SHOPS PLUS

Sources for Family Planning in 36 Countries

Where Women Go and Why It Matters

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Summary

Understanding where women obtain family planning methods and how sources vary across user groups is essential to improve contraceptive access and ensure an equitable and sustainable future. This brief examines the roles of the public and private sectors in providing contraception and how they can best collaborate to expand contraceptive access and choice. It also looks at how these sectors can best meet the needs and preferences of current and future contraceptive users. This brief examines the roles the public and private sectors have played in recent contraceptive prevalence increases; sources of contraception by region, country, and method; types of sources within the private sector; source patterns by age, marital status, geography, and socioeconomic status; and settings in which the private sector plays a larger role in providing modern contraception. It concludes with implications for designing programs and policies with a total market approach.

Keywords: Africa, Asia, condoms, contraception, family planning, Family Planning 2020, injectables, intrauterine device, long-acting reversible methods, oral contraception, pharmacies, social marketing, total market approach

Cover photo: Joshua Yospyn/JSI

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Sources for Family Planning in 36 Countries: Where Women Go and Why It Matters

Across the 69 poorest countries in the world, an estimated 314 million women are using modern contraception (FP2020 2019). Since 2012, when the London Summit and subsequent Family Planning 2020 (FP2020) partnership galvanized the global development community to re-focus efforts on family planning, 53 million more women and girls in FP2020 focus countries are using modern contraception (FP2020 2019). This brief examines the contributions of the public and private sectors to achieving this remarkable progress and how the sectors can best collaborate to continue expanding contraceptive access, choice, and use. The following pages aim to answer these questions:

1. What roles have the public and private sectors played in recent modern contraceptive prevalence rate (mCPR) increases?
2. Currently, where do women obtain their contraceptives, and how do sources vary by region, country, and contraceptive method?
3. Within the private sector, what are the relative roles of private clinics, pharmacies, general shops, and NGOs in providing contraception?
4. How do source patterns vary by women's age, marital status, geography, and socioeconomic status?
5. In which settings does the private sector play a larger role in providing modern contraception?

Understanding where women obtain family planning methods and how sources vary across user groups is essential to improve contraceptive access and choice and ensure an equitable and sustainable future.

Photo: Naimat Rawan

Box 1. A total market approach

A total market approach is a lens that can be applied to develop strategies that increase access to priority health products in an equitable and sustainable manner. This approach considers all market actors and resources—free, donated, subsidized, and commercial—to understand their comparative advantages so that sectors and stakeholders can complement one another. In combination with an in-depth understanding of distinct population segments and their preferences and needs for family planning, a total market approach helps to *efficiently* target products and services to increase contraceptive access, choice, and use for all population groups to close equity gaps.

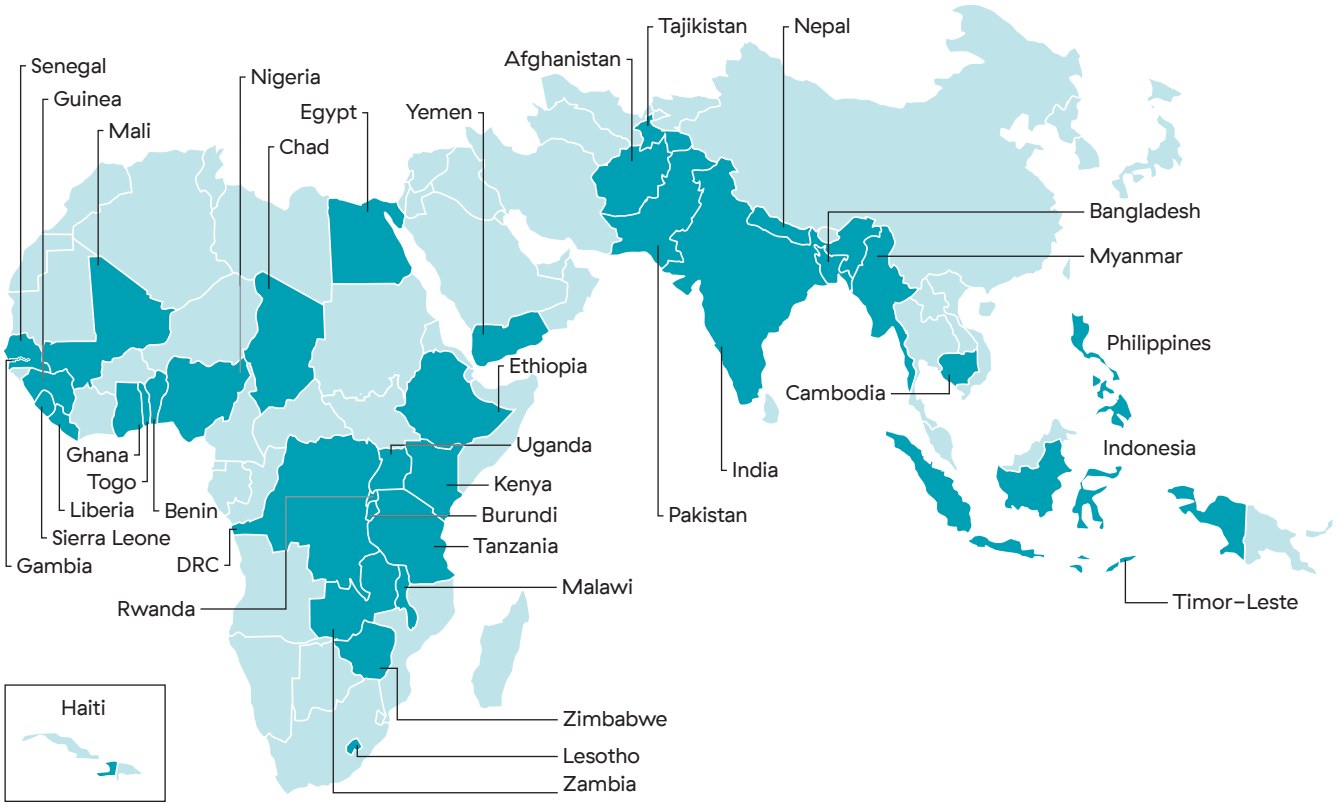
The analysis presented in this brief uses this total market lens to inform data interpretation and potential implications. The authors analyzed the contraceptive method and source mix for key population segments (married and unmarried, across ages, urban and rural, poorer and wealthier) to better understand how the family planning market differs for each group and where potential inefficiencies and inequities exist. For more information on specific countries, download the country briefs at SHOPSPlusProject.org/sources-family-planning-materials.

