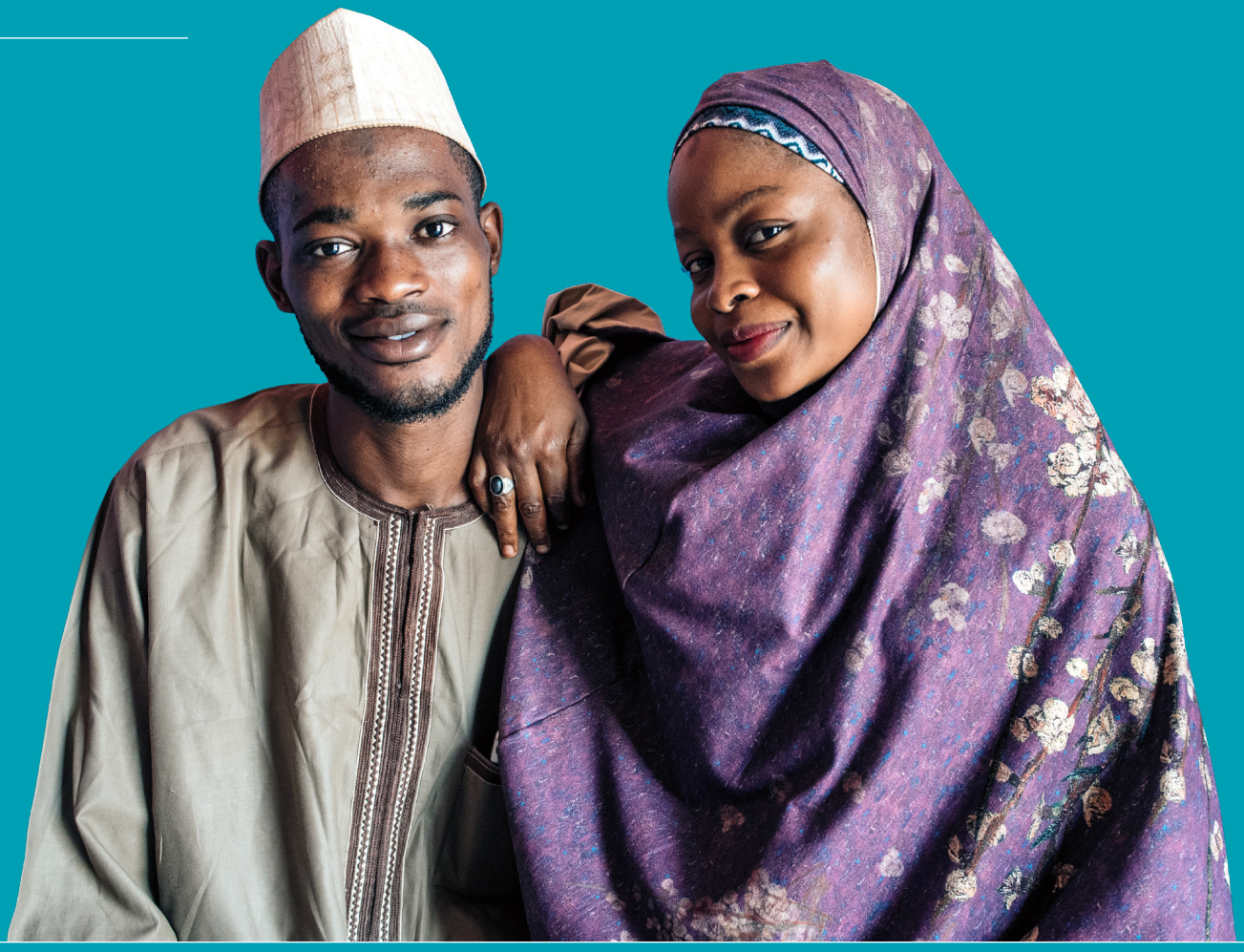
SHOPS PLUS

Factors Influencing the Private Sector's Contributions to Family Planning Market Growth

A Synthesis of Six Country Analyses



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Summary

A review of trends in modern contraceptive prevalence rates across low- and middle-income countries has led stakeholders to develop a normative S-shaped pattern for how family planning markets grow. In this model, low prevalence and little growth occur on one end, with high prevalence and low growth on the other, and a period of potentially rapid growth in between. Understanding what specific types of interventions work best at each stage of the S-curve can help countries better leverage the resources available in the private sector and accelerate achievement of their national family planning goals. The USAID-funded SHOPS Plus project analyzed six countries where (1) the private sector has played a significant role in the family planning market and (2) the private sector role has increased as the modern contraceptive prevalence rate grew. Drawing on Demographic and Health Survey data, as well as key informant interviews with market experts, individual country briefs highlight the macro-environmental, sociocultural, policy, and programmatic factors that facilitated, or in one country example, inhibited, the overall market and private sector contributions in these countries. This synthesis pulls out country findings across the six countries and makes recommendations for donors, governments, and the private sector. These recommendations, organized around the three S-curve stages, are intended to help family planning stakeholders consider how to make more targeted investments in their private health sectors to help countries and individuals achieve their voluntary family planning goals.

Keywords: family planning, contraceptives, Bangladesh, Cambodia, Kenya, Nigeria, Philippines, Tanzania

Cover photo: KC Nwakalor

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SHOPSPLUS
Public-private engagement for better health

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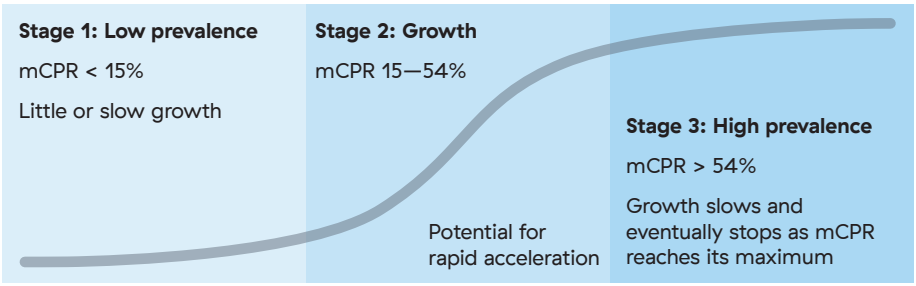
Factors Influencing the Private Sector's Contributions to Family Planning Market Growth: A Synthesis of Six Country Analyses

Over the past several decades, family planning markets have grown and evolved in many countries. Government, donor, and private sector investments have helped shape these markets in numerous ways. Behavior change and demand creation efforts have helped educate women and their partners on the importance of family planning. Social marketing programs have helped to introduce a greater variety of methods at various price points in the private sector. And investments along the supply chain have reduced stockouts, expanded access, and increased contribution of for-profit and nonprofit family planning marketers and service providers. As family planning markets grew and evolved, the investments responded to new challenges and opportunities that emerged in the market.

