The Private Sector's Contributions to Family Planning Market Growth

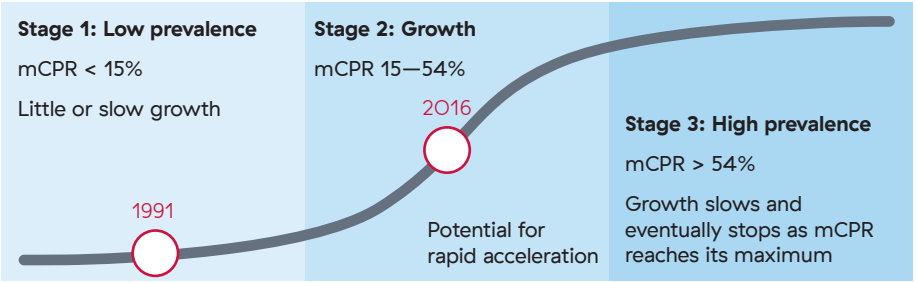
Tanzania

The Tanzanian family planning market experienced significant growth from 1991 to 2016, with modern contraceptive prevalence rate among married women increasing from 6.6 to 32.0 percent. The private sector played a large role in this market growth. A SHOPS Plus analysis revealed several macro-environmental, 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

Tanzania's mCPR is marked in red



Program focus

Stage 1: Change norms to increase demand and provide services

Stage 2: Reduce barriers to access, improve quality, sustain demand generation

Stage 3: Sustain gains

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 macro-environmental, 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 1991 and 2016, Tanzania transitioned from the middle of Stage 1 to the middle of Stage 2 (STATcompiler 2019). To take the country to Stage 3, family planning stakeholders will need to continue investing in demand creation and making a wider range of private sector products and services affordable to more Tanzanians. This brief recommends strategies for stakeholders to leverage the private sector's contributions to growth.

Methods

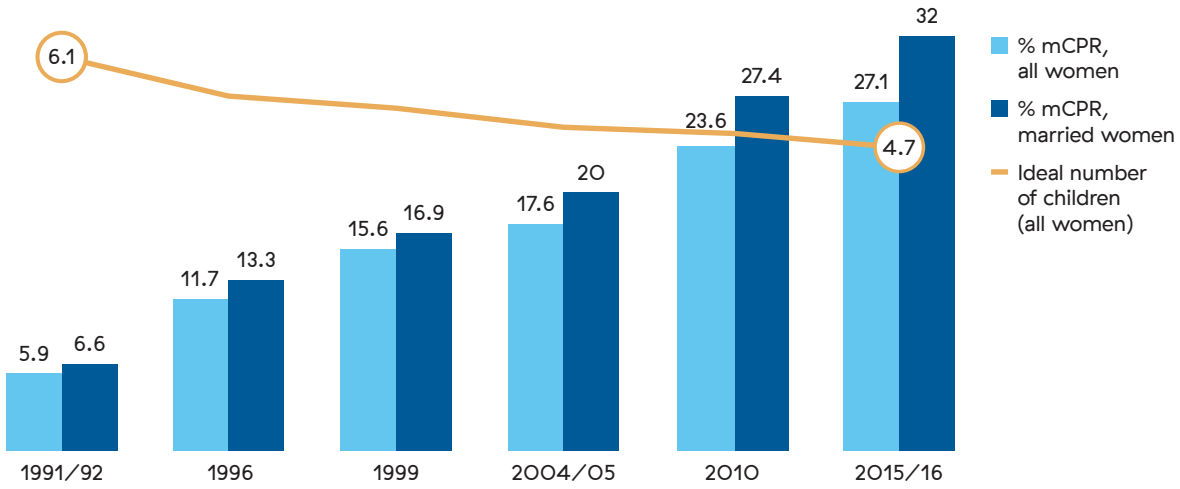
This is one in a series of briefs that examines the family planning markets in six countries since 1990. Five countries in Stages 2 and 3 (Bangladesh, Cambodia, Kenya, the Philippines, and Tanzania) saw increases in mCPR and private sector contributions. One country (Nigeria) saw substantial private 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 Tanzania's family planning market between 1991 and 2016 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.