Photo: Joshua Yospyn/JSI

Methods

To answer the research questions on page 1, the Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project analyzed data from 1.85 million women surveyed in 36 low- and middle-income countries. Researchers included data from every USAID Population and Reproductive Health priority country or FP2020 focus country that conducted a Demographic and Health Survey (DHS) since the FP2020 summit, for a total of 36 countries.[1] To make comparisons over time, the authors paired each survey conducted since 2013, hereafter referred to as *new*, with a survey conducted in 2012 or earlier in the same country, hereafter referred to as *old*. In two countries with very recent DHS data, Nigeria and the Philippines, the old survey data are from 2013. Time comparisons exclude five countries—Afghanistan, Gambia, Myanmar, Togo, and Yemen—in which no prior DHS survey exists or has been conducted since 2000.

Figure 1. DHS survey data analyzed from 36 FP2020 focus countries



[1] The analysis includes the most recent survey in each country that was publicly available on the DHS Program website as of December 1, 2019. Surveys included by region: Asia — Afghanistan 2015, Bangladesh 2011 and 2014, Cambodia 2010 and 2014, India 2005—06 and 2015—16, Indonesia 2012 and 2017, Myanmar 2015—16, Nepal 2011 and 2016, Pakistan 2012—13 and 2017—18, Philippines 2013 and 2017, Tajikistan 2012 and 2017, Timor-Leste 2009—10 and 2016; East and Southern Africa — Burundi 2010 and 2016—17, Ethiopia 2011 and 2016, Kenya 2008—09 and 2014; Lesotho 2009 and 2014, Malawi 2010 and 2015—16, Rwanda 2010 and 2014—15, Tanzania 2010 and 2015—16, Uganda 2011 and 2016, Zambia 2007 and 2013—14, Zimbabwe 2010—11 and 2015; West and Central Africa — Benin 2011—12 and 2017—18, Chad 2004 and 2014—15, Democratic Republic of the Congo 2007 and 2013—14, Gambia 2013, Ghana 2008 and 2014, Guinea 2012 and 2018, Liberia 2007 and 2013, Mali 2012—13 and 2018, Nigeria 2013 and 2018, Senegal 2010—11 and 2017, Sierra Leone 2008 and 2013, Togo 2013—14; Other regions — Egypt 2008 and 2014, Haiti 2012 and 2016—17, Yemen 2013.

In DHS surveys, interviewers ask women of reproductive age (age 15 to 49) if they are currently using a method to avoid pregnancy. Interviewers then ask users of modern contraceptive methods (condoms, pills, injectables, IUDs, implants, or sterilization)[2] where they obtained the method the last time. Women can answer this question in a variety of ways, including with the names of country-specific clinic types (e.g., Marie Stopes Afghanistan), though the level of specificity of the categories varies by country. The authors worked with country experts to standardize the classification of each source into the six categories shown in the following table, largely following the source categories used in Campbell et al. (2015). The color coding in the table is used throughout the rest of this brief: dark blue (or, later in this brief, shades of purple) shows private sector sources, light blue represents the public sector, and other sources are shown in gray.

It is important to note that these categorizations may not perfectly represent all contraceptive sources in every country for several reasons. First, women are asked where they obtained contraception, rather than who provided their service, which could result in some sector misclassifications. For example, in cases where private providers work in public sector clinics, women who are asked where they received their method likely report the public clinic rather than the private provider. In addition, women may report where they obtained their method, even if it was administered (in the case of injectables), inserted (in the case of implants and IUDs), or prescribed (in the case of pills) by a different provider. A woman may not know the source of her method if it was obtained by her partner, as commonly occurs with condoms. And it is unclear how women report sources if the contraceptive was delivered to their home, as may be the case with community health worker (CHW) programs. Finally, there is also an unavoidable degree of uncertainty with self-reporting, as a woman who attended, for example, a clinic run by an NGO may report that source as a private clinic rather than naming the clinic as an NGO. Despite these limitations, the authors believe the opportunities for misclassification in most settings is minor and that estimates based on self-reported sources are generally reliable, in line with previous analyses (e.g., Campbell et al. 2015).

[2] 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.

Classifications for family planning sources

Private clinical	Hospital, clinic, doctor, nurse, midwife, health center, maternity home, other private medical
Private pharmacy or drug shop	Pharmacy, drug shop, dispensary, chemist
Private shop or market	Shop, market, bar, disco, vending machine, gas station, grocery store, guest house or hotel, warehouse, other private
NGO (includes faith-based organizations)	Mission hospital, mission health center or clinic, church, mosque, religious institution, NGO health facility, NGO mobile clinics, NGO CHW
Public	All public sources including hospitals, clinics, and CHWs
Other/don't know/missing	Friend, relative, partner, traditional healer, traditional birth attendant, school, the respondent herself, other, don't know, missing data

When presenting pooled results across countries or regions, each country is weighted equally. The authors considered weighting results by the population size in each country, but found that nearly three-quarters of the population-weighted sample would be from Asia because the Asian countries in the analysis are more populous.[3] Instead, each country is weighted equally, so that India contributes just as much to the results as Gambia, and results can be interpreted as averages across countries. In the results section, unless otherwise specified, all average percentages should be interpreted as the average *across the countries analyzed* with each country weighted equally. Similarly, all regional results are not representative of the entire region but should be interpreted as the average across countries analyzed in each region. All analyses use DHS sampling weights. Country results are only shown if there are more than 50 (unweighted) cases in the denominator of the estimate. If the denominator is less than 50, data are included in pooled analyses but not shown at the country level.