A review of trends in the modern contraceptive prevalence rate (mCPR) across low- and middle-income countries has led stakeholders to develop a normative S-shaped pattern for growth (Figure 1). In this model, low prevalence and little growth occur on one end, with high prevalence and low growth on the other, and a period of potentially rapid growth in between (Track20 2017). While country growth patterns can vary substantially, the S-curve model serves as a framework to categorize countries to one of these three stages based on their mCPR (Feyisetan et al. 2017). The model can assist stakeholders in assessing the appropriate level of investment, type, and timing of interventions to help their countries' mCPR growth better mirror the S-curve, enabling more men and women to achieve their reproductive intentions.

Figure 1. The S–curve for family planning markets



Source: Track20 (2017)

Understanding the types of interventions that work best at each stage of the S-curve is necessary to create optimal family planning outcomes. The USAID-funded Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project sought to identify those interventions that could best harness the private health sector within each stage of the S-curve.[1] The project examined countries where (1) the private sector has played a significant role in the family planning market and (2) the private sector role has increased as mCPR grew. This analysis revealed macro-environmental, sociocultural, policy, and programmatic factors that facilitated increased private sector contributions in these countries. Understanding these factors can help donors and country governments better consider appropriate private health sector investments and interventions in their family planning programs.

Based on these criteria, the project examined family planning markets in five countries: Bangladesh, Cambodia, Kenya, Philippines, and Tanzania. To strengthen the analysis, the project included Nigeria, which saw limited growth in the total family planning market despite substantial private sector contributions. By examining all six countries, the project identified factors that are necessary for leveraging the private sector's contributions to growth.

SHOPS Plus conducted extensive secondary analysis of Demographic and Health Survey (DHS) data to examine trends in the use of modern contraceptive methods by reported sources of supply, translating use rates into absolute numbers of women using United Nations Development Programme's World Population Prospects (2019 Revision) projections. DHS data were compared to DKT social marketing statistics to understand the relative role of social marketing organizations to the total private sector market. This analysis was complemented by country-specific literature reviews and key informant interviews with experts who worked in each country to explain the trends revealed through the DHS data analysis. The goal was to better understand factors that enabled or inhibited the private sector's contributions to mCPR growth. Individual briefs highlight country-specific findings and recommendations. This brief pulls out country findings across the six countries and makes recommendations for donors, governments, and the private sector. The recommendations, organized around the three stages of the S-curve, are intended to help family planning stakeholders consider how to make more targeted investments in their private health sectors to help countries and individuals achieve their voluntary family planning goals.

[1] Private sector in this brief refers to the full range of non–state actors, including for–profit, nonprofit, and faith–based service providers; pharmacies, drug shops, and retail outlets; and product manufacturers, distributors, and wholesalers.

Overview of country findings

Overview of country findings

The analysis examined trends in family planning markets in the six countries. Based on available DHS data, the time periods under consideration varied slightly, but generally looked at the 30 years between 1990 and 2018 (Table 1). One limitation resulting from the reliance on DHS data meant that the most recent market developments, including innovations by social marketing organizations, could not be captured in this analysis. To understand trends in both market size and market share, the analysis considered both the percentage and absolute number of women using each method, from each source. In Bangladesh, where multiple survey rounds did not ask family planning questions of unmarried women, the analysis used results from all women who had ever been married.

Table 1. Country DHS data used in analysis

Country	DHS years	Population surveyed for family planning	First mCPR*	Last mCPR*
Bangladesh**	1994, 1997, 2000, 2004, 2007, 2011, 2014	• Currently married women • Ever married women	36.6% (Stage 2)	54.1% (Stage 3)
Cambodia	2000, 2005, 2010, 2014	• Currently married women • All women	18.8% (Borderline Stage 1—2)	38.8% (Stage 2)
Kenya	1993, 1998, 2003, 2008/09, 2014	• Currently married women • All women	17.9% (Borderline Stage 1—2)	53.2% (Borderline Stage 2—3)
Nigeria	1990, 2003, 2008, 2013, 2018	• Currently married women • All women	3.5% (Stage 1)	12.0% (Stage 1)
Philippines	1993, 1998, 2003, 2008, 2013, 2017	• Currently married women • All women	24.9% (Stage 2)	40.4% (Stage 2)
Tanzania	1991/92, 1996, 1999, 2004/05, 2010, 2015/16	• Currently married women • All women	6.6% (Stage 1)	32% (Stage 2)

* Among currently married women.

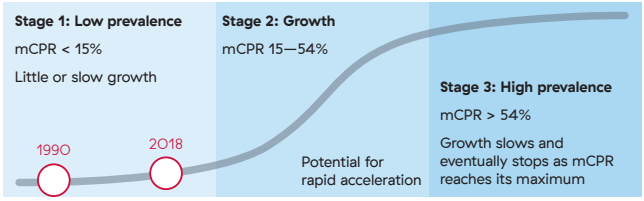
** While Bangladesh completed a DHS in 2018, the data are not yet publicly available and were excluded from this analysis.

Photo (previous page): KC Nwakalor

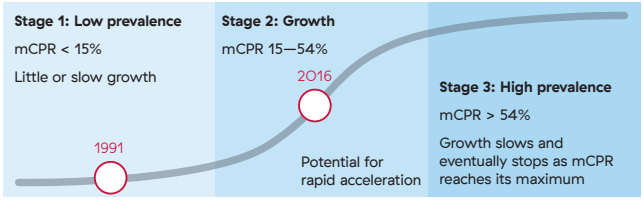
Overall, the countries, except Nigeria, exhibited sustained growth in mCPR as they moved along the S-curve (Figure 2). A closer examination of Nigeria revealed two distinct markets in southern and northern Nigeria. The mCPR grew more in the south—reaching Stage 2—while the north exhibited very low growth (Figure 3). Accordingly, these have been treated separately for the purposes of this analysis. In the six countries, short-acting methods (SAMs) grew the most and dominated the method mix in every stage of the S-curve. In the three Asian countries, pills were the most popular method throughout, while injectables grew more substantially in sub-Saharan Africa. Countries in sub-Saharan Africa also exhibited greater increases in the use of implants.

