The Private Sector's Contributions to Family Planning Market Growth

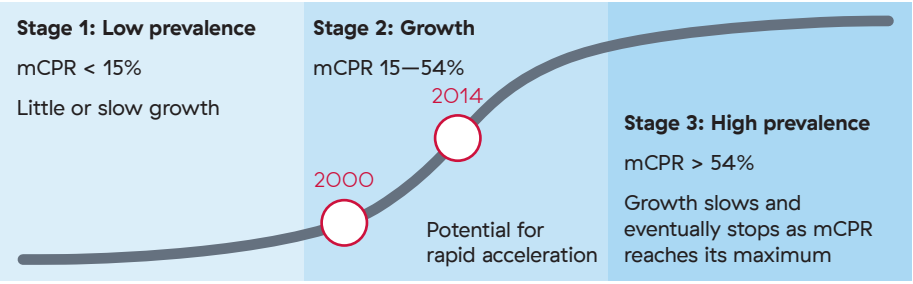
Cambodia

The Cambodian family planning market experienced significant growth from 2000 to 2014, with the modern contraceptive prevalence rate among married women increasing from 18.8 to 38.8 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 have 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 have varied substantially, in reality 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

Cambodia'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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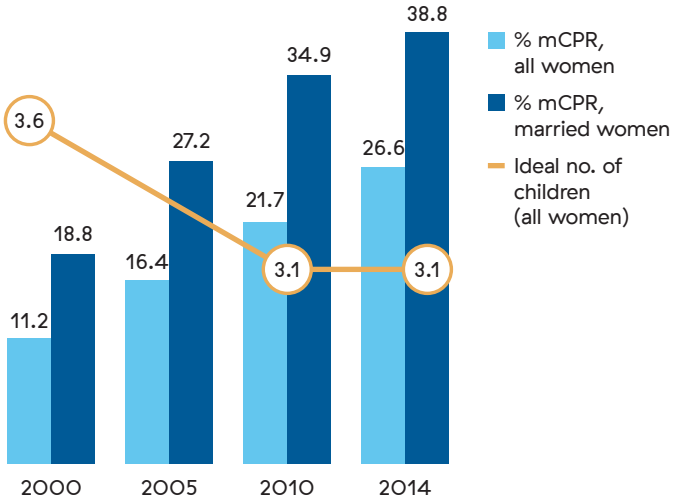
Understanding the types of interventions that work best at each stage of the S-curve is necessary to create optimal family planning outcomes. The USAID-funded Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project sought to identify those interventions that could best harness the 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 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 2000 and 2014, Cambodia moved from the borderline of Stage 1 and Stage 2 to the middle of Stage 2 (STATcompiler 2019). To take the country to Stage 3, family planning stakeholders will need to continue reducing barriers to access, improving quality, and sustaining demand generation. This brief recommends strategies for stakeholders to leverage the private sector's contributions to growth.

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



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 Cambodia's family planning market between 2000 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.

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

Beginning in the late 1990s, the government began an effort to rebuild and strengthen public services that had been largely destroyed during decades of conflict. Between 2000 and 2014, mCPR among *married* women increased from 18.8 percent to 38.8 percent. mCPR among all women similarly increased from 11.2 percent to 26.6 percent. In that same period, the ideal number of children a woman desired to have in her lifetime declined slightly from 3.6 to 3.1, indicating a modest uptick in the proportion of women desiring to delay or limit pregnancies (Figure 2). At this rate of desired fertility, Track20 modeling indicates that fertility preference is not a barrier to mCPR growth.

Among all women, growth occurred across every method (Figure 3). Most modern methods—pills, implants, IUDs, and sterilization—exhibited increased use between 2000 and 2014, although injectable and condom use declined slightly between 2010 and 2014. Short-acting methods—primarily pills and injectables—dominated the market, accounting for approximately three-quarters of all modern method users during the entire period. The share of long-acting reversible contraceptive (LARC) users among all modern method users increased as well, while the share of other modern method users, such as diaphragm[1] users, decreased.