In five countries (Afghanistan, Bangladesh, Egypt, Pakistan, and Yemen), the DHS did not collect family planning information from never-married women, so results for these countries reflect ever-married women only. Data from these countries are excluded when results are disaggregated by marital status. Unless otherwise noted, results from all other countries are presented for all women (rather than just married women) to accurately portray contraceptive sources among all users, married and unmarried.

This analysis used the DHS wealth quintiles to examine results by socioeconomic status. The wealth quintiles divide the population surveyed in each country into evenly sized quintiles based on their household assets (Rutstein and Johnson 2004). The authors used the bottom and top quintiles, respectively, to represent women from the poorest 20 percent and wealthiest 20 percent of households in each country.

[3] The authors also repeated this analysis using population weights, and results were not substantially different.

Results

Roles of the public and private sectors in recent mCPR increases

To understand the roles of the public and private sectors in recent mCPR increases, the authors first examined the overall changes seen in the mCPR and the method mix in the 31 countries analyzed before and after the FP2020 summit, as method mix is closely related to source patterns (Figure 2). On average across the group of countries analyzed in the post-2012 era, more than one out of every four women is using a modern contraceptive method (26 percent). This is four percentage points higher than the same countries in the pre-2012 era (22 percent).[4] The mCPR increase is much larger in the East and Southern African countries analyzed, where modern contraceptive use has increased from one-fourth to one-third of all women of reproductive age. This translates into an average annual mCPR increase of 1.5 percentage points across countries analyzed in this region. Countries in West and Central Africa have the lowest mCPR, but the rate nearly doubled, from 8.3 percent before the London Summit to the current mCPR of 13.4 percent, resulting in a 0.9 annual percentage point rate of change. In contrast to these African regions, the average mCPR in the Asian countries analyzed remained nearly stable, increasing from 29 to 30 percent (an average annual increase of 0.3 percentage points). In the post-2012 era, East and Southern African countries have attained a higher average mCPR than Asian countries analyzed (33 versus 30 percent, respectively). Note that these averages are estimated among all women,[5] not just married women. However, these comparative patterns hold true when the analysis is restricted to married women only.

Photo: Sama Jahanpour

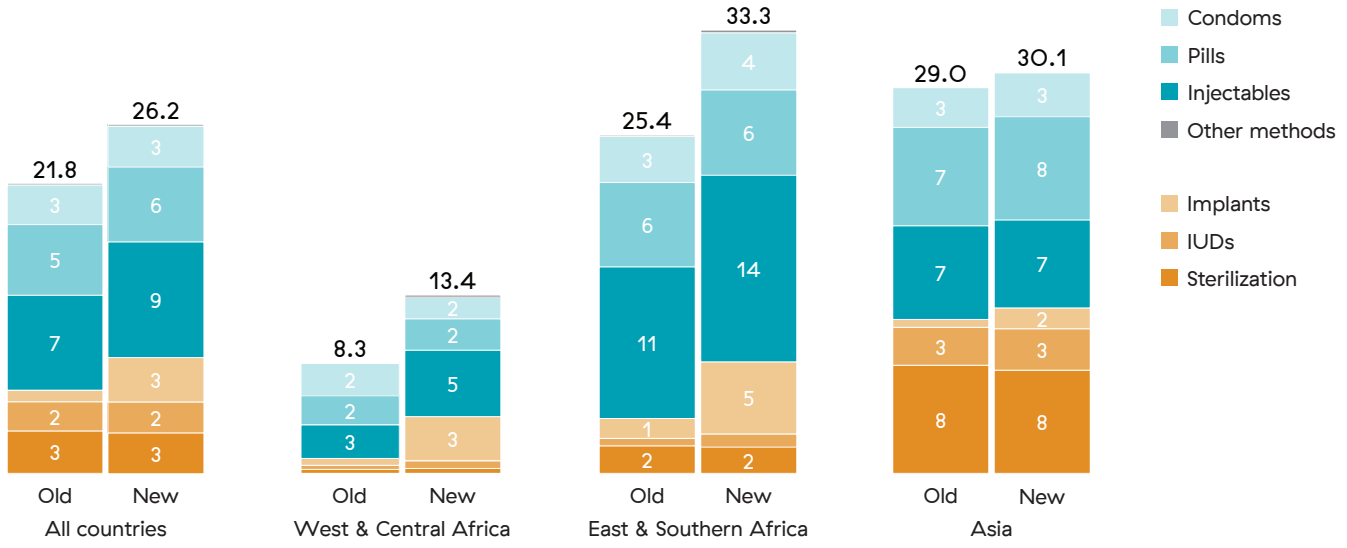
[4] Most countries included in this analysis include two DHS surveys conducted approximately five years apart. However, there are some exceptions to this: the Chad and India surveys are 10 years apart, most of the West and Central African surveys are 6 years apart, and the Bangladesh surveys are 3 years apart. The average annual mCPR increase across all countries analyzed is 0.8 percentage points.

[5] In this brief, *all women* refers to all women interviewed in the DHS surveys that the authors analyzed. In Afghanistan, Bangladesh, Egypt, and Pakistan, only ever-married women were interviewed in the DHS. In these countries, *all women* therefore refers only to ever-married women. In Yemen, all women of reproductive age were interviewed, but never-married women were not asked questions about contraception. In Yemen, therefore, all women are included in analysis, but never-married women are assumed not to be using contraception. The authors compared the results shown in Figures 2 through 4 against a second set of analyses restricting the sample to currently married women in all countries. Though the married mCPR is higher in most countries, all patterns described in the text for *all women* were consistent with those for married women.

Figure 2. Growth in contraceptive use among all women in the pre– and post–2012 era

Percent of all women using contraception, by region and contraceptive method

Old = pre–2012 surveys, New = post–2012



Note: Figures represent pooled averages across countries analyzed in each region.

