Equity of Access to RH/FP Products and Services: Does Private Sector Expansion Help or Hurt?

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Background

- Interest in increasing the role of the commercial market as concerns about sustainability grow
- Also concern about inequality as a result of private sector expansion
- There has been no systematic investigation of the effects of private sector expansion on SES inequality in contraceptive use

The public sector's role in preventing inequality?

- Use of public sector by the rich reflects:
  - Early phase of program:
    - Public sector being primary source of contraceptives
    - Commercial sector not involved in contraceptive supply
  - Later phase:
    - Inadequate targeting
    - No change in inequality if commercial sector expansion only results in wealthy users switch from public to commercial sector
- As long as public sector available to the poor, commercial sector expansion not necessarily result in increased inequality

Methodology

- Selection of countries:
  - Contraceptive prevalence of 20% or more
  - Commercial sector share of 30% or more
  - Three or more rounds of DHS data
- Countries: Morocco, Kenya, Indonesia, Bangladesh and Ghana
- Dependent variable: modern contraceptive use
- Independent variable:
  - Share of commercial sector contraceptive supply
  - SES

Morocco: The Program

- National family planning program started in the late 1960s
- The program expanded under favorable political environment, with all contraceptives purchased by USAID until 2000, when contraceptive purchase transferred to MOH
- Commercial sector became active by 1987 and supplied 36% of all methods by 1992
- SM of pills initiated in 1992 and succeeded because of high acceptability of pills in Morocco

Figure 1. Current modern contraceptive use among women in union, Morocco, 1987-2003

