The Private Sector's Contributions to Family Planning Market Growth

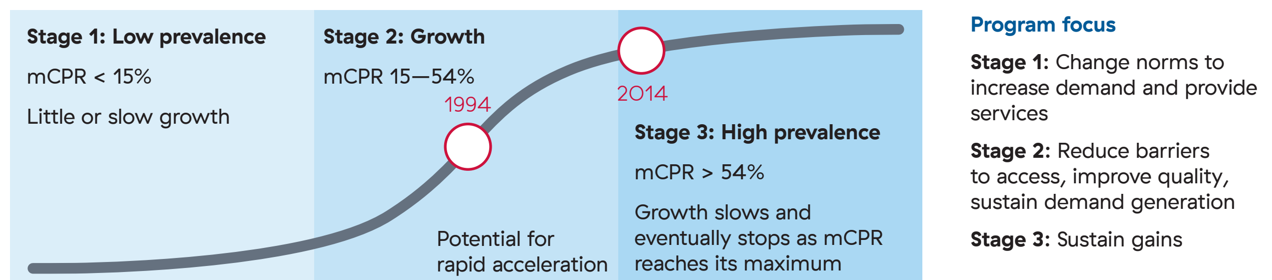
Bangladesh

The Bangladeshi family planning market experienced significant growth from 1994 to 2014. Over that 20-year period, the modern contraceptive prevalence rate among married women increased from 36.6 percent to 54.1 percent. The private sector played a large role in this market growth. A SHOPS Plus analysis revealed several economic, sociocultural, policy, and programmatic factors that facilitated the private sector's contributions to increase the modern contraceptive prevalence rate. Understanding these factors can help donors and country governments better consider appropriate private health sector investments and interventions in their family planning programs.

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

Bangladesh's mCPR is marked in red



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

This is one in a series of briefs that examines family planning market growth since 1990.

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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. 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 economic, sociocultural, policy, and programmatic factors that facilitated increased private sector contributions. Understanding these factors can help donors and country governments better consider appropriate private health sector investments and interventions in their family planning programs.

Between 1994 and 2014, Bangladesh moved from mid-level of Stage 2 to the beginning of Stage 3 on the S-curve (STATcompiler 2019). To further these gains in Stage 3, family planning stakeholders will need to sustain the private sector's provision of short-acting methods (SAMs) and continue expanding the market for long-acting reversible contraceptives (LARCs). This brief recommends strategies for stakeholders to leverage the private sector's contributions to growth.

Methods

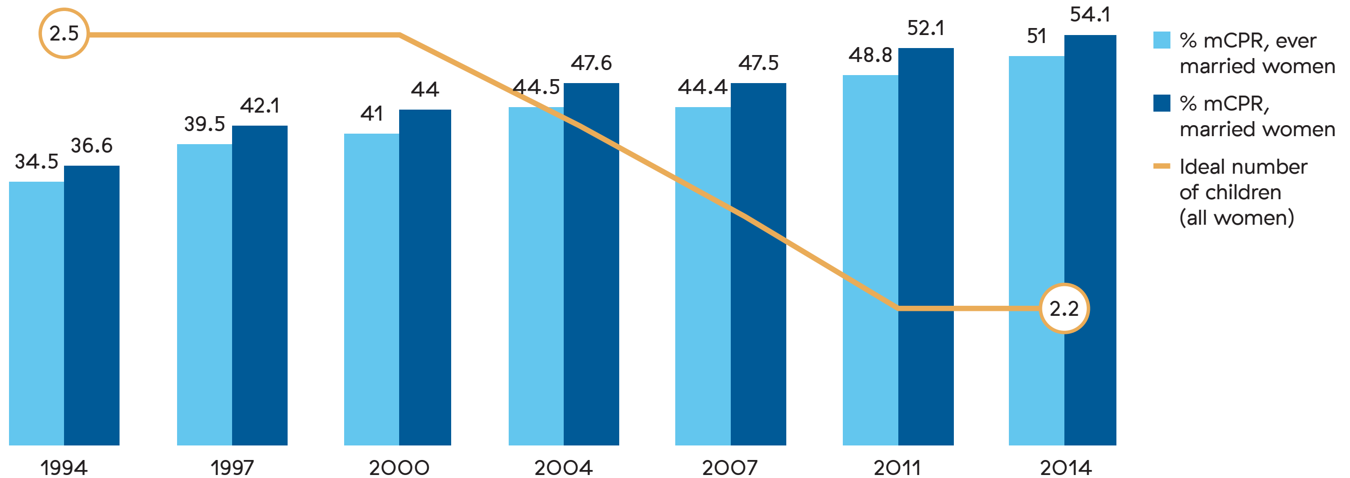
This is one in a series of briefs that examines the family planning markets in six countries since 1990. Five countries in Stages 2 and 3 (Bangladesh, Cambodia, Kenya, the Philippines, and Tanzania) saw increases in mCPR and private sector contributions. One country (Nigeria) saw substantial private sector contributions, but low growth in mCPR, and remained in Stage 1. Examining all six countries helps identify what factors 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. The project conducted country-specific literature reviews and key informant interviews with experts who worked in Bangladesh's family planning market between 1994 and 2014 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.