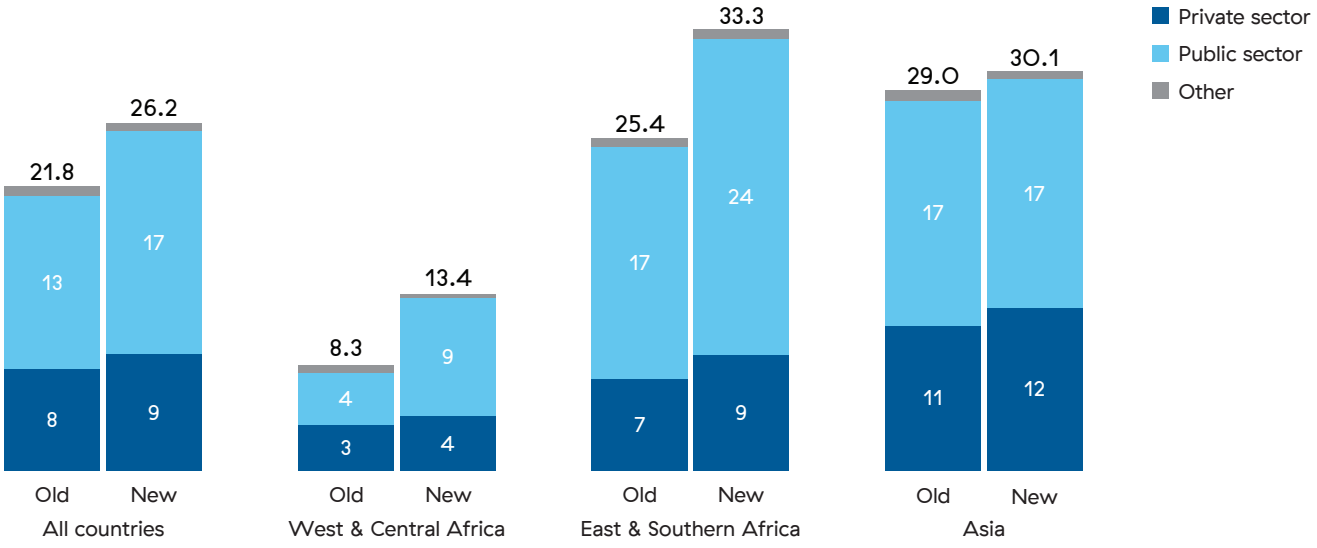
As shown in Figure 2, contraceptive growth is due primarily to large increases in two methods: injectables (a short-acting method or SAM) and implants (a long-acting reversible contraceptive, or LARC). The increases in these two methods are predominantly in sub-Saharan Africa. In the East and Southern African countries analyzed, 14 percent of all women are currently using injectables, up from 11 percent before 2012. Though fewer women in the region use implants (5 percent), the role of this method increased five-fold from the pre-2012 era. In the countries analyzed in West and Central Africa, 5 percent of all women are currently using injectables and 3 percent are using implants, up from 3 percent and less than 1 percent, respectively, before 2012.

As in Figure 2, the bars in Figure 3 sum to the mCPR in each region, but the bars are now color-coded by source of contraception. As shown, both the public and private sectors play an important role in modern contraceptive use. Use of contraception from public sector sources grew substantially in sub-Saharan African countries analyzed, and remained flat across countries analyzed in Asia. Growth in contraceptive use from private sector sources has been more modest in the analyzed countries, from 3 to 4 percent in West and Central Africa, 7 to 9 percent in East and Southern Africa, and 11 to 12 percent in Asia.

Figure 3. Both public and private sectors contributed to recent mCPR growth

Percent of all women using contraception from each source, by region

Old = pre–2012 surveys, New = post–2012



Note: Figures represent pooled averages across countries analyzed in each region.

As a share of mCPR, the relatively larger increase in public sector reliance is closely connected to method mix changes. Figure 4 shows changes in the percentage of all women using each method in the pre- and post-2012 era by source, across all countries analyzed. The public and private sectors have both contributed to modest increases in condom and pill use. Levels of IUD and sterilization use, and their respective sources, have remained essentially unchanged in countries analyzed. Injectables and implants are the two methods that have primarily driven recent contraceptive growth, and as Figure 4 shows, most of this growth has been through public sector sources.

Box 2. A closer look at injectable and implant growth

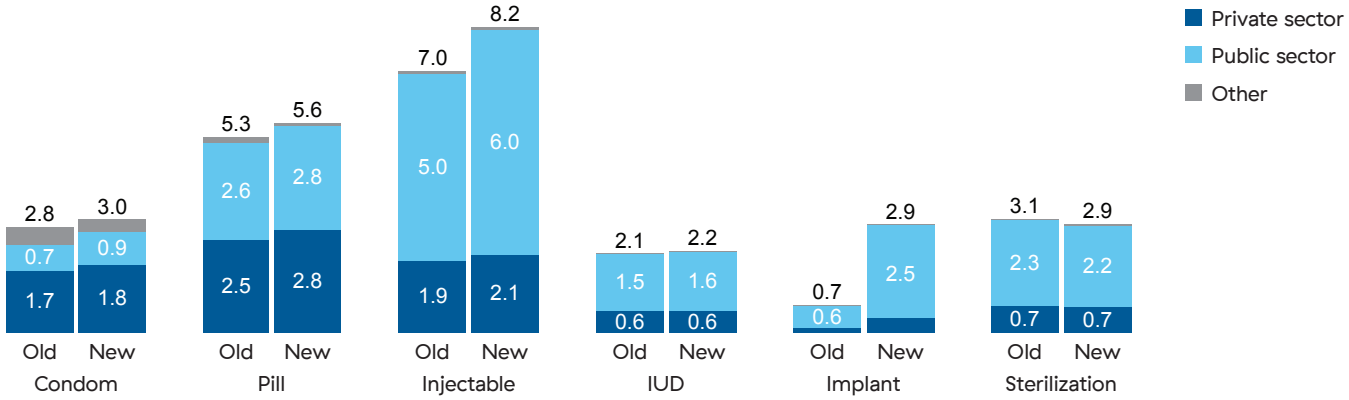
Adoption of task–sharing policies that allow lower–level health cadres such as nurse–midwives and community health workers (CHWs) to provide injectables has made this method more accessible, particularly at the community level and in rural areas (WHO 2017). Task–sharing policies and implementation guidelines for injectables have largely focused on public CHWs (FHI360 2018; WHO, USAID, and FHI 2010).