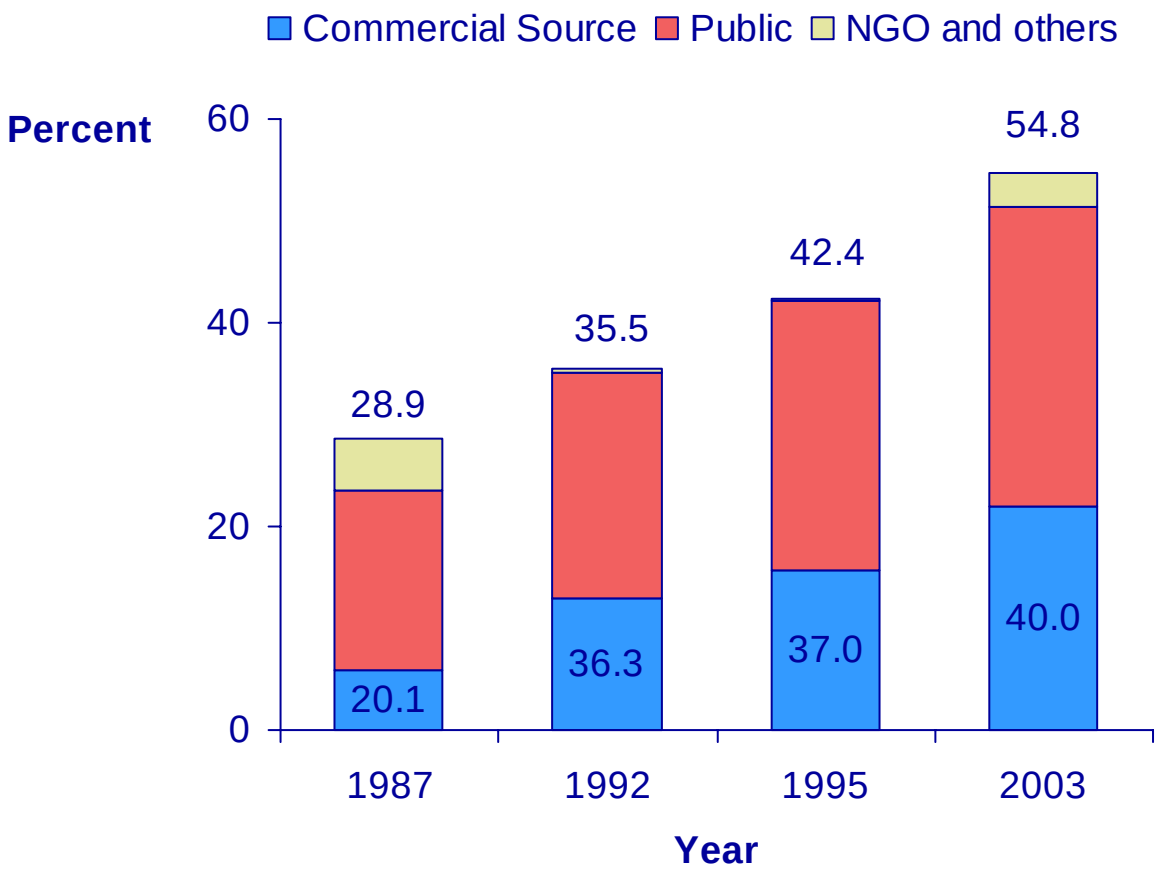

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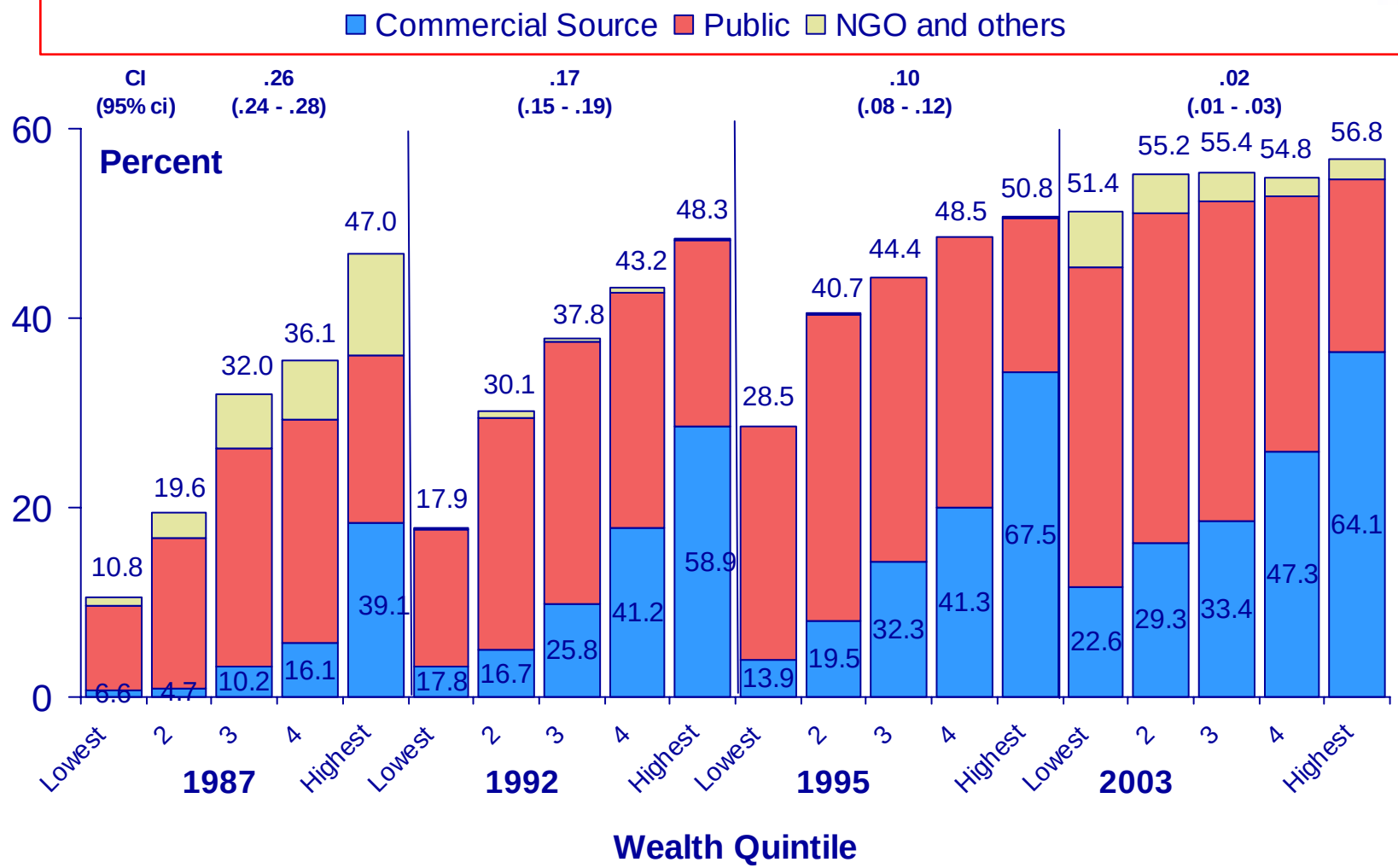
Figure 2. Current modern contraceptive use among women in union by wealth quintile, Morocco, 1987-2003



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Kenya: The Program

- National family planning program started in 1967, but active policy was not enacted until mid-1970s-early 1980s for population control purposes
- Heavy dependence on donor contribution (90%) until early 1990s when:
  - Donor focus shifted from family planning to HIV/AIDS
  - Increased contraceptive use put additional pressure on funding through health financing and cost sharing initiatives

Figure 3. Current modern contraceptive use among women in union, Kenya, 1989-2003