Increased sustainability through private sector family planning supplies

The Bangladeshi family planning market experienced significant growth between 1994 and 2014, with mCPR among currently married women increasing from 36.6 percent to 54.1 percent. The mCPR among all women who had ever been married—including women who were widows, divorced, or separated—similarly increased from 34.5 percent to 51.0 percent. In that same time period, the mean ideal number of children a woman desired to have in her lifetime declined slightly from 2.5 to 2.2, with most of that change occurring between 2000 and 2011, indicating a modest uptick in desire of women to delay or limit future pregnancies (Figure 2).

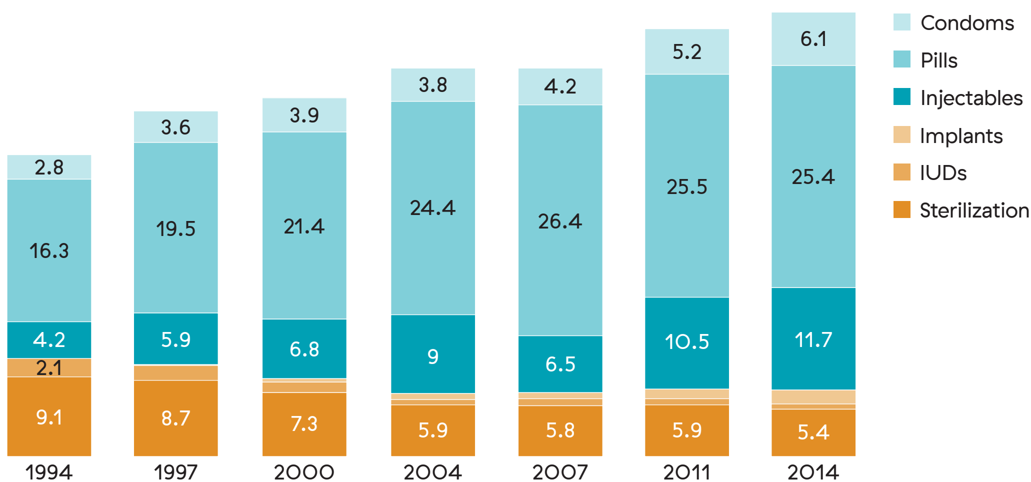
Figure 2. Changes in family planning use and childbearing preferences, 2000—2014



Among all women who had ever been married, this growth occurred mostly in the use of SAMs (Figure 3).[1] Between 1994 and 2007, the percentage of women using pills, injectables, and condoms all increased; after 2007, pill use leveled off while the other two SAMs continued growing. With the exception of implants, which experienced modest increases, the use of long-acting and permanent methods (LAPM) declined. These two trends—increases in SAM use coupled with decreases in LAPM use—aided a shift toward SAMs in the overall market. In 1994, condoms, pills, and injectables accounted for two-thirds of family planning use. By 2014, this number had increased to 85 percent.