Figure 2. mCPR growth on the S-curve, by country

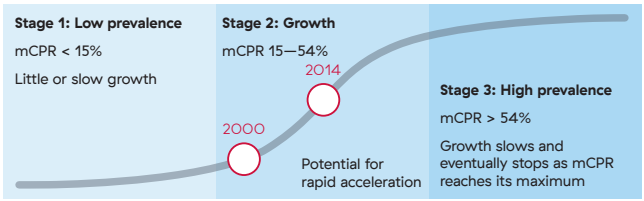
Nigeria



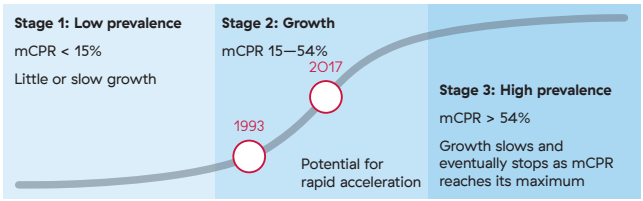
Tanzania



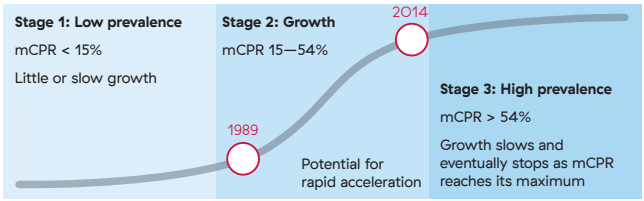
Cambodia



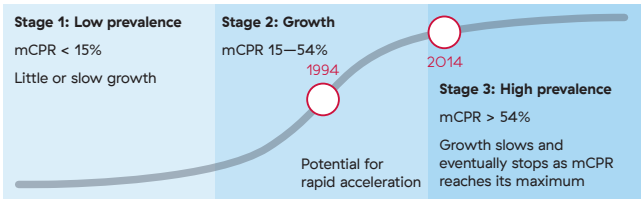
Philippines



Kenya

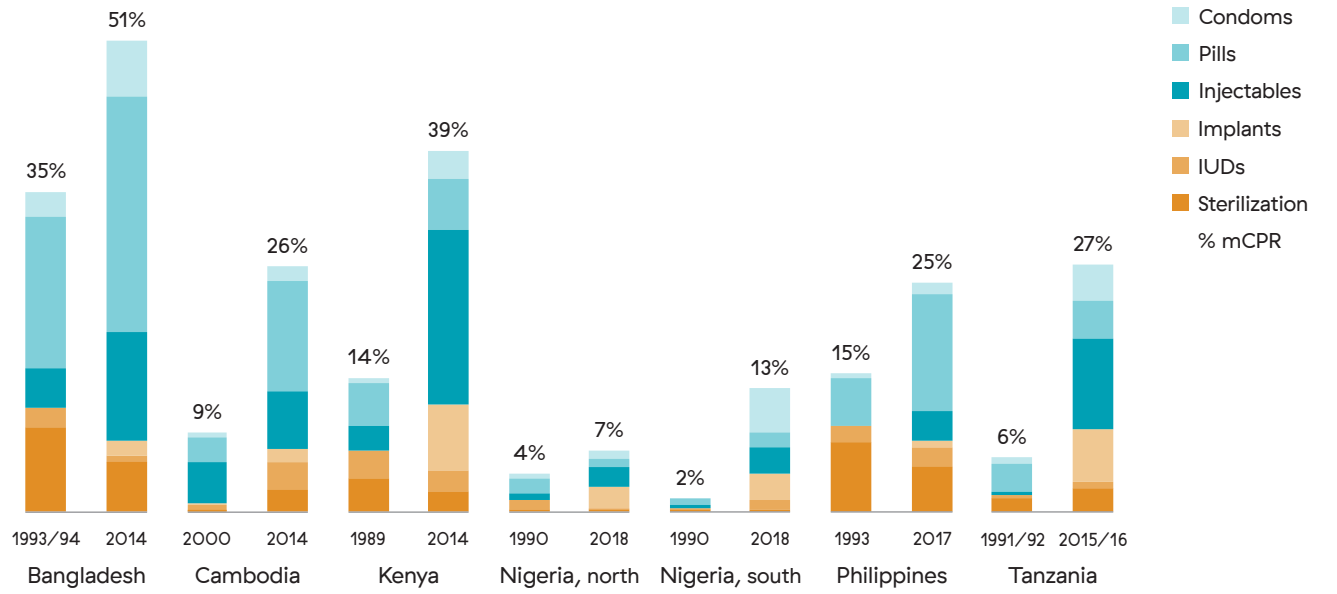


Bangladesh



Note: The mCPR percentages depicted in this figure are among currently married women.
Source: Track20 (2017)

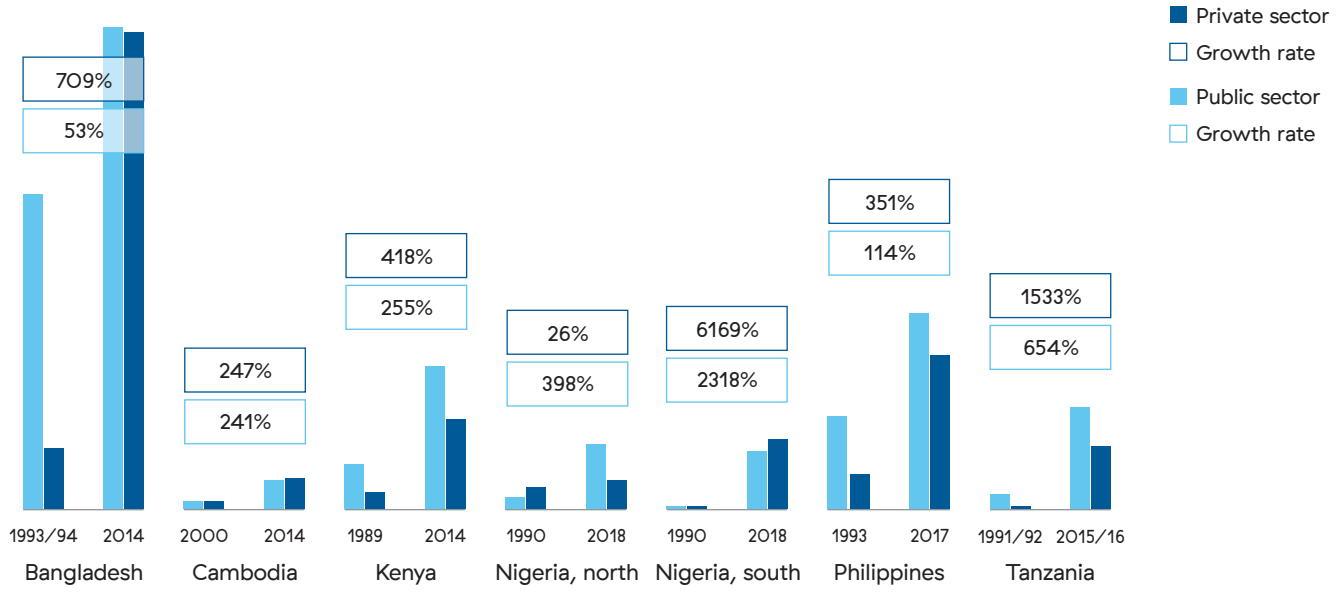
Figure 3. Trends in mCPR and method mix



As they moved along the S-curve, all of the countries saw the number of women accessing a modern method in both the public and private sectors increase in absolute terms. This growth resulted from increases in both the population size, as well as the rate of use (i.e., mCPR growth) (Figure 4).