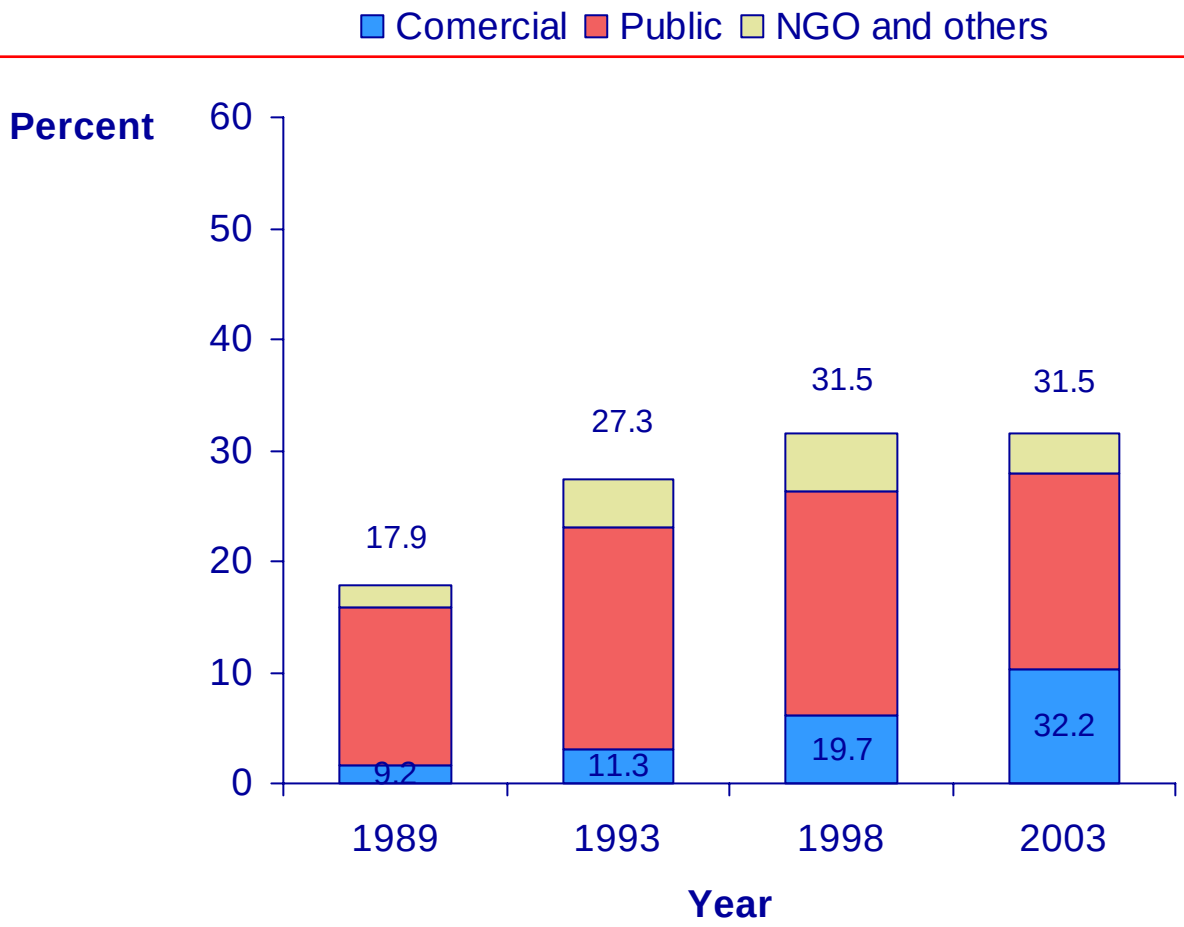

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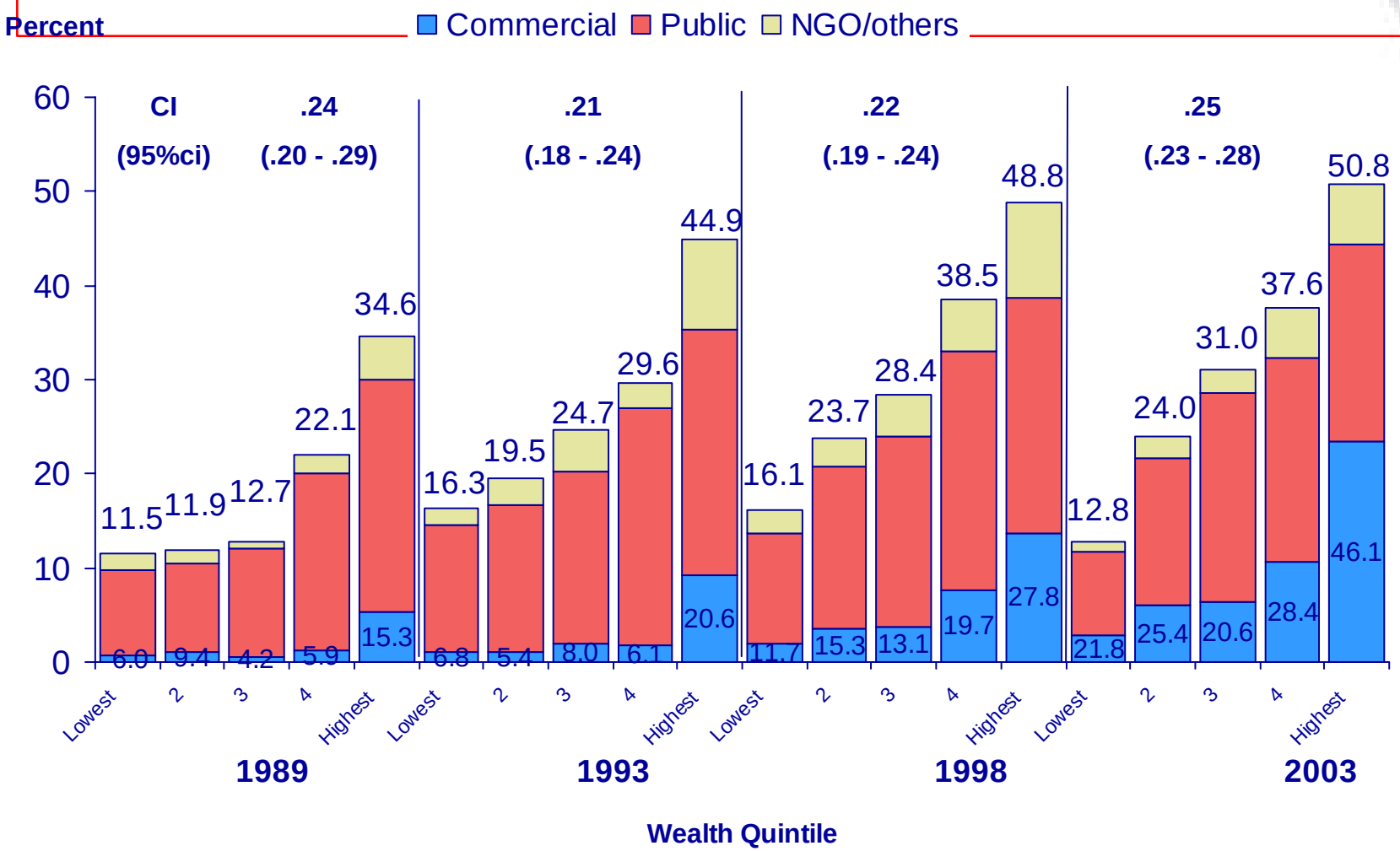
Figure 4. Current modern contraceptive use among women in union by wealth quintile, Kenya, 1989-2003