The Implant Access Program, launched in 2013, supplies two implant brands to FP2020 country governments and NGOs at a subsidized price under a volume guarantee. The program has substantially expanded implant access—primarily through the public sector and to a lesser extent through NGOs—and will operate through 2023 (FP2020 2018).

Figure 4. Injectables and implants have driven contraceptive growth, primarily through public sector sources

Percent of all women using contraception from each source

Old = pre–2012 surveys, New = post–2012



Note: Figures represent pooled averages across countries analyzed.

Where women currently obtain their contraceptives by region, country, and method

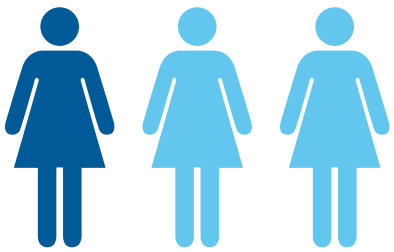
The prior section examined changes in contraceptive use among all women, including women not using contraception. This section analyzes the most recent data from all 36 countries and focuses only on women using modern contraception to examine where they get their methods.

On average across all countries analyzed, more than one out of every three modern method users rely on private sector sources (34 percent). Sixty-three percent use public sources, and 3 percent use other sources such as a partner, friend, or relative.

On average across the 36 countries analyzed,

1 in 3 modern contraceptive users

obtains her method from a private source.

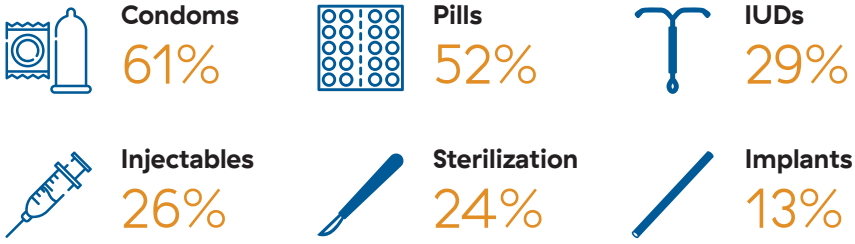


Women go to different sources for different contraceptive methods. On average across analyzed countries, the majority of short-term resupply methods, such as condoms and pills, are obtained from private sector sources (61 and 52 percent, respectively, as shown in Figure 5). For clinical methods, including injectables, LARCs, and permanent methods (PMs), the public sector is the primary provider. The private sector still plays a role in providing clinical methods, however. Approximately one-quarter of IUD users, injectable users, and sterilized women went to private sector sources for their method (29, 26, and 24 percent, respectively). Other sources—primarily friends, husbands, or other family members—provided condoms to 11 percent of users.

Women also use different sources for contraception in different regions of the world. On average across the Asian countries analyzed, 41 percent of users obtain their method from private sector sources (Figure 6). In the West and Central African countries, an average of 31 percent of users rely on private sources, and on average across East and Southern African countries, 26 percent go to a private source.

Figure 5. The role of the private sector is largest in providing condoms and pills

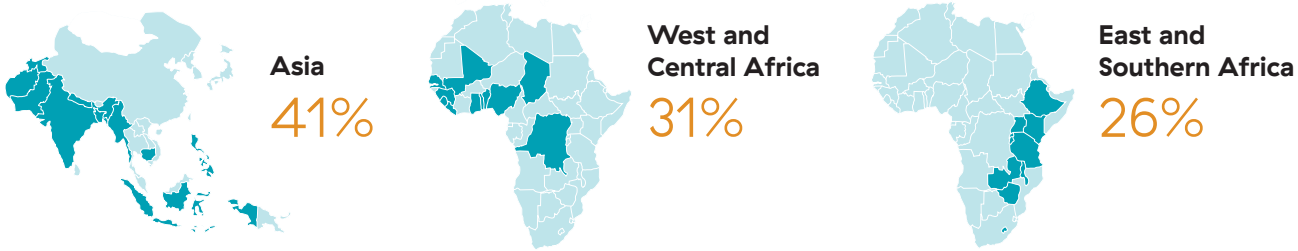
Percent of modern contraceptive users who obtain their method from private sector sources



Note: Figures represent pooled averages across countries analyzed.