Figure 4. Changes in number of modern method users

In thousands, by source and country



As Figure 4 demonstrates, in most of the countries, the first round of DHS data analyzed revealed a relatively small private sector market share as opposed to the public sector. Reflecting this low starting point, most countries saw the private sector grow at a much higher percentage rate than the public sector over the period of analysis. For example, in Bangladesh, the number of women opting for a private source increased by over 700 percent, while the number choosing a public source increased by only 53 percent. In Cambodia, however, which started with a more even split between public and private sources, the two sectors grew at similar rates—by 241 percent and 247 percent, respectively.

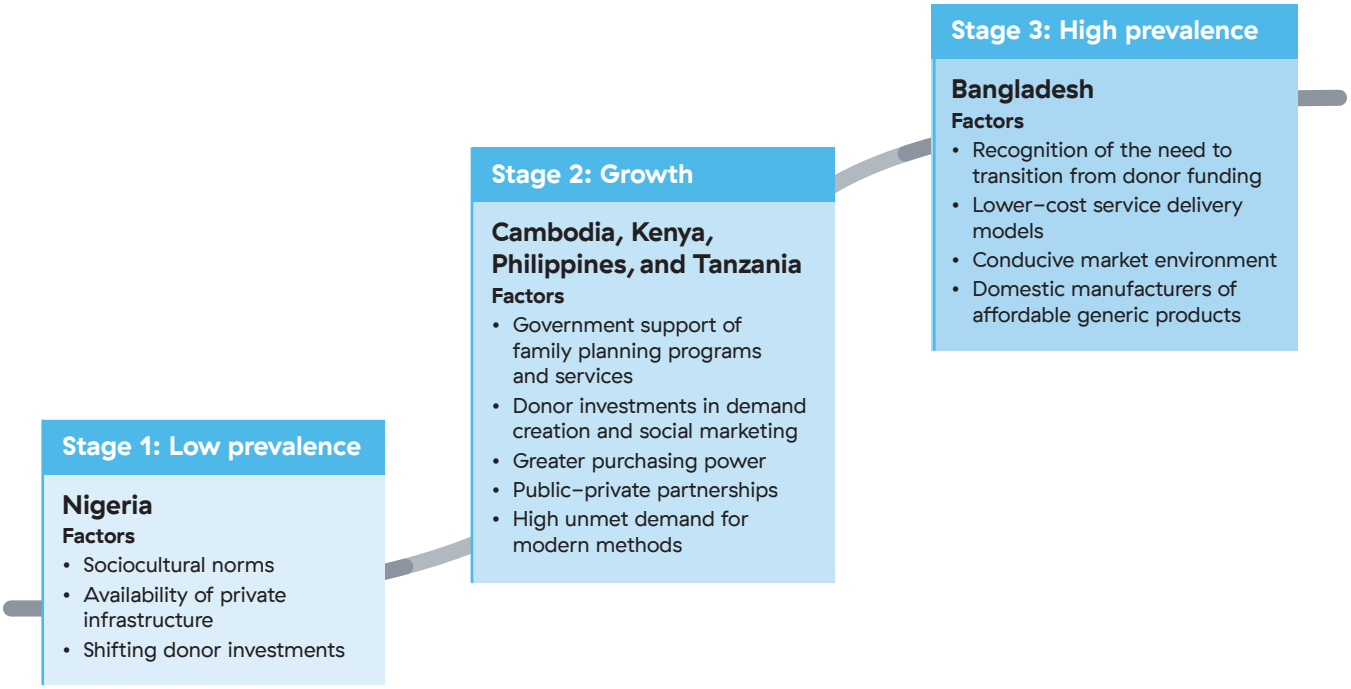
While all countries saw the private sector grow at a similar or higher rate than the public sector over the entire time period considered, they each exhibited different patterns. For example, Cambodia saw consistent rates of growth in public and private sector contributions throughout, regardless of its S-curve stage. In the Philippines, though, the private sector grew much faster than the public sector early in Stage 2, but saw resurgent public sector contributions as its mCPR reached the upper range of Stage 2. And in Tanzania, the rate at which private sector growth outpaced public sector growth increased as the country moved from Stage 1 further into Stage 2.

Photo: KC Nwakalor

Country vignettes

Delving deeper into the data—examining sourcing patterns for each method and shifts within private sector sourcing—helped identify specific factors, programs, and conditions that contributed to, or in the case of Nigeria, inhibited, high-level changes in the market (Figure 5). These findings—discussed in more detail in the individual country briefs in this series—are summarized here in short vignettes.

Figure 5. Key factors, by stage and country



Bangladesh

Bangladesh highlights the important role the private sector can play to improve the sustainability of family planning markets. Over the 20-year period between 1994–2014, mCPR among married women increased almost 20 percentage points. By 2014, mCPR had reached 54.1 percent, putting the country in Stage 3 of the S-curve. Women adopting SAMs, primarily pills, were the main source of this growth. Women choosing long-acting reversible contraceptives (LARCs) declined slightly as a share of the market. Consistent with the growth in SAM use, the private sector came to be an equal player in the market. In 1994, fewer than one in five women using a modern method went to the private sector; by 2014, that percentage more than doubled. Key informants cited several factors that contributed to this consistent, gradual shift: early recognition of the need to transition from donor funding, adoption of lower-cost service delivery models in the private sector, a conducive market environment for private sector expansion, and the emergence of domestic manufacturers of affordable generic products.

Cambodia

Cambodia highlights how the private sector can complement public sector efforts and support comprehensive growth across SAMs and LARCs. From 2000 to 2018, mCPR among married women grew from 18.8 percent to 38.8 percent. During this time, SAMs maintained a consistent majority share of the method mix, accounting for approximately two-thirds of women using a modern method. LARC use increased by 10 percentage points as women switched from other modern methods (e.g., lactational amenorrhea). Notably, as the market grew, the private and public sector market shares stayed relatively equal. Part of this consistency derived from the consistent rate with which SAMs and LARCs grew. Pills, which are mostly provided by private pharmacies, clinics, and drug shops, remained the most widely used method. Unlike many other countries, Cambodia's private sector—mainly its social marketing organizations—made significant contributions to LARCs, accounting for half of all women using an implant. Key informants attributed these results to the Cambodian government's sound policies and commitment to family planning, as well as application of global lessons to effectively target and use public subsidies to establish the value of paying for family planning.

Kenya

Kenya demonstrated consistent mCPR growth, with public and private sectors leading that growth at different points in time. Between 1989 and 2014, mCPR among married women increased from 17.9 percent to 53.2 percent, moving the country from the end of Stage 1 to the threshold of Stage 3 of the S-curve. As the country moved through the lower levels of Stage 2, private sector increases in injectables and condom provision accounted for the majority of mCPR growth. After a brief period of stagnation, mCPR began to increase again after 2003. As the country neared Stage 3, growth was more balanced between SAMs (primarily injectables) and LARCs (primarily implants), and between public and private sources. Key informants identified several factors behind this evolution. In the early years, the private sector benefited from government investments in demand creation, gaps in the health system's ability to meet that demand, a relatively high ease of doing business, and donor investments in social marketing. In later years, government investments in public service delivery infrastructure helped increase the public sector's share. Public-private partnerships also facilitated private provider access to donated commodities, which helped bring down costs (especially of implants) and supported private providers' ability to affordably offer LARCs.