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Indonesia: The Program

- Family planning program initiated in 1950s
- Initially relied on clinic based service delivery: increased demand for short-term methods
- In late 1970s: de-centralized community-based approach to promote long-term methods and increase contraceptive use in rural areas
- Heavily relied on donors until 1980s:
  - Condom SM program in 1980s
  - Cost-recovery in public sector in 1989
  - Contraceptives introduced through SM and private provider networks
- Commercial sector growth likely to be contributed by:
  - Economic growth in 1980s
  - Public sector's inability to provide contraceptives for free or a minimal fee

Figure 5. Current modern contraceptive use among currently married women, Indonesia, 1987-2002

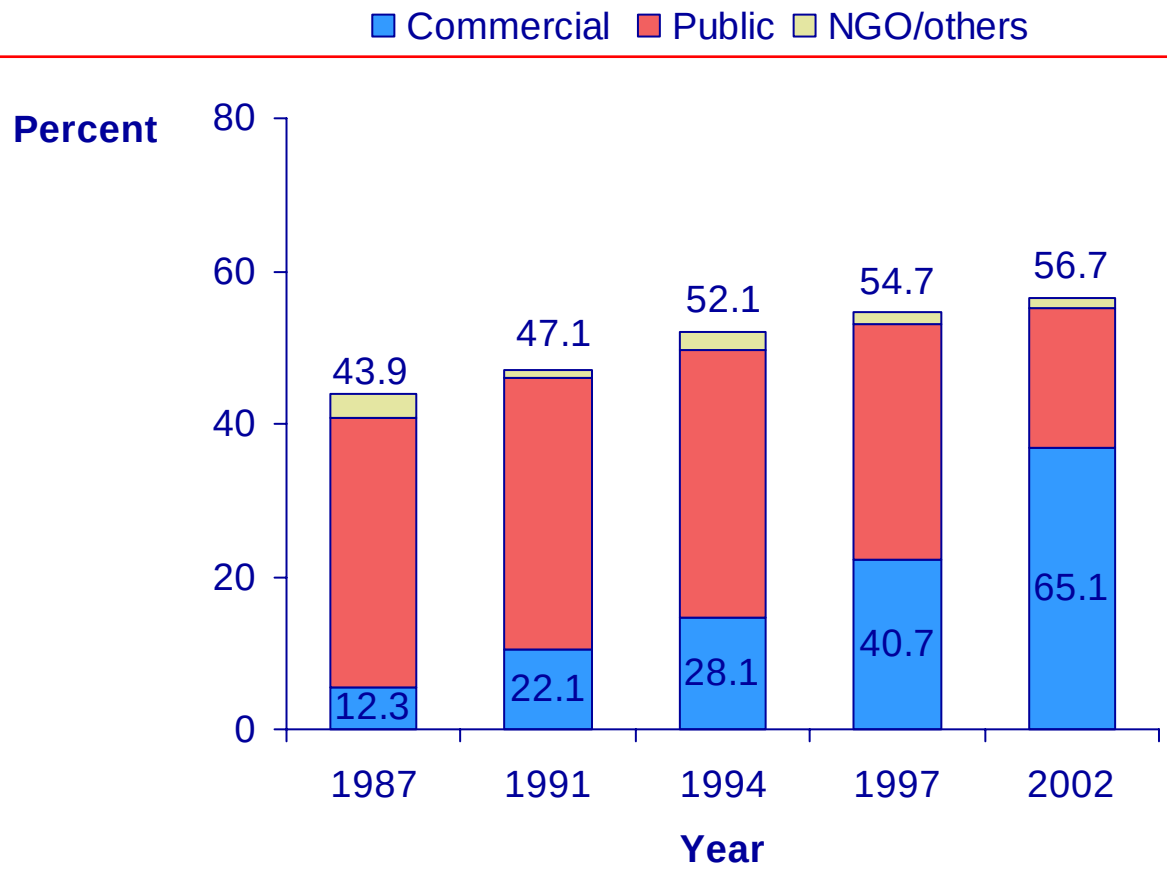
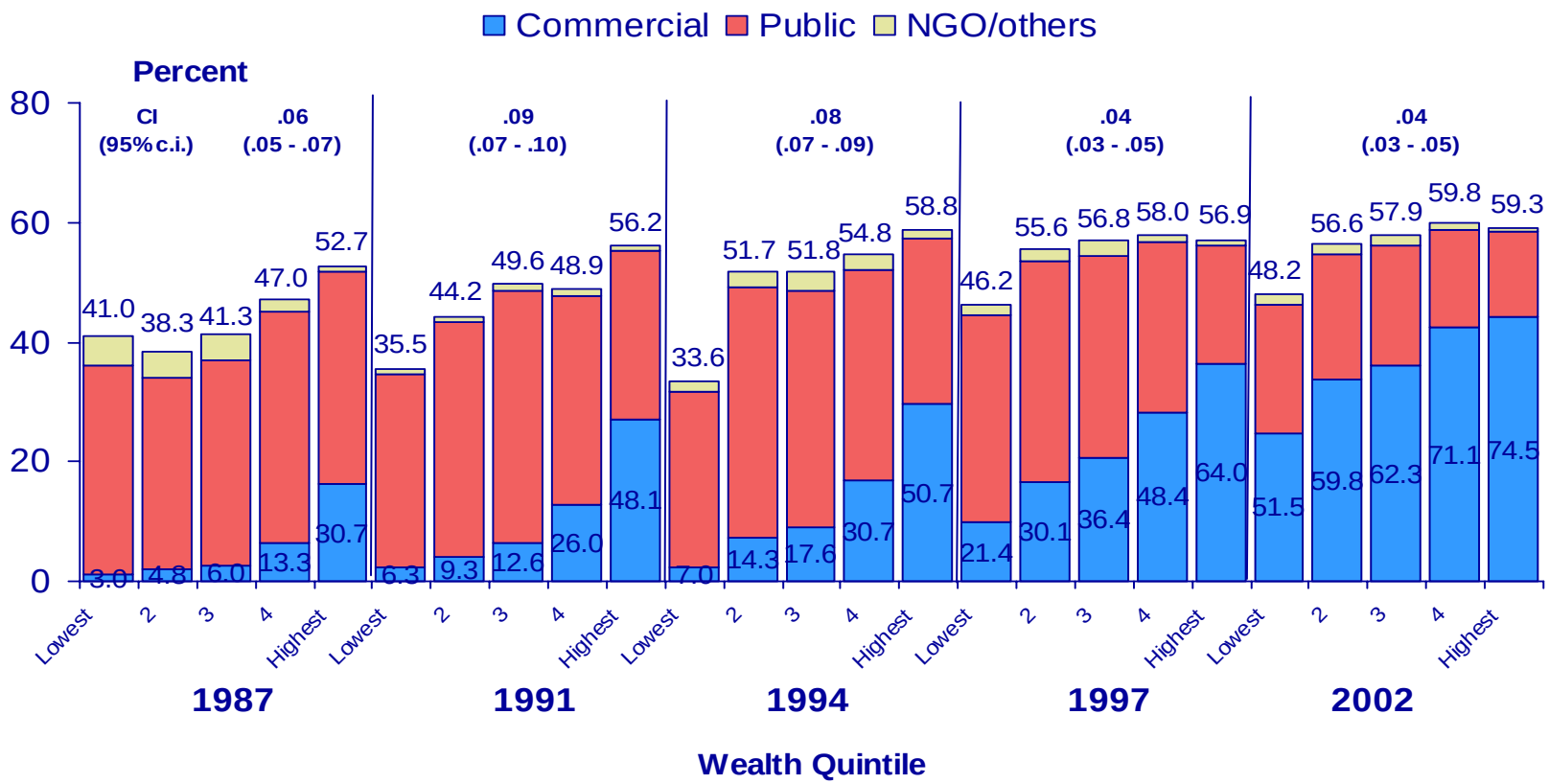


Figure 6. Current modern contraceptive use among currently married women, by wealth quintile, Indonesia, 1987-2002



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Conclusions

- Increased commercial sector contraceptive provision not necessarily result in increased inequality
  - Only evidence of increased inequality in rural Kenya: due to declined public sector supply
- Strong influence of the public sector market development
- Public sector remained important in several countries (Morocco and Bangladesh)