Figure 6. Sources of contraception vary by region

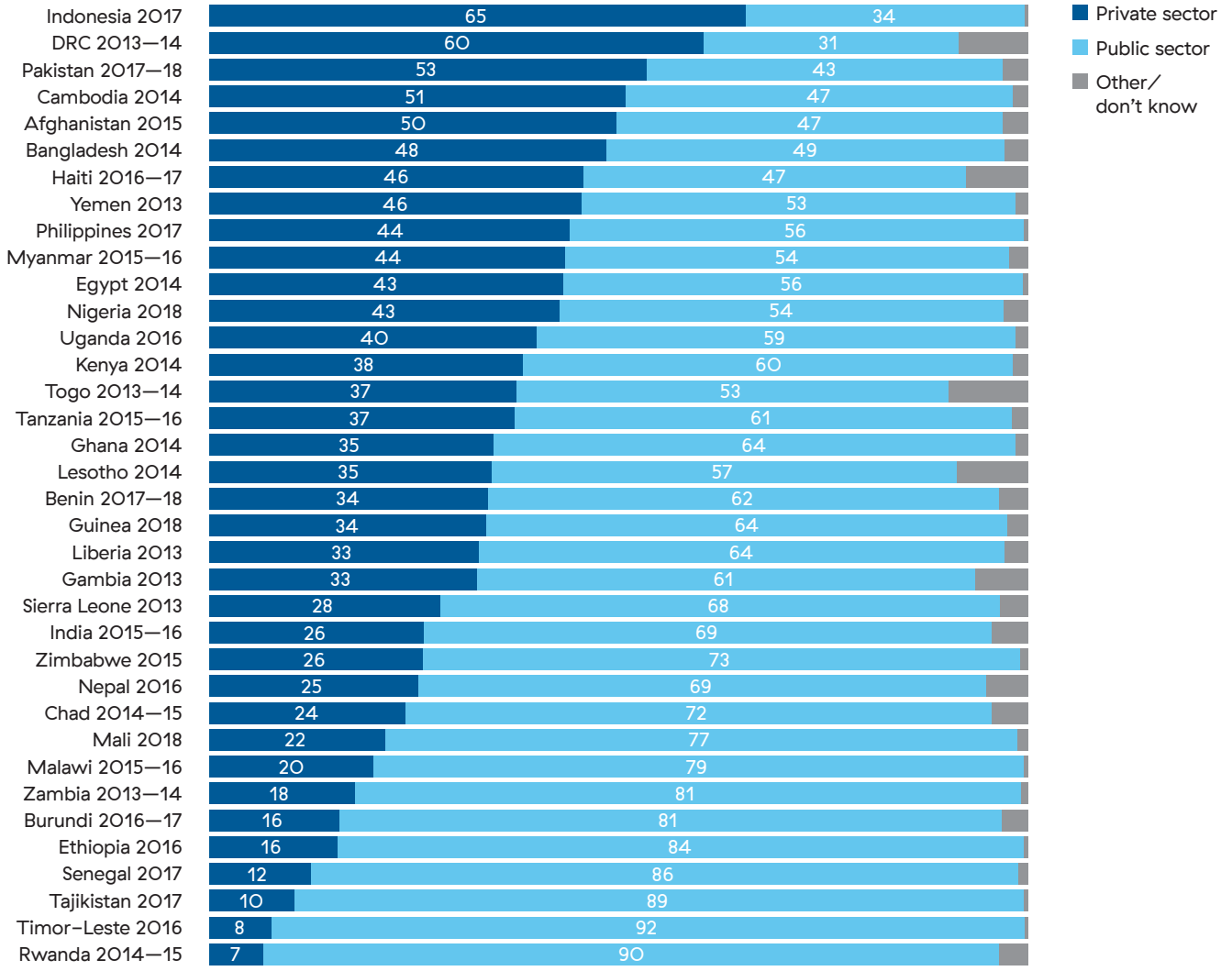
Percent of modern contraceptive users who obtain their method from private sector sources



Note: Figures represent pooled averages across countries analyzed in each region.

Figure 7. Source patterns for contraception differ greatly by country

Percent of modern contraceptive users who obtain their method from private sector sources

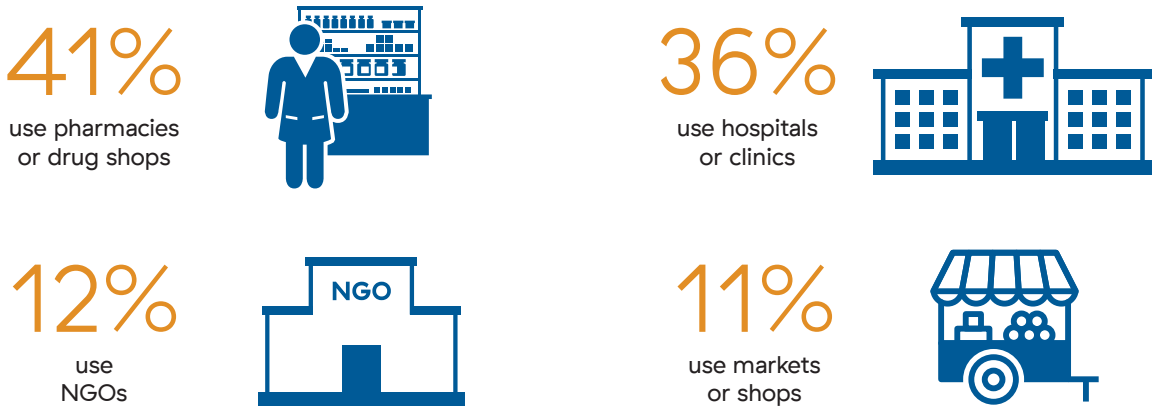


The private sector sources clients use

Narrowing the focus to women who go to private sector sources for contraception, the authors find that on average across the 36 countries analyzed, 41 percent of women get their method from pharmacies or drug shops and 11 percent from general shops or markets (Figure 8). More than half of private sector users, therefore, obtain contraception from non-clinical sources (pharmacies, shops, or markets). Hospitals and clinics are also an important private sector source, serving more than 1 in 3 (36 percent) private sector users. NGOs have a more limited role on average (12 percent) but play a much larger role in certain countries (Figure 9).

Figure 8. More than half of private sector clients obtain their method from a pharmacy or shop