Nigeria

Nigeria was intended to serve as a "control" country; it demonstrated high contributions from the private sector, yet has failed to move past Stage 1. A closer examination of regional data presents two starkly different family planning markets in the southern and the northern regions of Nigeria. In southern Nigeria, mCPR among married women grew throughout the 2000s, reaching 19.4 percent (early Stage 2) in 2013, before declining back to 15.3 percent by 2018. In the north, mCPR remained consistently low (approximately 5 percent) before a slight uptick to 7.2 percent in 2018. In the south, growth occurred mostly through increased private provision of SAMs; in the north, recent upticks mainly occurred from public provision of LARCs. Local stakeholders highlighted several factors behind these differences: sociocultural norms around fertility and family planning; regional variation in availability of private sector infrastructure; and shifting donor investments from private sector programs in the south to public sector programs in the north. This last factor reinforced the need for continued investments in demand creation through early levels of Stage 2. Key informants cited the combination of high price sensitivity and the withdrawal of donor subsidies as driving factors behind the mCPR decline in the south between 2013 and 2018.

Philippines

Similar to Kenya, the Philippines market grew in two stages over the 24-year period. From 1993 to 2017, mCPR among married women increased from 24.9 percent to 40.4 percent. In the first 15 years, the private sector accounted for the majority of this growth. Key informants attributed this trend to the government's emphasis on traditional methods (and thus high unmet demand for modern methods) and rising incomes that made for greater purchasing power. While social marketing organizations initially benefited from donor subsidies as they entered the market, many transitioned over time to sustainable, cost recovery models. Over time, private sector channels met most of the demand in its target market segments (i.e., urban, middle/upper socioeconomic groups) and growth leveled off. Following 2013, targeted government investments in the public family planning program helped reinvigorate mCPR growth, mainly among poorer and more rural populations.

Tanzania

In Tanzania, the family planning market moved from Stage 1 to Stage 2, and private sector contributions increased rapidly. From 1991/92 to 2015/16, mCPR among married women grew from 6.6 percent to 32.0 percent. During that time period, the number of women served by the private sector increased twice as fast as the number of women served by the public sector. Initially, private sector growth focused on pills and condoms, the latter of which benefited from donor-funded HIV prevention efforts. In later years, pharmacies began to increase their delivery of injectable methods, further contributing to private sector market growth. Implants, the other fast-growing method, continued to be primarily delivered through the public sector. Key informants attributed private sector growth to an overall improvement in the operating environment: the end of a government ban on private health services in 1991, increased mechanisms for public-private engagement in health, and overall economic growth. Private actors also benefited from donor investments in demand creation and social marketing.

Lessons and programmatic considerations

Lessons and programmatic considerations

Based on the six country analyses, SHOPS Plus identified several lessons and programmatic considerations that donors and country governments looking to leverage the private sector to help grow its family planning markets should consider. The lessons and considerations are grouped into those related to the broader country context and those that are specific to each of the three stages. It is important to note that the factors discussed under the stage-specific findings can likely be found in family planning markets at every stage of the S-curve; however, the discussion below is meant to highlight where they might be most relevant at specific points of the market's development.

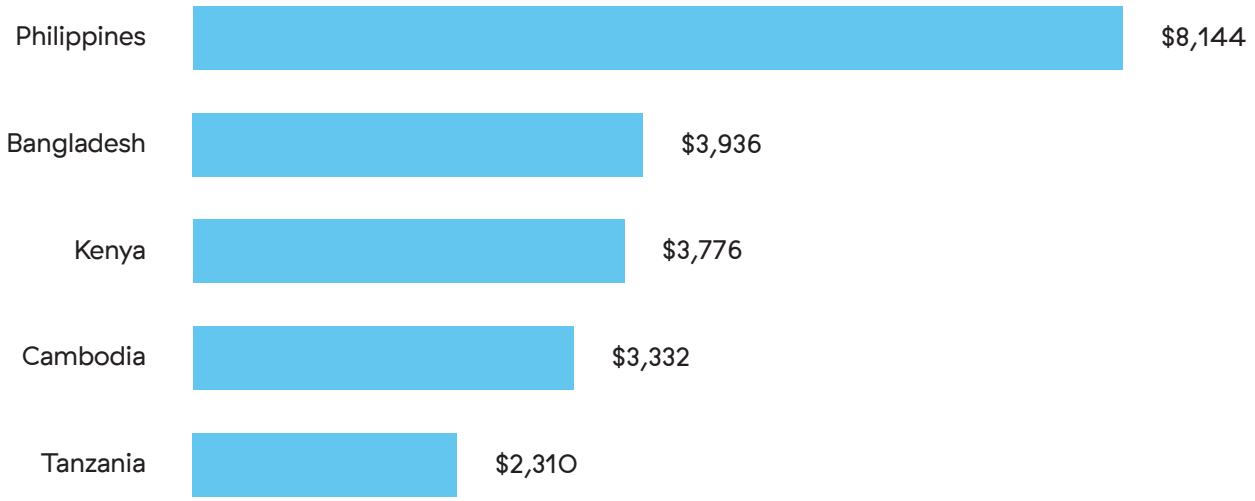
Country contextual factors

Economic growth matters—for increases in both demand for and supply of private sector products and services. Key informants in every country examined indicated that economic growth contributed to the private sector's expansion from both a supply and a demand perspective. From a demand perspective, country experts articulated the expected link between a country's economic growth, increased purchasing power of users, and demand for private sources of family planning. From a supply perspective, key informants stated that economic growth coincided with improvements in the ease of doing business and growth in private sector infrastructure, such as pharmacies, shops, and clinics. These factors resulted in an increase in the number and geographic coverage of private sector channels that could be leveraged to distribute family planning. The contrasting growth of private sector contributions to mCPR in southern and northern Nigeria highlight this. Southern Nigeria, which had higher rates of economic growth, experienced greater mCPR growth with greater private sector contributions than the north. These trends are aligned with where more private health infrastructure is located (Johnson et al. 2014). Therefore, donors should consider incorporating economic growth indices as a factor when prioritizing countries for private sector programming.

Photo: DDC/Sama Jahanpour

Private sector contributions can be significant and can increase at various income levels—not just once a country reaches a certain threshold. The per capita gross national income levels of the five countries that showed significant mCPR growth (Figure 6)[2] ranges significantly, from $2,310 in Tanzania to $8,144 in the Philippines. This demonstrates that, with the right strategies and investments, the private sector can contribute to more women achieving their reproductive intentions in countries across a spectrum of income levels.