Family planning growth through strong, comprehensive public and private sector contributions

Between 1991 and 2016, mCPR among married women increased from 6.6 percent to 32.0 percent. The mCPR among all women—married and unmarried—similarly increased at a slightly slower rate, from 5.9 percent to 27.1 percent. In that same time period, the ideal number of children a woman desired to have in her lifetime continuously declined from 6.1 to 4.7, indicating an increasing desire among women to delay or limit pregnancies (Figure 2).

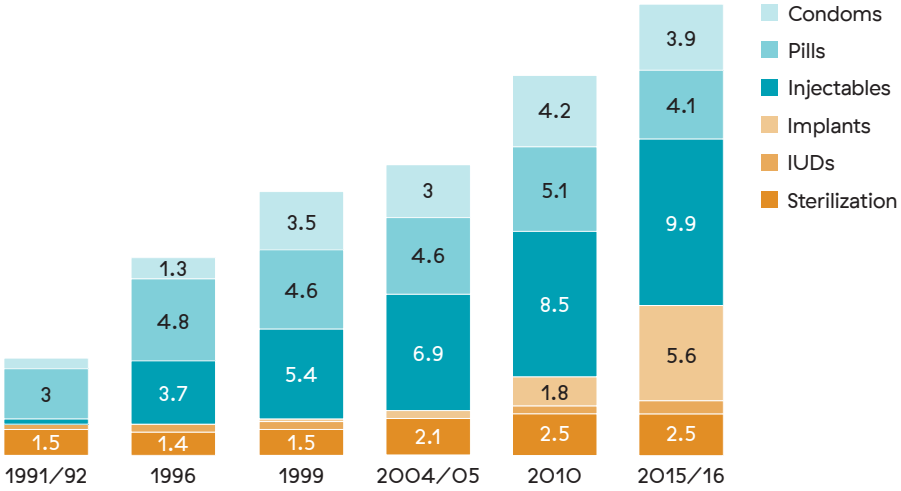
Figure 2. Changes in family planning use and childbearing preferences, 1993—2017



Among all women, growth occurred the most in four methods (Figure 3).[1] Use of injectables and implants continuously increased from 0.3 to 9.9 percent and from 0 to 5.6 percent, respectively. Prevalence of condom and pill use also increased for most of this period—from 0.7 percent and 3.0 percent to a peak of 4.2 percent and 5.1 percent, respectively—but declined marginally in the most recent DHS. Use of IUDs and sterilization also increased, albeit at a much slower rate.

Figure 3. Modern contraceptive use by method

All women (%)

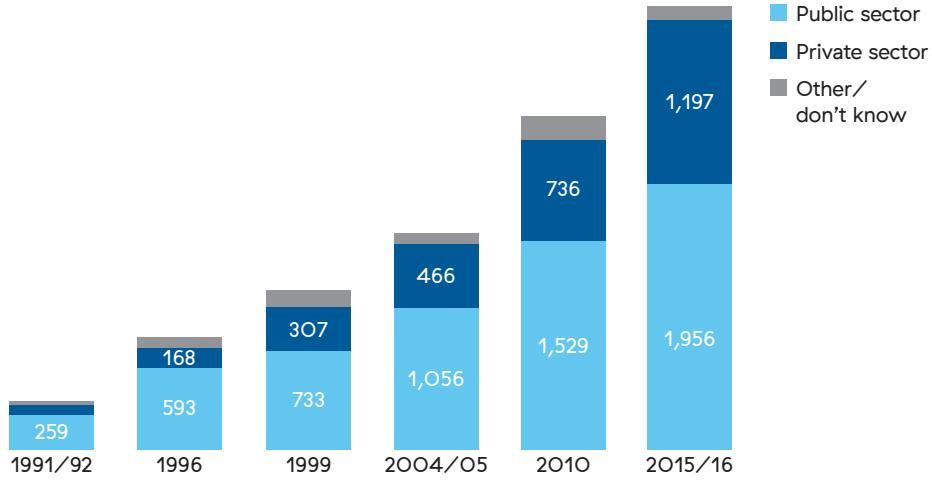


[1] Diaphragms, contraceptive foam or jelly, female condoms, and emergency contraception are included in graphs that show all modern contraceptives combined, but are not shown separately due to small sample sizes. This analysis excludes the lactational amenorrhea method, Standard Days Method, other fertility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