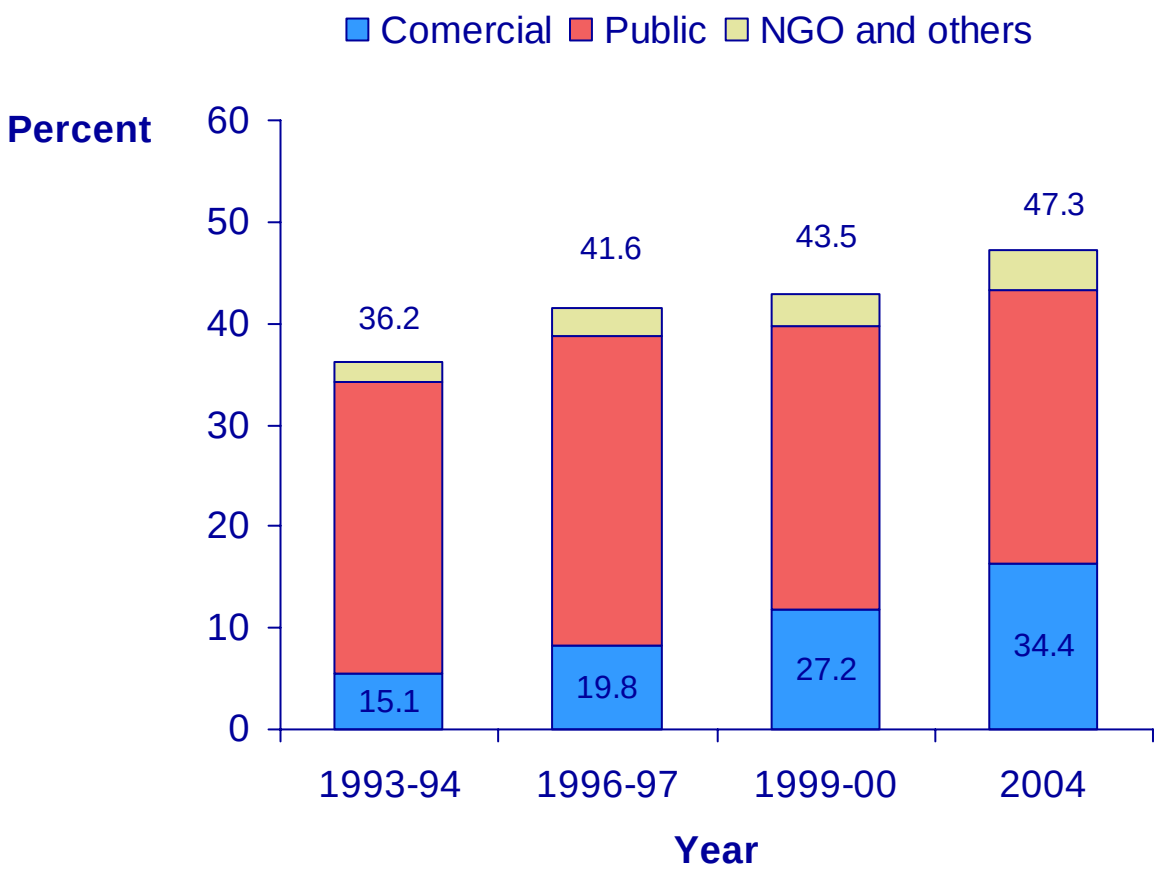
Conclusions

- Commercial sector expansion generally due to women in upper income quintiles substituting commercial sector for public sector sources
- Commercial sector expansion not result in increased inequality if:
  - Public sector remained important supplier for the poor (Kenya)
  - Private sector expanded provision to the lowest quintile (Morocco, Indonesia)
- Contraceptive use among the poorest not negatively effected by commercial sector expansion

Bangladesh: The Program

- Family planning program began in early 1970s with central strategy of service delivery to women's homes
- Matlab project as a learning model for the government in door-to-door provision of non-clinical contraceptives
- By the 1990s, doorstep delivery had proven successful in increasing the uptake and continuity of contraceptive use
- In 1997, the government and NGOs shifted focus to clinic-based service delivery to provide a range of health services and ensure equitable access
- Social Marketing Company is dominant in the private sector, and relied heavily on donor supplied contraceptives, as in the public sector

Current modern contraceptive use among married women, Bangladesh, 1993-2004



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Current modern contraceptive use among married women by wealth quintile, Bangladesh, 1993-2004