Figure 6. Per capita gross national income, 2015



Demand is essential for both public and private sectors to grow, and some countries may require significant complementary investments to address underlying factors behind low demand. Analysis by Avenir Health done through the Track20 project has proposed a "demand curve" that investigates the link between mCPR and a woman's desired family size (Weinberger 2017). The curve presents a theoretical mCPR ceiling for countries based on the average number of children that a woman desires, and can help countries understand when social norms and other underlying factors can limit family planning market growth. Across the countries examined by SHOPS Plus, and at various points along the S-curve, the analyses showed that overall mCPR growth and increased private sector contributions occurred either when desired fertility was already low, or was decreasing. Conversely, in northern Nigeria, where ideal family size among women remained high, mCPR levels and

[2] Figure 6 uses World Bank data on per capita gross national income in 2017 dollars, adjusted for purchasing power parity.

the contributions of public and private sectors did not increase substantially through the entire period despite substantial investments on the supply side. These findings reinforce the importance of considering women's desired fertility levels in designing public and private sector family planning programs. In countries where women's fertility intentions are likely to limit further increases in voluntary adoption of family planning, significant complementary investments to address the underlying factors may be necessary. For example, where desired fertility is high because of high child mortality, donors and governments could consider addressing the causes of high child mortality. Parallel investments in education campaigns that position family planning as a method to space births and improve child survival outcomes may also be necessary in such contexts.

Willingness to pay is a key factor to understand the extent of subsidies needed. The analyses demonstrate multiple ways in which donor or government subsidies have been used to bring down family planning costs in the private sector. Key informants cited several strategies that have been employed to ensure that family planning products and services in the private sector are available to clients at affordable, competitive prices:

- Subsidizing social marketing programs
- Increasing access to low-cost commodities through global price agreements with manufacturers
- Enabling private health facilities to access commodities from the public sector supply chain
- Contracting private facilities through social contracts or insurance programs

The case of Nigeria demonstrates how important it is to periodically assess clients' willingness to pay and make decisions about how to deploy subsidies. In Nigeria, despite growing income and ability to pay, willingness to pay for contraceptives had not increased sufficiently for the use to be sustained in southern Nigeria after donors shifted their subsidies to focus on northern states between 2013 and 2018. Nigeria is reported to be one of the most price-sensitive markets for most products and services, including family planning, in sub-Saharan Africa. Market research reveals that Nigerian consumers prioritize price over other access and quality factors in determining their purchases (Fiorini 2013). Subsidies had initially helped to align private family planning options with consumers' willingness to pay and helped southern Nigeria reach Stage 2; by not taking the full context of consumers' willingness to pay into account as part of their decision to transition subsidies to northern Nigeria, donors may have overestimated the strength of southern Nigeria's family planning market. Following the withdrawal of subsidies, social marketing organizations had to raise prices and struggled to maintain their sales volumes.

Kenya and Tanzania offer examples of persisting subsidies that hampered private sector growth. The number of users accessing injectables from private health facilities increased substantially over the entire period. However, social marketing organization sales of injectables did not increase at the same rate and commercial brands were nonexistent. Family planning experts in these countries attributed this trend to policies that allow private health facilities to access the public sector supply chain for injectables. Consequently, social marketing organization supplies primarily cater to facilities that lack regular access to the public sector supply chain or during phases when public sector stocks are constrained. Reducing these subsidies by transitioning private facilities to private supplies of injectables, supported by willingness-to-pay assessments, can help further grow the private sector supplies commodity and services for injectables in these countries.

Cambodia offers an example of another aspect of willingness to pay—the signaling effect of public sector fees on price expectations. In Cambodia, family planning is not free in the public sector; it is similar in price to social marketing prices in other countries, with vouchers and health equity funds used to target subsidies to those in most need. Key informants indicated that charging a price in the public sector has helped establish a higher price expectation—and willingness to pay—for family planning products regardless of source. This expectation has enabled Cambodian social marketing organizations to operate with lower subsidies and to transition away from external funding support earlier than other countries despite low per capita gross national income.

Donor investments influence and shape markets at every stage of the S-curve. Trends in use of condoms and pills in the three sub-Saharan African countries are different from the trends in the three countries in Asia. Pills were instrumental in the initial growth before stagnating or declining in the three sub-Saharan African countries, while their use continued to grow in the three Asian countries and they now have a substantial share of the method mix. Condom use patterns showed the opposite. Condom use for family planning has remained low in the Asian countries, and steadily increased in the sub-Saharan African countries. Key informants attributed these trends to shifts in levels of donor support for these methods. In sub-Saharan Africa, increased investments in condom programs for HIV prevention is believed to have had a halo effect on condom use for family planning. Increased donor investments in injectables and LARCs in sub-Saharan Africa may have reduced resources and management attention away from pills. The decline in pill use in the three sub-Saharan African countries has important implications on the private sector market share, given the method's importance to private retail outlets.

Stage-specific findings

Moving from Stage 1 (low prevalence) to Stage 2 (growth): Social marketing programs increase acceptance and fulfill demand through sales of condoms and pills

Countries in Stage 1 have low acceptance and use of family planning overall, and a nascent private sector market for these products and services. Users are fewer, and their willingness to pay for the benefits offered by contraception is lower, compared to more developed family planning markets. Importers, distributors, retailers, and service providers are often unsure of the business proposition in offering family planning products and services at this stage and hesitate to invest in them. Among the countries examined, Tanzania and southern Nigeria successfully moved from Stage 1 to Stage 2, whereas northern Nigeria remained at Stage 1 throughout. The lessons from these countries' experiences and their social marketing programs are described below. The contribution of social marketing programs in a country's growth in Stage 1 to reach Stage 2 is highlighted. The programs appear to have made the greatest contribution to private sector growth in this stage, while other private sector interventions were either not appropriate at this stage or did not have substantial contributions.

Social marketing programs drive access to and acceptance of SAMs in the private sector. Tanzania and southern Nigeria had strong social marketing programs, and rapidly scaled up access to and use of condoms through pharmacies and shops in both countries, as well as pills in southern Nigeria. The social marketing programs also played an important role in increasing the acceptance and demand for family planning, as well as for shops and pharmacies as sources of family planning products. These programs also demonstrated that certain population segments were willing to pay for family planning products and services. Additionally, though Kenya and Cambodia were in Stage 2 of the S-curve at the beginning of the review period, key informant interviews and literature review reinforce this finding, as social marketing programs in these countries had made similar contributions when they were in Stage 1 of the S-curve. Social marketing programs, and the private sector overall, do not appear to have made substantial contributions to uptake of other methods during Stage 1 growth. Key informants hypothesized that the uptake of condoms and pills present an easier goal in early stages of the S-curve because provider-dependent methods are more complex to scale up and require greater levels of donor support. Additionally, they state that the presence and utilization of private health facilities may have been low while the countries were in Stage 1.