Examining family planning source patterns reveals the private sector's continued importance throughout this period (Figure 4). The number of users served by both the public and private sectors increased consistently in absolute terms over all time points, though the private sector has grown at a faster pace and increasingly accounts for a larger share of the market. Between 1991/92 and 2015/16, the number of users served by the public sector increased 8 times from 260,000 to 2 million.[2] During the same period, the number of users served by the private sector increased 16 times from 73,000 to 1.2 million.

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

In thousands, by source



Trends in sources of methods

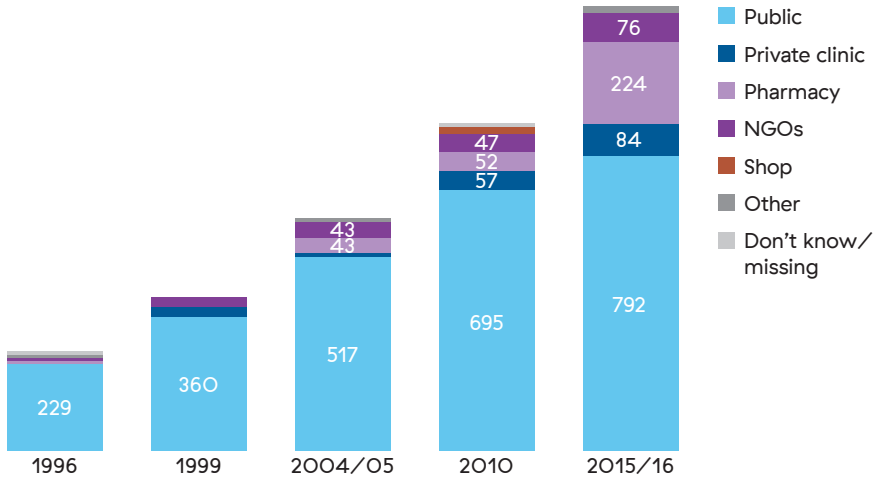
Injectables have had the greatest contribution to mCPR growth in Tanzania between 1996 and 2015/16. Over this time period, the public and private sectors both saw increases in the number of users accessing the method (Figure 5). While the public sector has remained the largest source, the private sector has taken on an increasingly larger share, especially over the past decade. This trend largely occurred through increased sales by private pharmacies and, to a lesser extent, by private for-profit and nongovernmental organization (NGO)[3] clinics.

[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.

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

Figure 5. Trends in number of injectable users

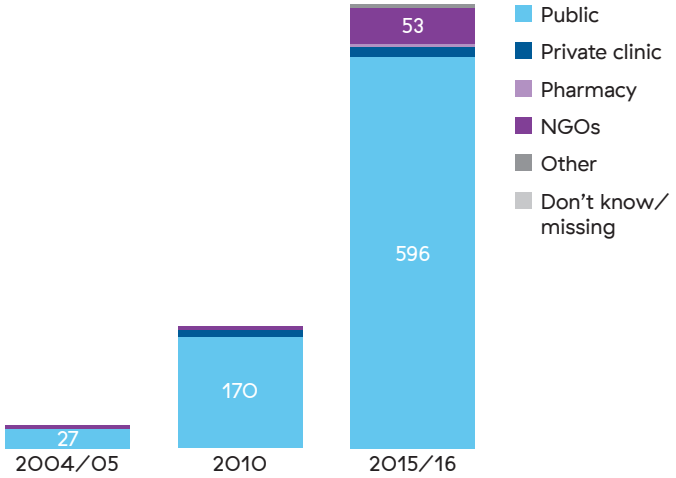
In thousands, by source (all women)



From 2004 to 2016, implants have also contributed to mCPR growth—mainly through public sector programs (Figure 6). During that time, the public sector's delivery of implants, including services delivered by NGOs at public facilities, grew nearly 2,100 percent, reaching almost 600,000 women by the most recent survey. Whereas the private sector—mainly NGOs delivering services at their own or franchised facilities—increased by 740 percent, reaching over 73,000 women, or only 11 percent of the total market volume.