Examining family planning source patterns reveals a unique trend: In Cambodia the public and private sectors simultaneously contributed to growth, while other countries in this series of briefs saw alternating phases of public and private sector-led growth. While there have been slight fluctuations in terms of market share, the number of users served by both the public and private sectors has increased consistently in absolute terms with the private sector usually possessing a slightly larger share of the market than the public sector (Figure 4). There has been notable similarity in the growth across the public and private sectors. Between 2000 and 2014, the number of users served by the public sector increased 240 percent from 155,000 to 527,000. During the same period, the number of users[2] served by the private sector increased 250 percent from 163,000 to 567,000.

Figure 3. Modern contraceptive use by method

All women (%)

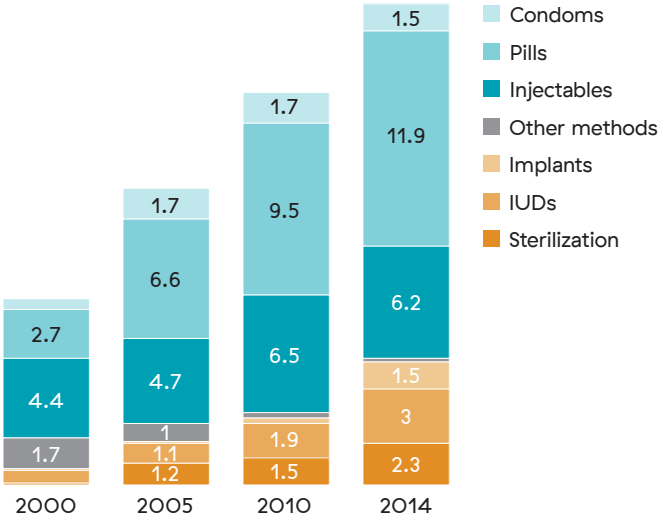
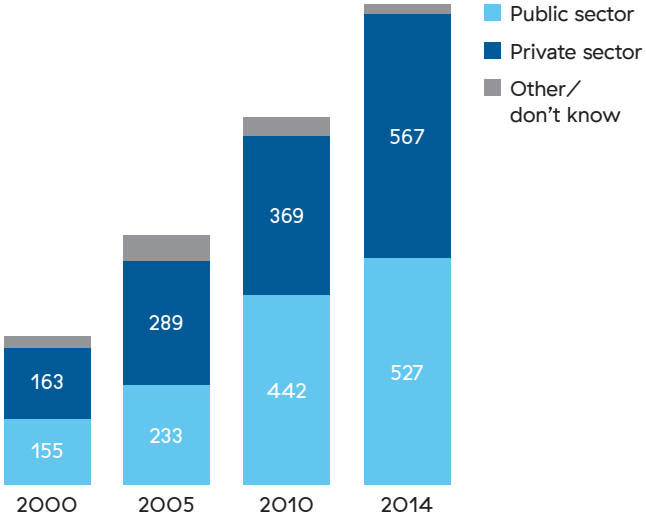


Figure 4. Sources of modern contraceptive methods by absolute number of users

In thousands, by source



[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.

[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.

Trends in sources of methods

Private sources have seen the largest increase in the use of pills, the most prevalent method in Cambodia (Figure 5). The number of pill users increased from 83,000 in 2000 to 500,000 in 2014. While the private sector served the majority of pill users throughout this period, pharmacies increasingly dominated private provision. Community-based distributors of NGOs[3] have also grown in importance for the private sector. Social marketing sales data revealed that most pill users who obtained their methods from the private sector used a socially marketed brand.

Injectables are the second most widely used modern contraceptive method. Unlike pills, the public sector has the larger share of the total market for injectables, growing from 77,000 users to 169,000 users between 2000 and 2014 (Figure 6). During that period, the private sector's contribution grew at a slightly slower rate from 54,000 to 90,000 users. Within the private sector, notable shifts occurred. In 2000, 57 percent of private sector injectable users sourced their method from an NGO or a community-based distributor associated with an NGO. By 2014, that figure had dropped to 7 percent. The role of private clinics doubled from 35 to 70 percent of private sector injectable users, and the role of pharmacies increased from negligible amounts through 2010 to almost one-fourth of all private sector users in 2014. Similar to pills, data reveal that social marketing accounts for the majority of private sector injectable sales.