Figure 3. Modern contraceptive use by method

Ever married women (%)

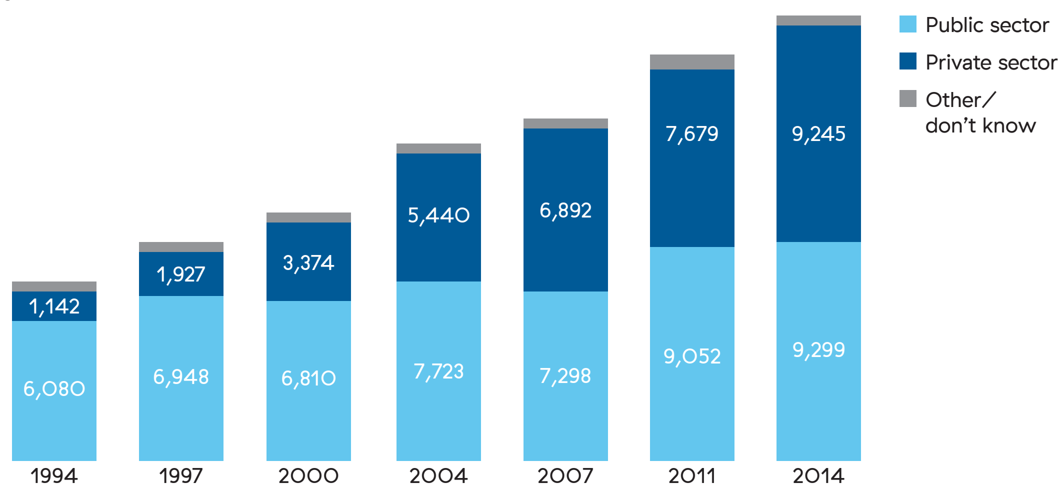


[1] Diaphragms, contraceptive foam or jelly, female condoms, and emergency contraception are included in graphs that show all modern contraceptives combined, but are not shown separately due to small sample sizes. This analysis excludes the lactational amenorrhea method, Standard Days Method, other fertility awareness methods, and DHS's category of other modern methods, as surveys do not systematically ask for sources of these methods.

As the country enters Stage 3 of the S-curve and faces potential graduation from United States government family planning assistance, the extent to which its reliance on domestic financing has increased and strategies that have enabled greater self-reliance are critical priorities to examine. Bangladesh underwent a significant shift in sourcing patterns that highlights the country's path to sustaining the gains it achieved (Figure 4). In 1994, the private sector served only 15 percent of family planning users; by 2014, it reached just under half of the market. While the absolute number of users served by the public sector increased by 53 percent between 1994 and 2014, the number of users served by the private sector increased by 710 percent. While population growth accounts for some of these increases, this trend indicates that the private sector contributed more to the growth of the overall market than the public sector and that women who had previously been served by public providers may have switched to private sources.