Figure 6. Trends in number of implant users

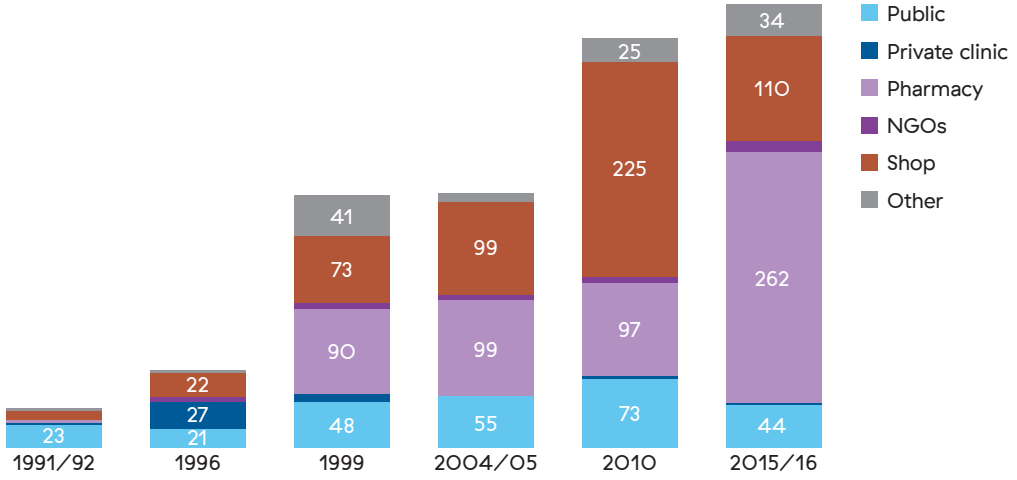
In thousands, by source (all women)



In contrast to injectables and implants, the private sector serves the majority of condom users (Figure 7). The number of private sector condom users increased from 17,000 in 1991/92 to 390,000 in 2015/16. Pharmacies—including lower tier accredited drug dispensing outlets (ADDOs)—and shops were the main sources of condoms from 1999 onward, with the absolute number of women reporting pharmacies and shops as their source of condoms increasing multifold over the entire period. The number of women reporting the public sector as their source of condoms increased as well, but at a much lower rate.

Figure 7. Trends in number of condom users

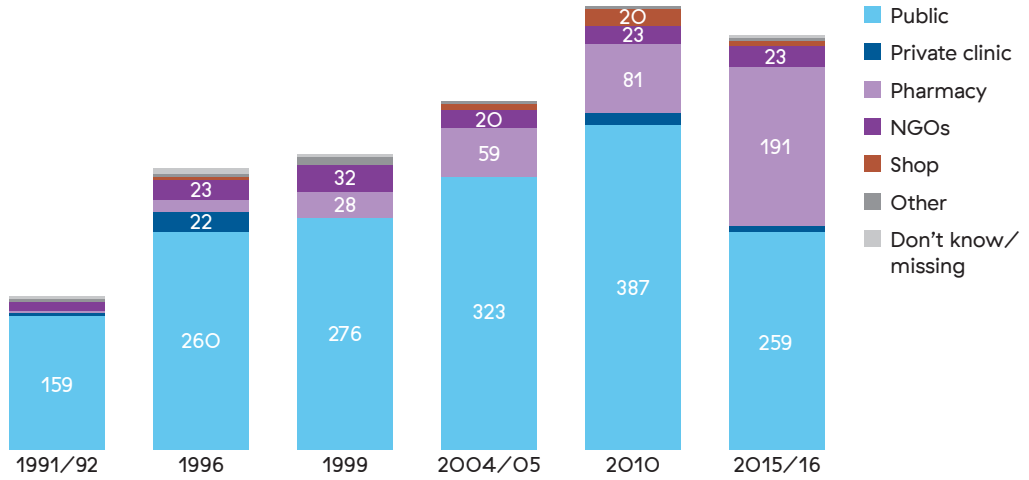
In thousands, by source (all women)