LARC use also consistently grew throughout this time period (Figure 7). Unlike many other countries, Cambodia's private sector made important contributions, with sizeable increases in the number of LARC users. From 2000 to 2014, the public sector's delivery of IUDs outpaced the private sector's, growing 963 percent. During that time, the private sector's provision of IUDs still grew 561 percent. At 40 percent of the IUD market, the private sector's contribution is much larger than what is typical in many countries. Implant use demonstrates a similar trend. The number

Figure 5. Trends in number of pill users

In thousands, by source (all women)

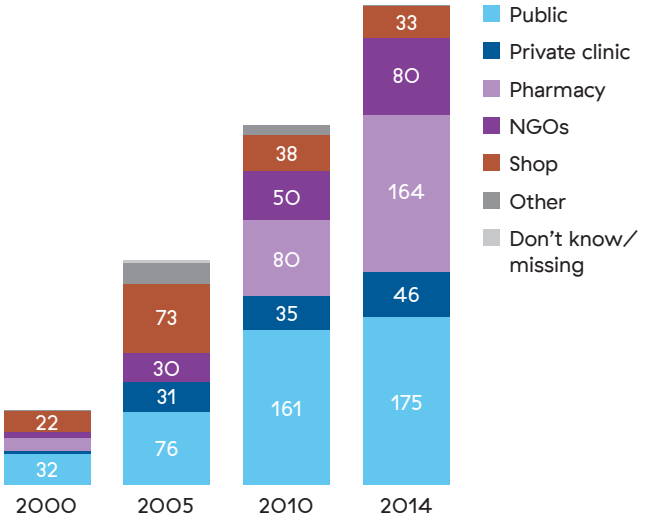
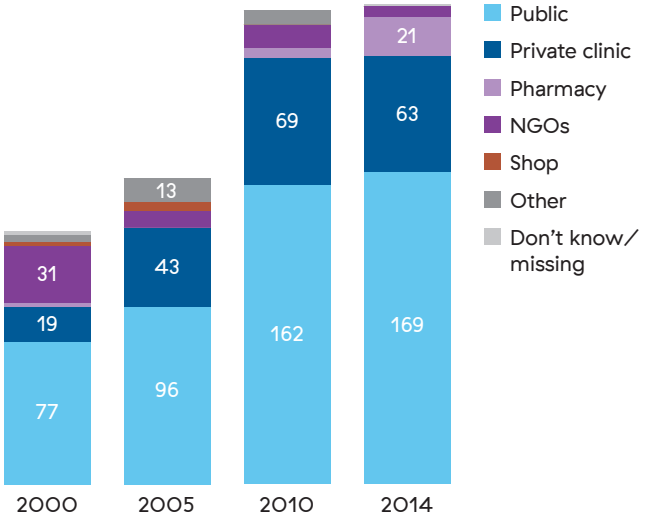


Figure 6. Trends in number of injectable users

In thousands, by source (all women)

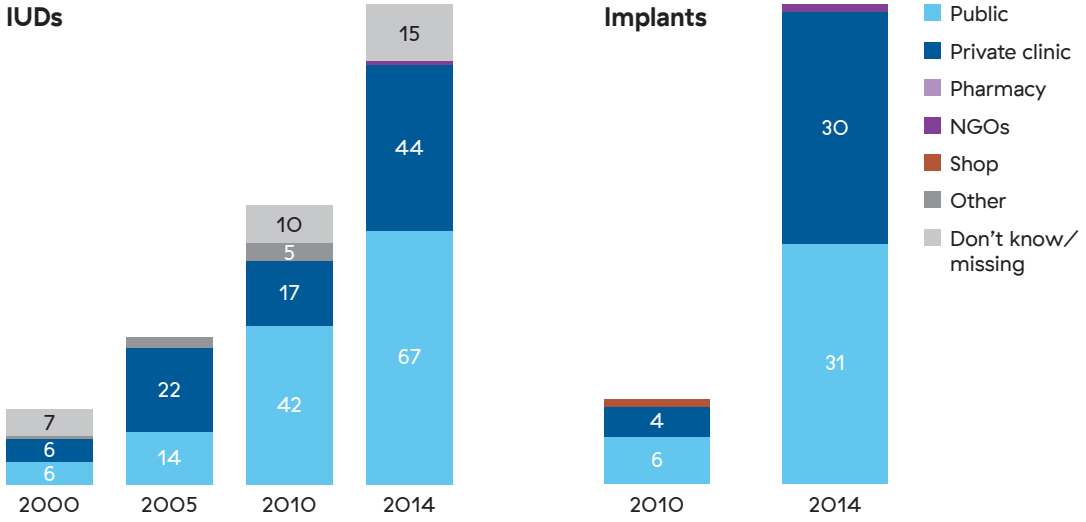


of public and private sector implant users grew 453 and 502 percent respectively between 2010 and 2014. As with IUDs, this relatively equal distribution between public and private sector users is different from more typical patterns of public sector dominance of LARCs.