Social marketing programs work with and without political and public sector support. In Stage 1, local government support for family planning does not seem to be a necessary condition for social marketing success. In southern Nigeria, social marketing programs were still effective in their early years and contributed to family planning market growth before political leadership and supportive policy frameworks had fully developed and been implemented. That is not to say that strong political and policy support does not contribute to the success of social marketing programs, though, as Cambodia's social marketing organizations have benefited from strong political and policy support for family planning from the onset.

Social marketing programs need support to overcome sociocultural barriers to demand for family planning. Key informant interviews revealed that a key factor in the success of social marketing programs in this early stage was the existence of latent demand, usually due to low or inconsistent coverage of public sector family planning services and the absence of other alternative supply sources. In Stage 1, social marketing programs have also been successful in increasing adoption of family planning among those who wish to delay or avoid a pregnancy. However, in regions where there are significant gender differences in desired family size, and religious or cultural norms oppose fertility regulation, social marketing programs require additional support to address these barriers before they can successfully increase demand for family planning and enable more couples to adopt contraception. This is evident from the contrasting results from three decades of social marketing programs in Nigeria. The social marketing program was substantially more successful in the south due to favorable sociocultural norms in the region than in northern Nigeria.

Social marketing programs need to capitalize on private sector retail outlets and service delivery points where they exist, and develop alternative distribution mechanisms where private sector infrastructure is weak. In the countries reviewed, social marketing programs leveraged existing drug shops, pharmacies, and private health facilities. Further, social marketing programs increased in coverage as these channels expanded. For example, social marketing programs in Tanzania benefited from support aimed at formalizing and strengthening drug shops into accredited drug dispensing outlets (ADDOs). To reach beyond the catchment areas of existing retail networks, social marketing programs have tapped into public and private sector networks of community health workers (CHWs) and community groups formed by microfinance institutions. This experience is in contrast to the social marketing programs in northern Nigeria. Northern Nigeria has a lower availability of

community pharmacies and patent and proprietary medicine vendors compared with southern states. Key informants cited this difference and the limited reach of social marketing programs to alternative distribution channels as key explanatory factors behind the limited role of the private sector and low growth of socially marketed products in the north.

Moving through Stage 2 (growth) into Stage 3 (high prevalence): Expanding method choice and the cadre of private sector actors offering family planning services help reach new population segments

Among the countries analyzed, Bangladesh and Kenya moved from Stage 2 to Stage 3 of the S-curve during the review period, and the Philippines and Cambodia made considerable progress within Stage 2. Key lessons from these countries in increasing private sector contribution to a country's growth in Stage 2 to reach Stage 3 are described below. Though all these countries benefited from social marketing programs, the factors highlighted in this section made significant contributions to private sector growth by themselves, and were important factors in building the contributions of social marketing programs. Further, though these factors could be applicable at any of the three stages, they are likely to be more relevant when self-care methods are widely available, particularly in areas with a dense network of drug shops and pharmacies, and when family planning programs aim to broaden method choice by increasing access to provider-dependent methods.

Community-based actors can help accelerate or reignite efforts to promote and distribute contraceptives. Community-based distribution and promotion of family planning has been an important element in countries rapidly increasing mCPR in Stage 2 of the S-curve. Bangladesh and Kenya developed strong, extensive community-based programs. At the peak of the program in Bangladesh, more than 30,000 female health workers were promoting and distributing contraceptives, and making substantial contributions to increased use of pills. Similarly, Kenya's community health strategy initiated in 2006–07 and the network of CHWs and community health extension workers (CHEWs) implemented strong community-based family planning programs that helped increase the program's coverage in rural areas, address misconceptions regarding modern methods, and increase access to condoms and pills. While these community-based programs were largely in the public sector, key informants cited spillover effects in the private market. Essentially, by creating demand for SAMs in rural and peri-urban areas, these programs created new markets that the private sector could help serve—in geographic areas where the private sector would not normally invest on its own.

Donor-supported provider networks and social franchising expanded method choice in the private sector. In Kenya, donors invested in social franchise networks that trained private providers in the provision of LARCs, provided supportive supervision and monitoring, and linked private health facilities to an assured supply of family planning commodities. In Bangladesh, donors made similar investments in non-governmental organizations (NGOs).[3] Key informants cited these investments as important factors that contributed to expanded method choice and increased contraceptive use through the private sector, especially in Kenya. Though the public sector is the main source of LARCs in most countries, key informants credited donor-supported private provider networks and social franchising as the main avenue for expanding access to IUDs and implants in the private sector. This strategy has often been paired with other interventions to make private provision of LARCs more available and more affordable, especially attempts to include health facilities operated by lower cadres of health workers through task-sharing policies.

Task-sharing reforms have been used to expand lower-tier private sector networks for family planning. Many countries have implemented task-sharing policies to formalize, strengthen, and expand family planning availability through private sector retail outlets and health facilities managed by lower cadres of health workers. Key informants generally indicated that these reforms were intended to increase the number of private sector outlets capable of providing family planning and to lower costs in the private sector. For example, creating ADDOs—a formally recognized lower-tier drug shop legally allowed to sell some SAMs—in Tanzania helped increase availability of over-the-counter products in rural areas. Task-shifting policies and regulations supportive of health facilities operated by nurses and midwives have helped increase availability of family planning services in Bangladesh, Cambodia, Kenya, and Tanzania. Since facilities operated by a lower cadre of health workers charge a lower fee to their clients than doctor-led facilities, and because they are more likely to be operating in rural and remote areas, such facilities make private family planning services accessible to more population segments.

Countries are beginning to pursue fuller integration of private providers into the health system through financing programs and commodity supplies to bring down financial barriers. Local experts interviewed suggested that strategies to make provider-dependent family planning methods—injectables, IUDs, and implants—more affordable to clients seeking these methods from the private sector can be a key factor in the private sector's contributions to uptake of these methods. Access to subsidized implants

[3] In this brief, NGOs include faith–based organizations.

by NGO facilities and private provider networks in many countries, and private facilities' access to publicly procured injectables in Kenya illustrate this approach, though such strategies are yet to achieve scale and may not be sustainable in the long term. Sustainable financing approaches that show promise include integration of private providers in PhilHealth for provision of IUDs and implants in the Philippines, and social contracting of private facilities for provision of LARCs in Tanzania. However, these approaches have not been widely applied or are at an early stage of implementation and have not shown significant results yet.