Figure 4. Sources of modern contraceptive methods by absolute number of users

In thousands, by source



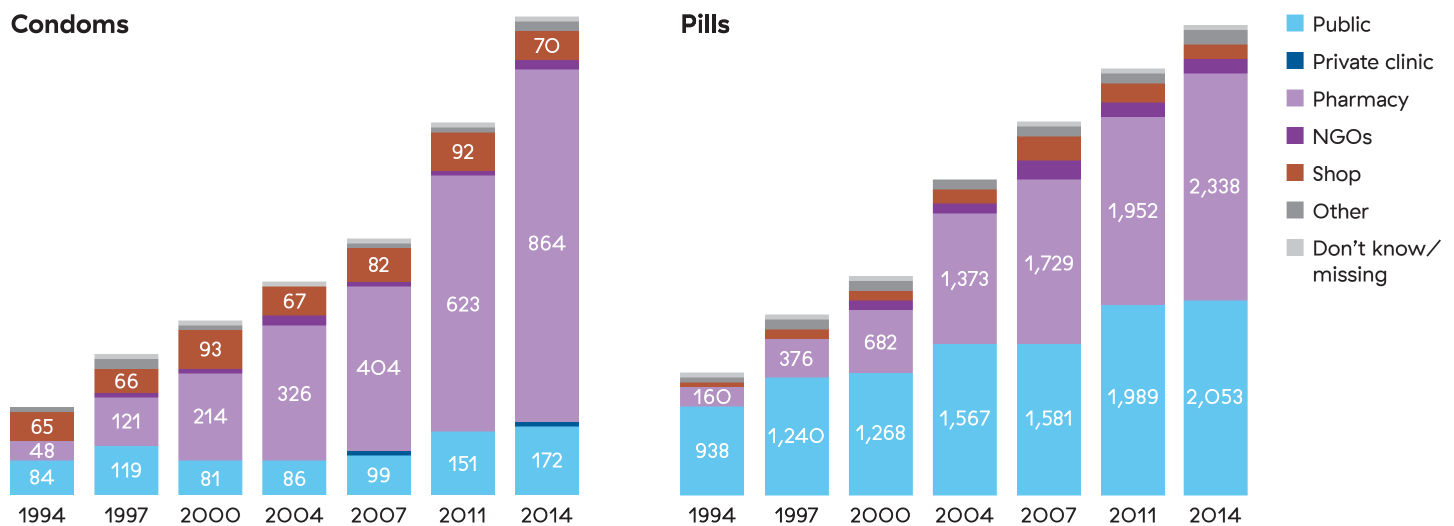
Trends in sources of methods

Compared to public sources, private sources have seen greater growth in the use of condoms and pills, two of the methods driving growth in mCPR in Bangladesh (Figure 5). The number of condom users increased by over 940,000 between 1994 and 2014.[2] Most of that growth came from increased sales at private pharmacies. In 1994, all private sector sources combined accounted for 53 percent of condom users. By 2014, private sector sources accounted for 83 percent of the condom market, with pharmacies alone accounting for 75 percent. From 2000 onward, the contributions of social marketing products increased at a lower rate than the rate at which the total private sector increased, indicating an increasing share of commercial condom brands in the market.

[2] All absolute numbers of users presented in this brief are derived from a secondary analysis of DHS data applied to United Nations Development Programme's World Population Prospects (2019 Revision) projections.

Figure 5. Trends in number of condom and pill users

In thousands, by source (ever married women)

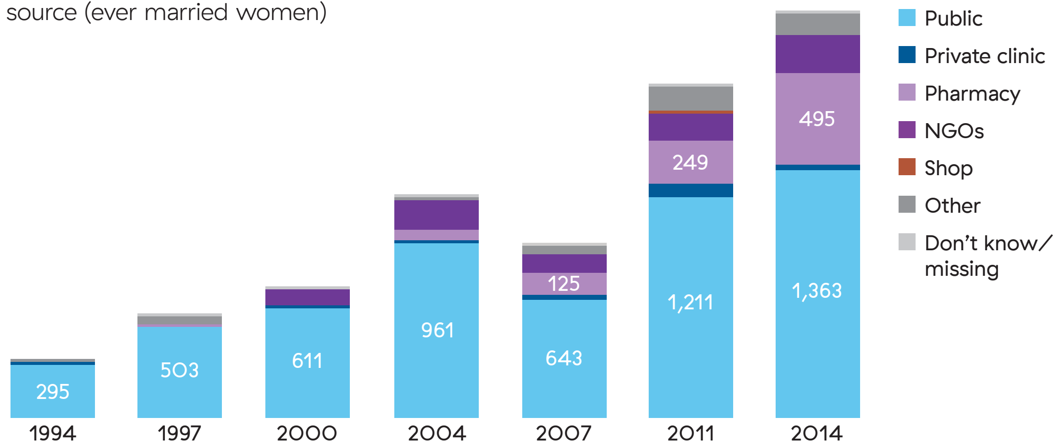


The market for contraceptive pills shows a similar shift from primarily public to primarily private sources. In 1994, public sources served 75 percent of pill users. Many of these women accessed their pills from public sector female health workers—an extensive network that included over 30,000 community-based workers at its peak. Over the next 20 years, the private sector grew more than 950 percent—primarily from an increased role for private pharmacies. During that same period, although the public sector also increased the absolute number of pill users it served, its share of the total market decreased to 42 percent. Unlike with condoms, increases in couple years of protection from socially marketed pills mirrored those of private sector users, revealing a limited presence of commercial brands in the market.

Injectables are the second most widely used modern contraceptive method. Unlike the other two SAMs, more injectable users accessed the method from public than private sectors throughout the 20-year period (Figure 6). However, the contribution of the private sector increased, particularly in recent years. The private sector served only 4 percent of injectable users in 1997; its share increased to 19 percent in 2004 and to 34 percent in 2014. Sales of socially marketed brands mirrored the number of private sector users until 2011. From 2011 to 2014, the number of private sector users outpaced sales of socially marketed brands, indicating a recent emergence of commercial brands in the supply chain.