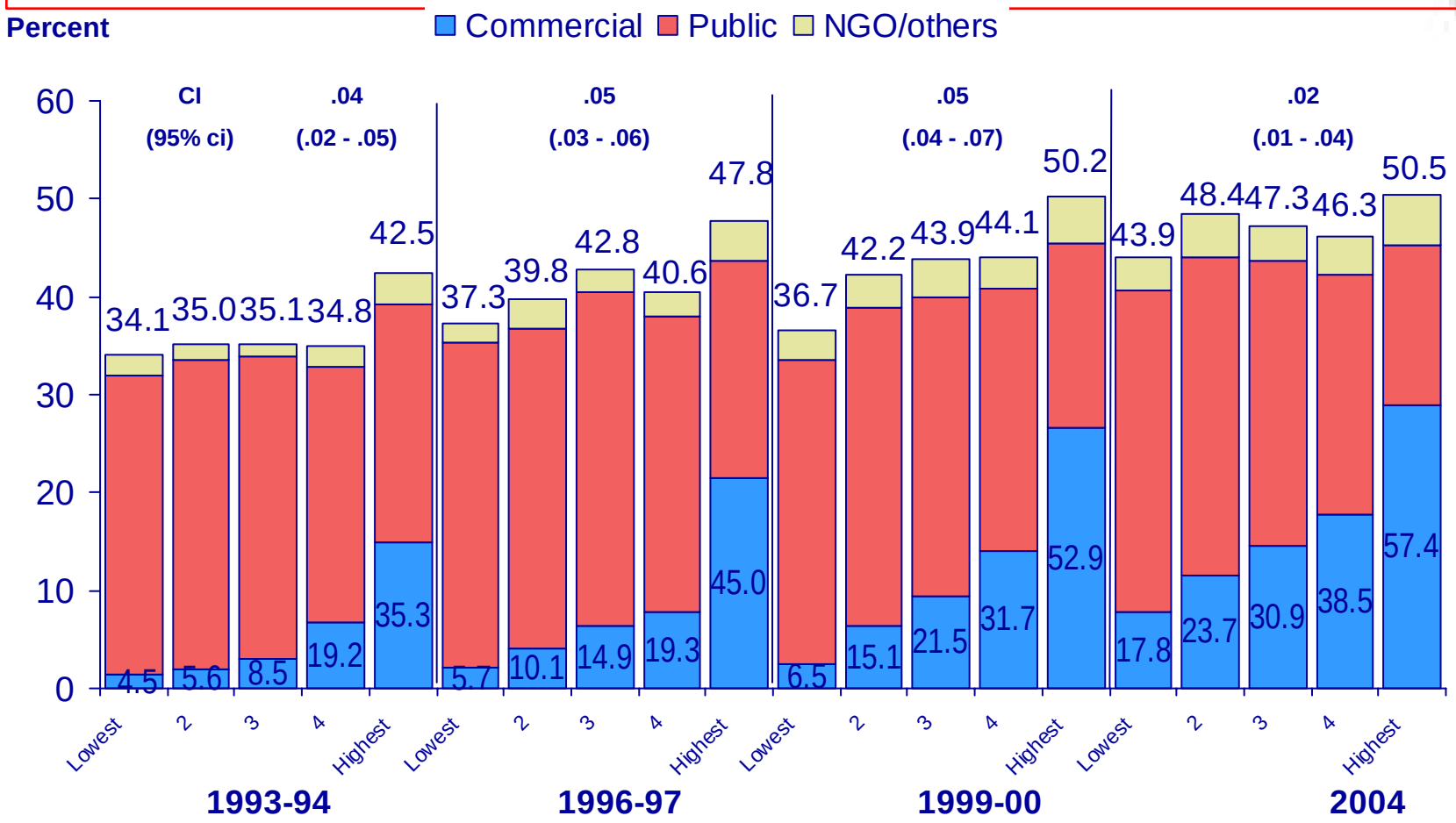

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Figure 1. Current modern contraceptive use among women in union, Ghana, 1988-2003