The market for pills in Tanzania has been characterized by inconsistent and varying growth patterns (Figure 8). Up until 2010, the overall market grew in fits and starts; between 2010 and 2016, the market contracted slightly. As the market grew in size through 2010, both the public and private sector contributed, with the private sector adding new users at a faster rate. While the public sector still accounts for the majority of women using pills, its overall market share declined from 86 percent in 1991/92 to 74 percent in 2010, and further to 53 percent in 2015/16. During this period, the private sector added nearly 210,000 pill users, with much of the increase coming between 2010 and 2015/16 from pharmacies, including ADDOs.

Figure 8. Trends in number of pill users

In thousands, by source (all women)



Private sector's contributions to growth in family planning provision

The private sector's role in the Tanzanian family planning market has consistently grown during this 25-year period and contributed to the growth of the overall market. 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 these trends. The interviews surfaced several insights into factors that shaped the trends in the number of private sector users of modern contraceptive methods.

Enabling factors

Macro-environmental changes conducive to private sector growth

Tanzania witnessed a period of rapid economic growth beginning in the mid-1990s. Between 1991 and 2016, the per capita gross national income, adjusted for purchasing power parity and expressed in current international dollars, increased from $990 to $2,860. With rising incomes, private sector products and services became affordable to more Tanzanians. Another key factor was rapid urbanization, which increased the size of the potential market easily accessible to the private sector. Between 1991 and 2016, the number of people living in urban areas increased from 5 million to 17 million, or from 19 percent to 32 percent of Tanzania's population.

Improved enabling environment

Three broad shifts in the policy environment helped the private sector grow. First, in 1991, Tanzania removed its longstanding ban on private health practices. This reform initiated the emergence of private commercial health care providers and retail outlets. A second key shift was the creation and scaling up of the ADDO program between 2005 and 2015.

The creation of a new accreditation framework to transform informal drug shops into more formal ADDOs facilitated interventions to train their staff to provide family planning information and dispense condoms and pills. It also paved the way for mapping of ADDOs, which gave private importers and distributors greater visibility into where these outlets were located, helping the private supply chain to effectively reach and supply more private outlets. The third shift featured the gradual development of a more supportive policy environment for private nurse- and midwife-owned and operated facilities. Improved clarity in registration of the facilities, formalized scopes of practice for these cadres, and task sharing guidelines allowing nurses and midwives to offer a wider range of family planning methods helped expand the number of lower-level private clinics offering family planning services.

Donor investments to introduce and scale up new methods

Donor investments in the private sector helped grow the total family planning market in two phases with differing emphasis on family planning methods and channels of delivery. From 1990–2010, when hardly any contraceptives were available in the for-profit private sector, donor investments focused on expanding access to condoms and pills through pharmacies and shops through sustained support of social marketing programs. This support was effective at rapidly increasing access to these commodities in the private sector. A strategic push in the 2000s to make condoms available beyond pharmacies—in shops and markets—helped significantly enhance convenient access. From 2010 onward, scaling up the ADDO program contributed to consolidating and further accelerating the gains from investments in social marketing of condoms and pills. In the second phase, starting in 2010, donors invested in scaling up access to injectables, IUDs, and implants through private sector clinical providers. These investments focused on strengthening and scaling up social franchises and clinic-based NGO provision of these methods by providing procurement support, trainings for private providers, and support to scale up and demand creation.

Multi-pronged investments in demand creation

In the last decade, significant investments in behavior change campaigns promoting condom use, though primarily aimed at HIV prevention, had a halo effect on condom use for family planning. In addition, government and donor door-to-door interpersonal communication outreach in rural areas between 2005 and 2010 are reported to have had an impact on uptake of family planning methods, particularly condoms and pills.

Increased mechanisms for public-private engagement

In recent years, nonprofit and for-profit health facilities have entered into service level agreements with the government of Tanzania. These service level agreements enable the facilities to access free family planning commodities—particularly IUDs, implants, and injectables—making these methods more affordable in the private sector.

Barriers to continued growth

Two potential challenges exist to the private sector's continued ability to contribute to mCPR growth.