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

Figure 7. Trends in number of LARC users

In thousands, by source (all women)



Private sector's contributions to growth in family planning provision

The private sector's role in Cambodia's family planning market has been significant in terms of its market share and contributions to increased voluntary adoption of modern contraceptive methods over the past 14 years. SHOPS Plus shared these trends with country family planning experts and conducted in-depth interviews to understand the underlying macro-environment, 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. As in other countries, high demand for family planning—as evidenced in the low and declining number of children women desire to have—is an important factor in mCPR growth in Cambodia. Rapid macro-environmental and social change in terms of growing purchasing power, development of infrastructure, and urbanization have also played a part in the private sector's contributions to mCPR growth. In addition, Cambodia's unique context and late start investing in national family planning programs enabled the country to learn from best practices developed globally and adopt specific approaches to rebuild the health system destroyed by decades of conflict. These policies helped the public and private sector markets to grow equitably and positioned Cambodia to further benefit from opportune timing of global policy shifts.

Government commitment to family planning from the outset ensured equitable growth and spurred demand

Learning from experiences in other countries, development and implementing partners ensured strong political support for family planning from the outset. The success of these efforts were reflected in a series of policies and strategies adopted by the Cambodian government that placed family planning as an important component of its path forward. They include the National Birth Spacing Policy in 1995 that first made family planning a

priority, as well as the 2008 Health Strategic Plan, Fast Track Initiative of 2010, and the Sector-Wide Management Approach that defined a path for stewarding the health system to achieve national goals. In addition, the government developed a clear national Reproductive Health Strategy (the latest one covers the period 2016–2020) that outlined implementation plans for the national family planning program. These spurred demand for modern contraceptives that the private sector could help fulfill and led to the equitable contribution of the public sector to mCPR growth in the country even in Stage 1 of the S-curve.

Investments in community-level demand generation increased uptake rapidly

Similar to most countries in this series of briefs (with the notable exception of Nigeria), Cambodia implemented community-level demand generation activities in rural areas where a majority of the population resides. Extensive community outreach by public sector community health workers supported by NGOs and donor-funded projects, and outreach workers directly associated with NGOs, were instrumental in helping women and families see the benefits of modern family planning methods and obtain products.

Policies supportive of task sharing for family planning lowered costs in the private sector

One key policy area where the Cambodian government made quick progress was in task sharing. As the country developed its family planning guidelines, policies allowed lower-level health workers such as midwives to insert IUDs and implants. Donors supported these policy initiatives through investments in capacity building, quality assurance, and service readiness in the private sector. These reforms and programs made private providers more attractive to potential clients, as they allowed lower-cost, quality service delivery models. Stakeholders note that private sector midwife-run clinics have contributed more to the provision of LARCs than doctor-led facilities. This trend has supported the view that the lower cost of midwife-led models helped increase financial access and demand for these methods in the private sector.

Targeted user fees for family planning in the public sector helped establish value of family planning

To attract a skilled health workforce back to the public health sector, Cambodia adopted a system in which public facilities charged users a fee for services, and a significant proportion of the fees collected at the facility was used for staff remuneration. User fees were established by local committees and ranged from 13¢ per cycle of pills to $15 for implant insertion. This system had several important consequences:

- User fees in the public sector appear to have had a signaling effect on perceptions of the acceptable price of contraceptive products and services, resulting in beneficiaries willing to pay a higher price for private sector family planning products and services.
- NGOs that implemented community-based distribution of family planning products stayed away from free commodity distribution in this context, preferring to source their supplies from social marketing organizations and distribute these products at market prices.