Percent of private sector clients who obtain contraception from each source



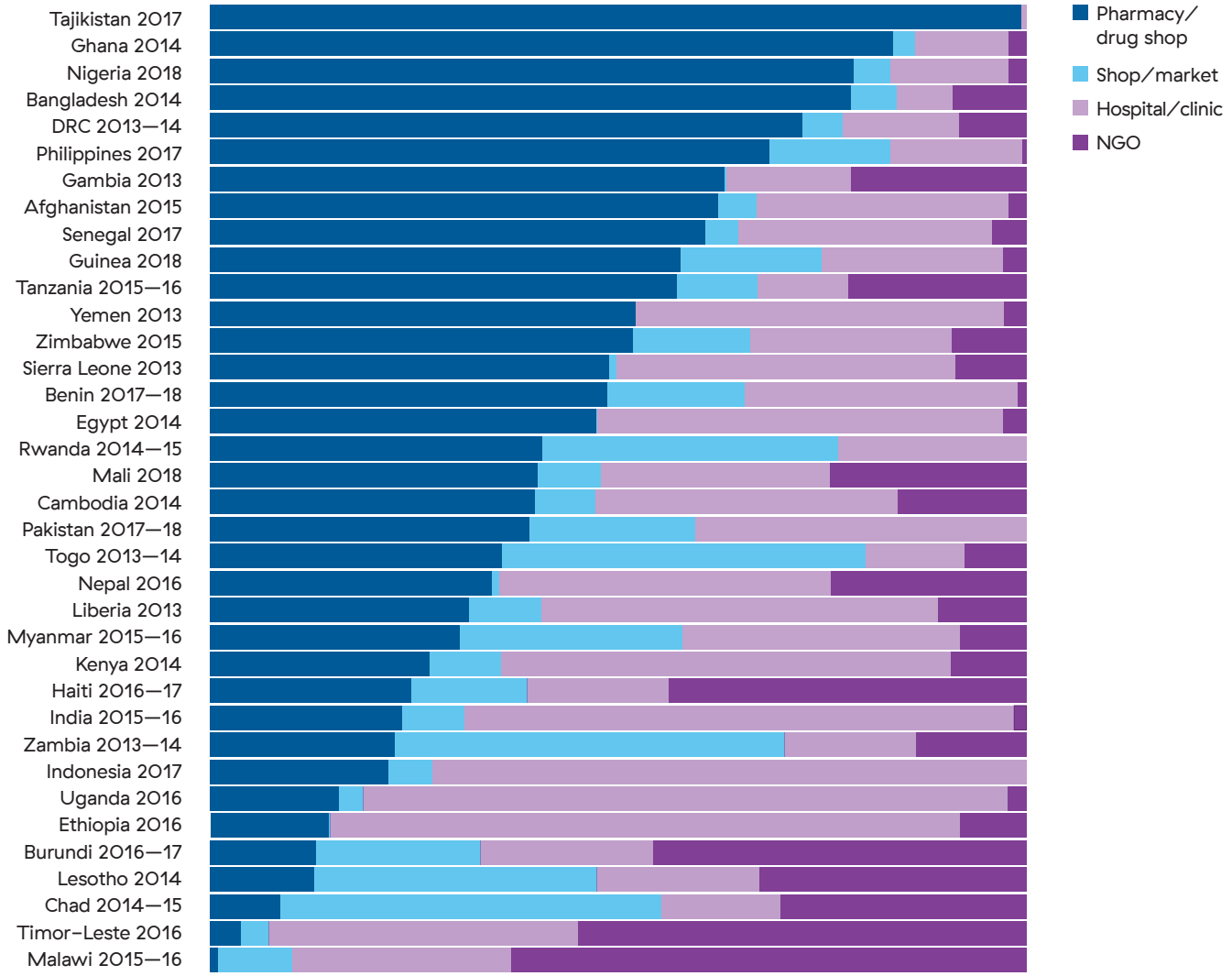
Note: Figures represent pooled averages across all countries analyzed.

The private sector comprises different types of sources in different regions and countries. The private sector is primarily non-clinical in West and Central African countries, where an average of 66 percent of private sector users get their method from pharmacies, shops, or markets. Private hospitals and clinics play a larger role, on average, in Asian countries (38 percent) and East and Southern African countries (36 percent). NGOs are most important in East and Southern Africa, serving more than 1 in 5 (21 percent) private sector users.

Figure 9 shows the great diversity across the private sector landscape in each country. More than 75 percent of private sector users in Tajikistan, Ghana, Nigeria, and Bangladesh get their contraception from pharmacies. In contrast, private clinics and hospitals serve the majority of private sector users in Uganda, Ethiopia, Indonesia, India, and Kenya. While the role of NGOs is limited at the global level, they are the dominant private sector source in Malawi and Timor-Leste and serve more than 40 percent of private sector contraceptive users in Burundi and Haiti.