Figure 6. Trends in number of injectable users

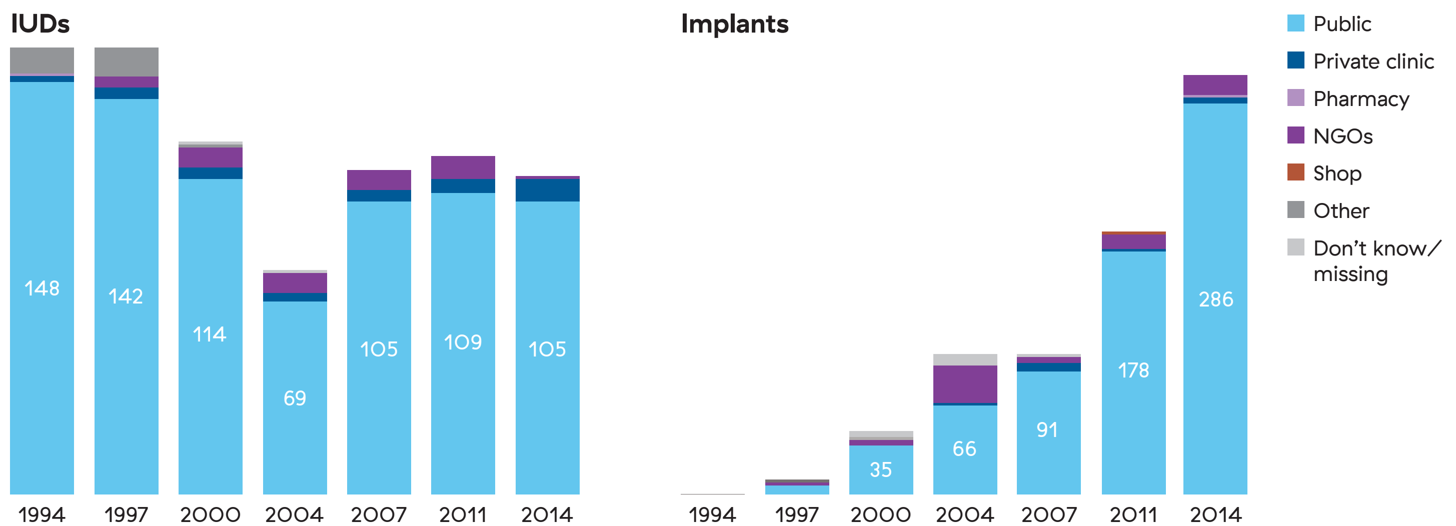
In thousands, by source (ever married women)



Bangladesh's market for LARCs constitutes a small proportion of the method mix. For both IUDs and implants, the public sector remained the dominant source throughout the entire time period (Figure 7). While private sector provision increased slightly, it only accounted for a small fraction of all users for both methods. Beyond the continued dominance of public sources, IUDs and implants differed in their growth patterns. Between 1994 and 2004, the number of IUD users dropped in half before recovering slightly over the next 10 years. Implants, however, demonstrated high levels of growth over the entire period, from just over 9,000 users in 1997 to just over 300,000 in 2014.

Figure 7. Trends in number of LARC users

In thousands, by source (ever married women)



Factors driving improvements in long-term sustainability of the market

The private sector's role in Bangladesh's family planning market, described in the previous section, shifted in the 20-year period from 1994 and 2014. SHOPS Plus shared these trends with local family planning experts and conducted in-depth interviews to understand the underlying economic, sociocultural, policy, and program factors that influenced them. The interviews surfaced several insights into factors that shaped the family planning market during this time. These factors, listed below, are similar to those identified in other countries in the series and are not elaborated on further in this brief.

- Low and declining levels of desired fertility and, consequently, the presence of a large cohort of men and women desiring to delay or limit pregnancies
- Strong political commitment to family planning and a robust and extensive family planning promotion and service delivery system in the public sector
- Extensive investments in community-based demand generation in rural areas where the majority of the population resides
- Sustained donor support that helped social marketing organizations and non-governmental organizations (NGOs)[3] increase the private sector market
- Two decades of strong socioeconomic development, resulting in increased purchasing power and expanded private sector supply chain for all products including modern family planning methods

Bangladesh is the only country analyzed in this series that moved to Stage 3 of the S-curve and made considerable progress in ensuring the long-term sustainability of its gains. Local family planning experts pointed to a combination of policy, program, and market factors that enabled the country's transition to a more sustainable market.

Early recognition of the need to transition from external funding fostered sustainable supplies of SAMs.