Moving into Stage 3: Leveraging the private sector to ensure sustainability of family planning use

Bangladesh is the only country in this analysis that is at Stage 3 of the S-curve. The private sector's share of the total family planning market increased from 15 percent in 1994 to nearly 50 percent in 2014. Most of the private sector supplies currently are not subsidized, and are financed through out-of-pocket payments by clients. In terms of aggregate ability to pay, Bangladesh is not an outlier. Bangladesh's gross national income per capita (purchasing power parity, 2017 dollars) was $3,936 in 2015, lower than Nigeria and the Philippines and in the same range as the other countries in the series. At the same time, three interrelated contextual factors that are not present in all countries enabled the rapid growth of private sector contributions in Bangladesh:

- **Large market size**: Bangladesh's family planning market is larger than most countries, as a function of the country's large population and high contraceptive use rates. This makes Bangladesh an attractive market for private sector actors to invest in, and provides economies of scale that help reduce the final cost to clients.
- **High density of demand**: Bangladesh has one of the highest population densities among low- and middle-income countries, which contributes to lower costs per user for distribution and marketing.
- **Dominance of resupply methods, particularly pills**: In most countries, women using SAMs generally opt for private sector sources, likely due to their convenience. Further, these methods are less expensive than LARCs for each purchase occasion, and hence more affordable to those who rely on out-of-pocket payments. Eighty-five percent of women using a modern contraceptive method in Bangladesh use a SAM, making the market more suitable for being sustained through private sector supplies.

Lessons on improving the sustainability of family planning use are drawn from the Bangladesh example. In addition, strategies that could help sustain family planning supplies, gleaned from the other country analyses, are highlighted below.

Local and regional manufacturing and availability of generic products can improve sustainability. Quality-assured generic commodities, particularly pills and injectables, have become more widely available over the last two decades. The commodity costs supplied by generic manufacturers are considerably lower than the cost of originator brands. Thus, by transitioning to suppliers of generic, quality-assured commodities, donor or government subsidies may no longer be required to ensure that private sector supplies of these methods are affordable to large sections of the population. In Bangladesh, emergence of local manufacturing of condoms and generic pills helped social marketing organizations maintain a low price when donor subsidies were withdrawn. It also facilitated the emergence of commercial marketers supplying these commodities at reasonable prices, further expanding the market.

Public CHWs/CHEWs can help open up private sector channels. In Kenya, which is on the threshold of Stage 3, private sector actors were allowed to engage with the public sector's CHWs and CHEWs, who offer private sector brands (both free and for a cost) to community members. Further, social marketing organizations use CHWs' services to promote underutilized methods and refer clients to private clinics while compensating the CHWs for services provided. By leveraging the excess capacity of the CHEWs and CHWs, the private sector has expanded its product and service coverage faster and at lower incremental costs, enabling growth.

More data are needed to evaluate strategies for transitioning donor-funded LARC programs to public or private accreditation and insurance mechanisms. Sustaining affordable services of LARCs in the private sector has been a challenge in many of the countries analyzed. As noted earlier, sustainable financing approaches that show promise include integration of private providers in PhilHealth for provision of IUDs and implants in the Philippines, and social contracting of private facilities for provision of LARCs in Tanzania. However, to date, the data are limited on the success of these efforts on a large scale, and their outcomes should be revisited to better understand their effectiveness.

Recommendations for strengthening private sector contributions in family planning

The findings from this analysis can provide governments and donors with recommendations for strengthening private sector contributions to a country's family planning market. Since the mCPR threshold for the S-curve stages are arbitrary, and the market conditions typical of one stage could exist to some extent in the next stage, the recommendations are not classified according to the S-curve stages. Rather, these recommendations are ordered to the level of mCPR in a country, with those listed first being most relevant to countries with lower mCPR, and later recommendations relevant to countries with mid- to high-mCPR.

1. **Assess demand for family planning and invest in addressing underlying barriers where necessary**. The series of country briefs highlights that when fewer women desire to avoid pregnancy, the room for further mCPR growth may be limited. Track20's "Maximum mCPR model" is an easy-to-use tool that can help assess the level of demand in a population. In countries where the scope for further increases in mCPR is constrained by desired fertility levels, programs should first seek to understand the underlying reasons—such as sociocultural norms regarding ideal birth intervals and family size, and concerns due to high child mortality rates—and address these barriers. Community-based health promotion strategies have been effective in increasing adoption of modern contraceptives in many of the countries analyzed, and could be considered as one of the options.
2. **Support social marketing to increase SAM options and strengthen private distribution channels**. Social marketing programs can rapidly scale up availability of affordable quality-assured contraceptives, particularly condoms and pills, through existing private sector channels. Support to social marketing programs should be considered when the private sector retail networks, particularly drug shops and pharmacies, are easily accessible to the target population and quality-assured and affordable SAMs are not widely available in these outlets. In regions where private retail outlets are scarce, social marketing programs will need support to develop alternative private sector networks, such as partnerships for community-based distribution. Policy advocacy, and support for formalizing, strengthening, and aggregating lower-tier shops (such as ADDOs in Tanzania) could also be explored.

3. **Support private health facilities to expand the basket of methods offered and monitor trends in availability and use of all methods**. Strengthening private health care providers' clinical, business, and counseling skills in the provision of newer methods, and ensuring uninterrupted supplies of family planning commodities has expanded the basket of methods available in the private sector and the adoption of modern contraceptive methods. In all the countries reviewed, such support appears to have contributed to overall increases in adoption of provider-dependent methods, and the private sector's contributions to provision of these methods, particularly implants and IUDs.
4. **Invest in strengthening lower-tier private sector health facilities**. The S-curve brief series repeatedly highlighted strategies to sustainably increase clients' physical and financial access to private sector services. Task-sharing policies supportive of family planning provision by a lower cadre of private health workers (such as nurses and midwives) and regulations that support easy registration of private facilities operated by such health workers helped increase access to provider-dependent family planning methods. Since facilities operated by lower cadres of health workers are more likely to be found in peri-urban and rural areas, and because such facilities charge a lower fee than do doctor-led facilities, family planning services offered by lower-tier health facilities are more accessible and affordable to populations living outside urbanized areas of a country.
5. **Invest in increasing availability of generic commodities**. Manufacturers of generic family planning products, such as pills and injectables, supply these commodities at a significantly lower price than originator brands. Where social marketing organizations and local importer-marketers transition their product sourcing to generic commodities, the price paid by clients for these products is significantly lower without the need for subsidies.
6. **Plan for transition to sustainability early, and monitor the market during the transition**. The Bangladesh experience highlights the importance of planning the transition to sustainability early. Planning for sustainability appears to have been initiated in the late 1990s, and even though certain contextual factors in Bangladesh were supportive of a greater private sector role in family planning provision, it took Bangladesh nearly 20 years to increase the share of private sector provision in family planning from 15 percent to 50 percent. The Nigeria brief highlights the importance of monitoring the market during transition. Family planning key informants in Nigeria hypothesized that "graduating" social marketing in Nigeria too early, before the market was ready to bear a non-subsidized price, may have affected family planning use.

Photo: Robin Keeley

The private sector has been and will likely continue to be an important actor in many countries' family planning markets. As governments and their donor partners seek to improve access to and increase use of modern family planning methods, they should consider how the private sector can best support these goals. This analysis demonstrates the need to take into account contextual factors—such as market size and S-curve stage—in making programmatic decisions. By tailoring interventions that seek to leverage the private sector to a country's particular context, governments and donors can enhance their ability to enable more women and couples to achieve their family planning goals.

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