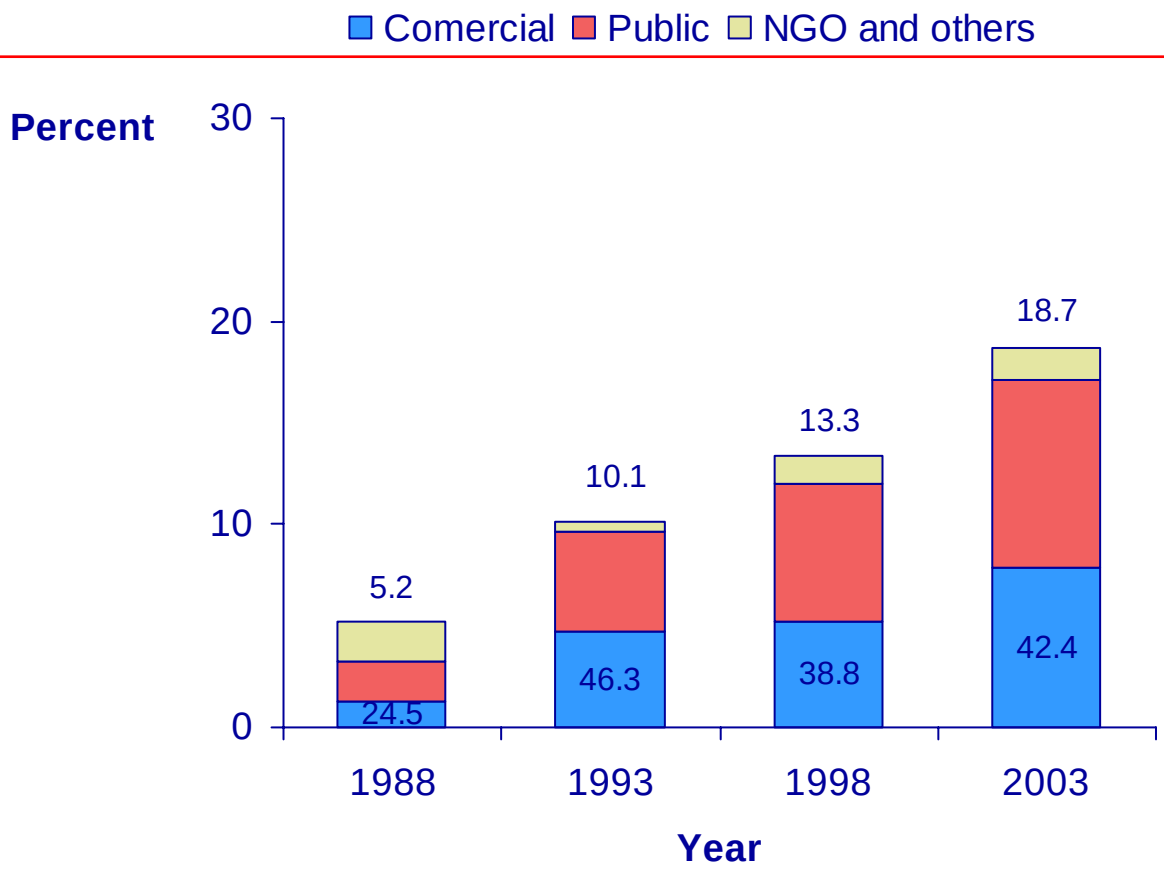

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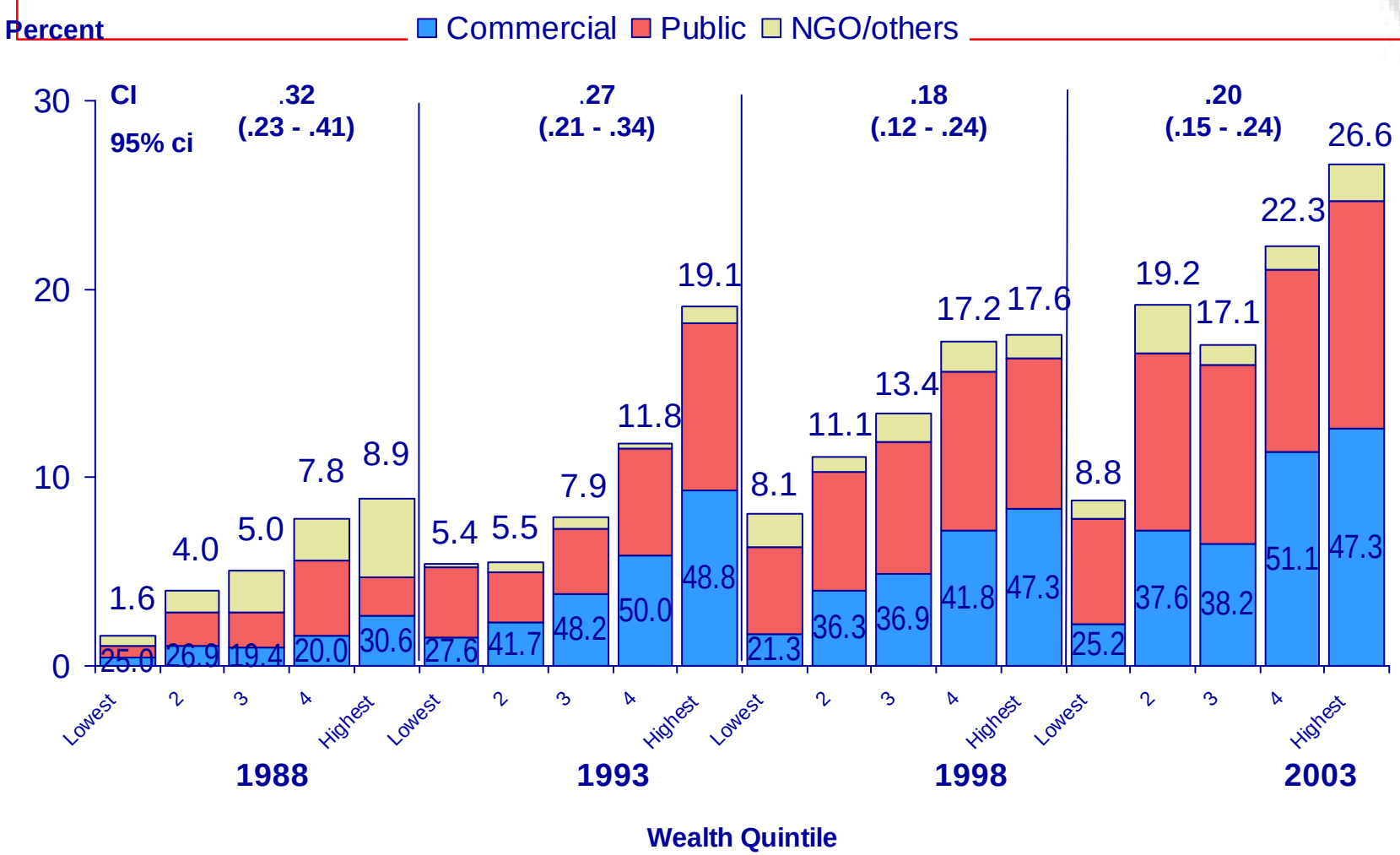
Figure 2. Current modern contraceptive use among women in union by wealth quintile, Ghana, 1988-2003



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