From the 1990s, social marketing programs were successful in increasing sales of donor-funded condoms and pills. With rapid increases in sales, social marketing programs needed more donated commodities each year, increasing the financial burden on donors. This created an impetus for strategies to ensure sustainability of supplies of these methods. In addition, a shift in donor and government focus to LARCs reduced funding available to support social marketing of SAMs.

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

Adoption of new service delivery methods lowered costs in the private sector.
As noted earlier, injectable contraceptives are the second most popular method in Bangladesh. The private sector's share of injectable users was only 3 percent in 1997, in part because service delivery fees in the private sector substantially increase costs for clients. The private sector's share of injectable users increased in the last two decades and reached 33 percent in 2014 due to new task-sharing policies that allowed the private sector to develop lower cost service delivery models and increased client access to private sector services. The government policy now allows paramedics at lower tier drug shops and trained rural doctors to provide injectable contraceptives. This policy change, coupled with donor support for social franchising (such as the Social Marketing Company's Blue Star and Green Star networks) and NGO-operated clinic networks, was an important factor that led to the private sector's increased contributions to injectable use. Lower cost models, such as nurse-led mini-clinics operated by Marie Stopes Bangladesh in urban slums, have also helped expand access to affordable private sector service delivery points.

Market factors supported cost-efficient operations.
A congruence of factors made the Bangladesh family planning market cost efficient for private sector marketers of SAMs and ensured that private sector products remained affordable without subsidies:

- A large population base coupled with one of the highest mCPR among low- and middle-income countries offered a large market.
- High population density and dominance of one supply channel—pharmacies—for the three most popular methods in Bangladesh offered high return on investments in promotion and distribution.
- Dominance of SAMs in the method mix made family planning more affordable to clients relying on out-of-pocket payments.

The emergence of local manufacturing brought down costs of commodities in the private sector.
Over the past two decades, several local manufacturers of condoms, pills, and injectables started operations. These companies are able to produce low cost, high quality generic products, which reduced input costs to social marketing organizations and other commercial marketers enabling them to keep their prices affordable to a large segment of the population.

Conclusion

In the 20-year period from 1994 to 2014, the family planning landscape in Bangladesh evolved greatly and Bangladesh made substantial progress in the long-term sustainability of its family planning market. This experience highlights several lessons for other countries and points to next steps for Bangladesh to further grow and sustain its market in Stage 3 of the S-curve. Going forward, family planning stakeholders should consider how they can further engage the private sector in the provision of SAMs and continue expanding the market for LARCs. With Bangladesh's urban population expected to exceed its rural population by 2030, these strategies will be especially important (Dhaka Tribune 2018). As the Ministry of Health and Family Welfare does not have legal jurisdiction over primary health care services in urban municipalities, stakeholders have indicated that the burden of serving these increased populations will largely fall on private providers and NGOs. The analysis highlights three strategies to consider:

- **Improve targeting of free oral and injectable contraceptive supplies**. Cambodia's example of setting user fees for services at public facilities while using voucher schemes and health equity funds to ensure the poor can afford family planning is a potential strategy for Bangladesh to consider as a means to increase the private sector's contribution to pills and injectables, thereby freeing up public resources to scale up LARC access and affordability.
- **Address financial barriers to accessing LARCs in the private sector.** While ability and willingness to pay for SAMs in the private sector is aligned with the prices charged by private outlets, there still may be financial barriers to accessing LARCs in the private sector. There are two potential routes to overcoming these barriers. First, the government could contract with NGO clinics or social franchise networks to cover service costs. Second, the government and donors could help private providers lower prices by reducing their input costs. They can specifically help providers access lower cost IUDs and implants, either by supporting the growth of local production or by facilitating access to generics on the international market.
- **Expand the number and types of private providers offering LARCs**. Task sharing is a key strategy to increasing access points in the private sector. While task sharing of injectables to drug shops has increased access to that method, there is a missed opportunity with regard to services led by nurses and midwives. Although a policy change in 2000 permitted these cadres to deliver injectables and IUDs, they have not significantly increased their delivery. Donors and the government should seek to better understand obstacles that they face and design interventions that empower them to serve more clients. Additionally, Bangladesh has an opportunity to increase access to implants by permitting nurses to provide them.

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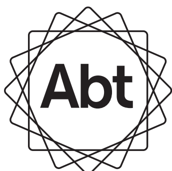

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