- Private sector suppliers, including social marketing organizations, were able to rapidly scale up access and demand for their products in the absence of these market distortions, further growing the private sector's contributions.
- To overcome inequities in access and use among poorer populations, Cambodia instituted voucher programs and the Health Equity Fund. These mechanisms, targeted specifically to lower-income population groups by design, reduced market distortions that could have resulted from broad-based provision of free products and services to all clients accessing services from the public sector.

Dual practice had positive effects on private sector service delivery

Dual practice is ubiquitous in Cambodia. Several reports note that the practice is highly valued by physicians due to reputational benefits, access to training provided by the public sector, and opportunities of interacting with subject matter experts. Thus, knowledge and techniques of providing new methods and counseling clients rapidly percolated to the private sector without the need for significant additional investments.

Opportune timing of global shifts in donor support spurred market development

As described previously, Cambodia's family planning market—and the private sector in particular—grew rapidly due to government policies and strategic investments in demand. Further, the policy of charging user fees in the public sector avoided market distortions and created a market that was willing to bear private sector prices. Consequently, extensive financial support that donors provided to social marketing organizations enabled growth of the private sector market for short-acting methods such as condoms and pills. By 2010, the number of women who accessed products in the private sector had grown large enough—and demand was sufficient—to make the private market for short-acting methods sustainable without donor subsidies. With a higher willingness to pay for family planning, private actors were able to maintain their contributions as subsidies for short-acting methods were withdrawn and transitioned to LARCs.

In the last decade, donor-funded programs helped train public and private providers and community health workers on LARCs; supported the growth of family planning-focused social franchises to increase the availability of affordable, quality LARC services in the private sector; and subsidized commodity access. Donor-supported voucher programs helped address demand-side financial barriers that could have limited access to LARCs for lower-income groups. With extensive dual practice in Cambodia, these investments accelerated provision of LARCs in the private sector.

The opportune timing of strategic shifts helped broaden the range of methods available in both the public and private sector, and contributed to mCPR growth that resulted from more comprehensive increases in both short- and long-acting methods.

Conclusion

The family planning market in Cambodia has grown consistently and comprehensively since the start of the 2000s. Much of this growth has come from well thought out strategies and programs to grow both public and private sector contributions. This experience highlights several lessons for other countries and points toward what the country needs to do to reach Stage 3 of the S-curve. As in other countries, Cambodia's mCPR increased steadily due to a combination of strong policies and government commitment, macro-environmental factors, and strategic donor investments.

Going forward, family planning stakeholders will need to continue reducing barriers to access, improving quality, and sustaining demand generation. The analysis points to three key strategies for Cambodia to consider:

- **Realign incentives for community-based distributors to expand access to LARCs**: As noted, the Cambodian government and donors have made significant investments in community-based distributors to promote demand for family planning and to sell short-acting methods such as condoms and pills. These programs have helped increase access to and use of these methods. As donors have shifted their focus to LARCs, family planning programs have not sufficiently considered community-based distributors as a channel for creating demand. These distributors have an incentive to focus on short-acting methods due to the revenue gained from their sales. Government and donors should consider how they can realign the incentives so that distributors are more willing to promote the full range of methods—including LARCs—to the rural and lower-income women they serve.
- **Strengthen public sector supply chains to prevent leakage into the private sector:** Stakeholders and multiple studies reveal that private outlets routinely access and sell leaked commodities that were procured for the public sector, likely due to excess procurement of these commodities. Access to these leaked commodities imposes challenges for private supply chain actors to serve these outlets, and in turn weakens the sustainability of the private family planning market. As the Cambodian government takes on more responsibility for financing the procurement of short-acting methods, the leakage will become a more salient issue. Donors can support the government to rationalize procurement and pricing, and monitor for leakages.
- **Strengthen and expand social contracting for LARCs to the private sector**: Since 2010, donors and the Cambodian government have rolled out and expanded the Health Equity Fund (HEF) and National Social Security Fund (NSSF) to enable the poorest Cambodians to access family planning, especially LARCs. While HEF has successfully expanded its geographic reach and benefit package, there is an existing opportunity to better engage the private sector. Currently, NGO clinics and social franchises cannot contract with HEF. Enabling contracts with these sources could help them serve a wider range of family planning clients and increase their provision of the full range of methods, including more expensive LARCs. This model could build on previous efforts by NSSF to expand its network of contracted providers for family planning from the public and private sectors.

Sources

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October 2020