Inadequate/intermittent supplies of pills

Social marketing organizations have been the main suppliers of pills to the private sector. Prior to 2010, funding constraints for commodity supplies, challenges in registration, and a change in the formulation of pills supplied through social marketing organizations contributed to supply disruptions in the private sector. The supply disruptions were an important factor in the inconsistent and varying growth patterns in use of the pill (Figure 6). In the last decade, multiple brands of socially marketed pills have obtained approval from local authorities. As more social marketing organizations have begun operating in Tanzania, some have brought new products to the private sector that are not reliant on donated commodities. Additionally, these new actors have complemented each other in ensuring consistent availability of products, so that when one brand experiences stockouts, others exist for women to use. While supply constraints still exist, the entrance of new private actors has started to address them. However, the historical legacy of inconsistent availability in the private sector has been an important factor contributing to the private sector's minority market share for pills—a trend that sets Tanzania apart from many countries in the region and those with similar mCPR levels.

Unsettled political support to family planning

In recent years, Tanzania has experienced shifts in the political landscape around family planning. While there is still support for family planning for birth spacing and the reduction of maternal, newborn, and child mortality, high-level policymakers have expressed opposition to its use for limiting births or "population control." Stakeholders interviewed hypothesized that this mixed messaging could have constrained demand generation activities and may have also affected provision of family planning services in the private and public sectors. Local experts anticipate greater negative impacts if this trend continues.

Conclusion

In the 25-year period from 1991 to 2016, the family planning landscape in Tanzania evolved greatly. This experience highlights several lessons for other countries and points towards what the country needs to do to reach Stage 3 of the S-curve. As in other countries, Tanzania's mCPR increased steadily due to a combination of macro-environmental factors and donor investments in demand generation and social marketing programs supporting short-acting methods. In recent years, donor support for commodity access programs and training for long-acting reversible contraceptives, as well as support for scaling up social franchising, have helped the market and method mix continue to grow. Importantly, Tanzania was able to turn around a small and weak private sector in the 1980s to an important contributor to family planning growth by formalizing and supporting growth of additional cadres of private providers (e.g., ADDOs and nurse- and midwife-run clinics). Supporting growth of additional cadres of private providers can be a relevant strategy, particularly for countries and subnational regions where limited availability of private sources is a challenge. The mCPR growth in Tanzania, and the private sector's contributions to this growth, could have been even higher throughout the 2000s if it were not for intermittent/inadequate supplies of pills to private sector sources. Though the private sector supply chain for pills has improved considerably in the last decade, this experience highlights the importance of assessing all family planning methods, across all sectors, and designing interventions to ensure that women can continue to access their preferred methods when one sector experiences challenges.

Going forward, family planning stakeholders in Tanzania should consider how they can continue accelerating mCPR growth to take the country to Stage 3 of the S-curve. The analysis points to two key strategies to consider:

Continue investments in demand creation: Analyses by Track20 suggest that, given current levels of desired fertility, further mCPR growth is unlikely. Continued investments in demand generation aimed at changing norms regarding ideal family size will be key to sustaining mCPR growth and growth in private sector contributions. As in other countries, community-based outreach for demand creation and supplies of short-acting methods were reported to have been instrumental in shaping norms and increasing demand for family planning in Tanzania during 2005–2010, particularly among rural populations. Tanzania could consider increasing the scale and sustaining investments for such community-based outreach.

Make private sector products and services affordable to more Tanzanians: The private sector is an important source of family planning because it offers convenience and anonymity and could fill gaps in availability of public sector services. To fully harness the potential of the private sector, policies and programs need to support increased presence of affordable private sector products and services in peri-urban and rural areas. Supporting the expansion and sustainability of ADDOs, and offering more lower cost generic family planning options in the private sector, could increase access to family planning commodities, particularly pills and injectables. In addition, supporting further growth in nurse- and midwife-run clinics to increase availability of affordable private sector service delivery points for family planning and expanding coverage of service level agreements and insurance for family planning services are potential strategies that Tanzania could adopt to increase affordable private sector service delivery points in peri-urban and rural areas.

Sources

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