacy", 6-7 June 2012, Brussels, Belgium. IPPF-EN and UNFPA 2012.
- Linking Sexual and Reproductive Health and HIV/AIDS, Gateways to Integration: A case study from Serbia, prepared and published by WHO, UNFPA, UNAIDS, IPPF, 2009.

- Boricic K et All. Results of Serbian Population Health Survey: Year of 2013. Institute of Public Health of Serbia „Dr Milan Jovanovic Batut“, Official Gazette, Belgrade, 2014
- Republic Fund for Health Insurance. Financial Report of the RFHI for 2013. Belgrade, April 2014

Annex 2

AGENDA
Market Segmentation Research
UNFPA
Oct 6th -10th

Monday October 6th	
09.00 - 10.00	Briefing meeting at UNFPA Sumatovacka 78- 80
10.00 – 11.00	Ministry of Health Prim dr Dragan Vukanić, Deputy Minister Dr Snežana Pantić Aksentijević, Adviser *Omladinskih brigada 1, Novi Beograd*
12.00 – 13.00	Institute Public Health Serbia dr Dragan Ilić, Director Dr Katarina Boričić, MD *Dr Subotića 5, Beograd*
14.00 – 15.00	National Health Insurance Fund Dr Ivana Mišić, Sector for Medical Affairs and New Health Technology Assessment *Jovana Marinovića 2, Beograd*

Tuesday October 7th	
10.00 – 11.00	Dr Katarina Sedlecki The National Center for Family Planning Institute for Health Protection of Mother and Child Serbia „Dr Vukan Čupić“ *Radoja Dakića 6-8 Novi Beograd*
11.30 – 13.00	Prof. Dr. Ana Mitrovic Jovanovic Head of the daily hospital Gynecology and Obstetrics Hospital „Narodni Front“ *Kraljice Natalije 62*
14.00 – 15.00	Medicines and Medical Devices Agency of Serbia Saša Jaćović, director Vesela Radonjić, Sector manager *Vojvode Stepe 458*
15.45- 17.00	Ivan Zivanov

	WHO Hadzi Milentijeva 30

Wednesday October 8th	
10.00 – 13.00	Dr Vasa Petrović, director DZ Inđija (Primary Health Care Center) Srpskocrkvena 5, Inđija
13.30 – 15.00	Provincial Secretariat for Health Care, Social Policy and Demography Prof r Vesna Kopitović, Secretary Dr Danijela Stanković Baričak, Secretary assistant Provincial Secretary for Sports and Youth Marinika Tepić, Secretary Aleksandra Ristić, Secretary assistant Prof dr Aleksandra Kapamadžija Family Planning Center, GAK / Clinical Center of Vojvodina Medical Faculty Novi Sad *Bulevar Mihajla Pupina 16, Novi Sad*

Thursday October 9th	
08.00 – 09.00	Olivera Jovanović Product Manager Women's Health Bayer d.o.o. Serbia Airport City, Belgrade, Omladinskih broigada 88, zgrada 1500 (lala)
10.00 – 11.00	Mirjana Rašević, Director Institute of Social Sciences *Kraljice Natalije 45 (Narodnog fronta 45)*
11.30 – 13.00	Dragana Stojanović Executive director Asocijacija za reproduktivno zdravlje Serbian Association for Sexual and Reproductive Health and Right – SRH Serbia – NGO Hajrija Mujović, Senior Research Adviser *Strahinjića Bana 55, Belgrade*

Friday October 10th	
10.00 – 11.00	Ministry of Health Prim dr Dragan Vukanić, Deputy Minister

	Dr Snežana Pantić Aksentijević, Adviser *Omladinskih brigada 1, Novi Beograd*
11.00- 12.00	Debriefing meeting at UNFPA Sumatovacka 78- 80