Figure 9. The private sector landscape differs across countries

Percent of private sector users who obtain contraception from each source

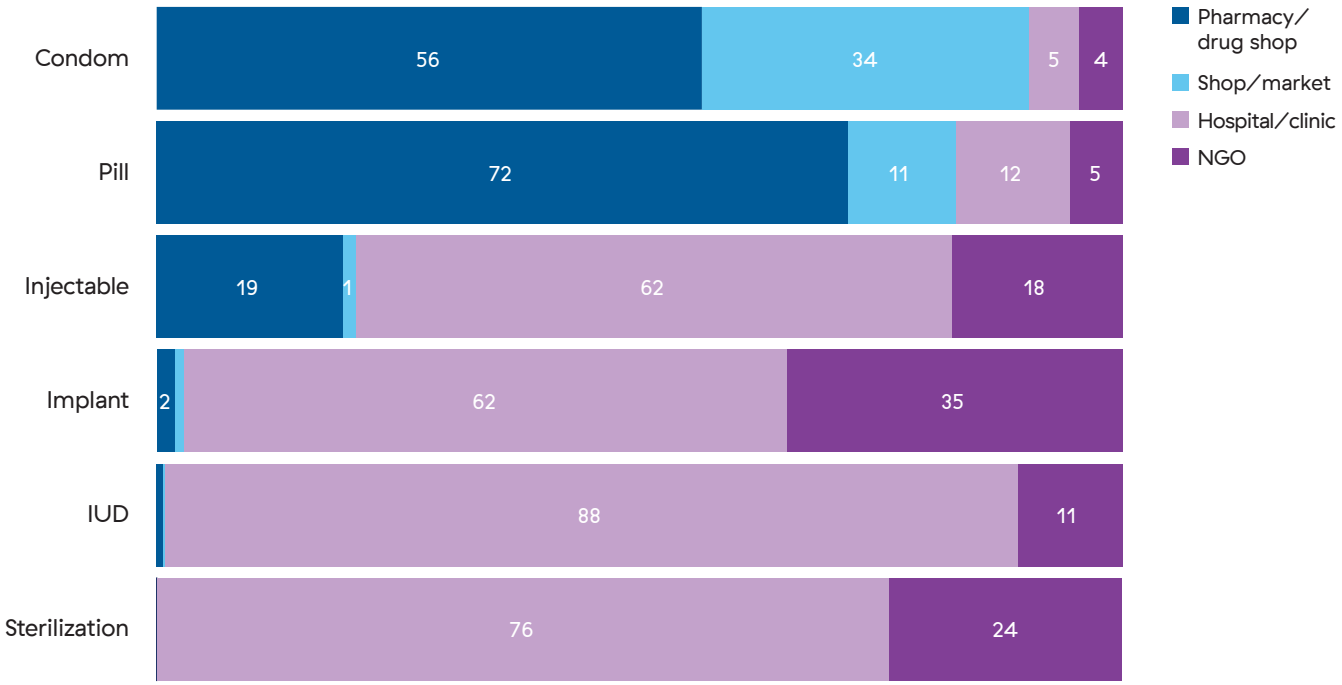


Private sector sources are, as expected, different for different methods (Figure 10). Pharmacies are, on average across countries analyzed, the dominant private source for pills (72 percent) and condoms (56 percent). Shops and markets are also a key source for private sector condom users (34 percent). In East and Southern African countries, shops and markets play a larger role, selling condoms to 60 percent of private sector condom users (not shown). Nearly one in five (19 percent) private sector injectable users obtain their method from a pharmacy, on average, which aligns with an increasing number of national policies that allow pharmacies to sell injectables. Private clinics, however, are

the primary private sector source for injectables and for LARCs and PMs. NGOs play the largest role (35 percent) for private sector implant users. While the (very small) percentage of users who report obtaining their injectable from a shop or their implant from a pharmacy may seem surprising, it is likely the case that these women purchased their method from one source and had it administered or inserted by a different provider. Overall, the private sector source mix in each country is closely related to the method mix. For example, in Indonesia private clinics are the dominant private sector source (73 percent) and, accordingly, injectables are the most commonly used method in the country.

Figure 10. Pharmacies and drug shops are a key private sector source for pills and condoms

Percent of private sector users who obtain their method from each source



Note: Figures represent pooled averages across all countries analyzed. Numbers may not add to 100 due to rounding.

Box 3. The role of social marketing

In many countries, social marketing is an important private sector mechanism to expand contraceptive access and choice by providing quality-assured subsidized commodities and services. For example, social marketing organizations in Afghanistan and Nepal, supported by SHOPS Plus, play a key role in contributing to the mCPR. In Afghanistan, where conflict has weakened government health systems, the Afghan Social Marketing Organization (ASMO) complements public sector strategies to increase access to contraception. Nearly one-fourth of modern contraceptive users in Afghanistan rely on products from ASMO, including 46 percent of all pill users. Similarly, in Nepal, 38 percent of short-acting method users rely on socially marketed products from the CRS Company, including more than half (58 percent) of pill users. In many countries, the role of social marketing is even larger. In Liberia, Nigeria, Zimbabwe, Rwanda, Malawi, Chad, Ethiopia, Benin, and Uganda, more than 90 percent of both pill and condom users rely on socially marketed brands (ICF 2015).

How contraceptive sources vary across population segments

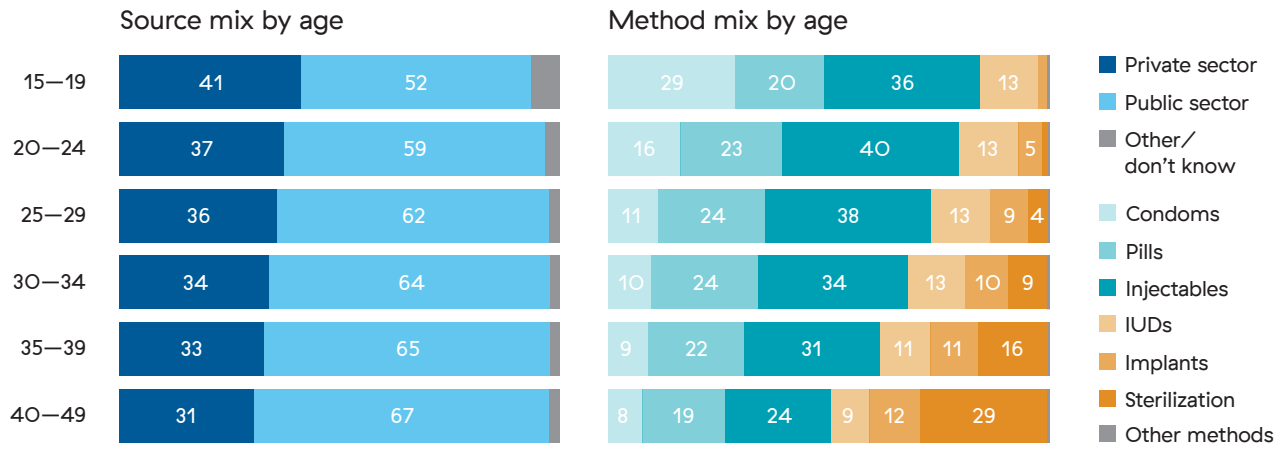
As noted at the beginning of this brief, a total market approach for family planning is rooted in an understanding of the different contraceptive sources, methods, and preferences across distinct population segments. This section explores the variation in contraceptive sources by age, marital status, residence, and wealth quintile.

Contraceptive source by age and marital status

Figure 11 shows source patterns among modern method users by age group on the left and method mix patterns by age on the right. The left panel shows a consistent pattern between contraceptive source and age: on average across the 36 countries, private sector use is highest (41 percent) among the youngest users (age 15 to 19) and lowest (31 percent) among the oldest age group, with a steady pattern of decreasing private sector reliance as women age. This source pattern aligns closely with method mix patterns by age. Younger women primarily rely on SAMs, shown in shades of teal in the right panel of Figure 11, while older women are much more likely to use LARCS and PMs, shown in orange. As expected, sterilization—a method for which nearly three-fourths of users rely on public sources—is much more common among users age 40 to 49 (29 percent) compared with no detectable use among 15 to 19 year olds and 1 percent among users ages 20 to 24. Conversely, condoms—the method most commonly sought from private sources—are much more common among the youngest than oldest users (29 versus 8 percent). Notably, use of pills (a SAM) and implants (a LARC) are used at similar levels across age groups, indicating that these two methods seem to have broad appeal and, perhaps, availability.

Figure 11. By age group, source and method mix are highly correlated

Percent of users in each age group who use each source (left) and use each method (right)

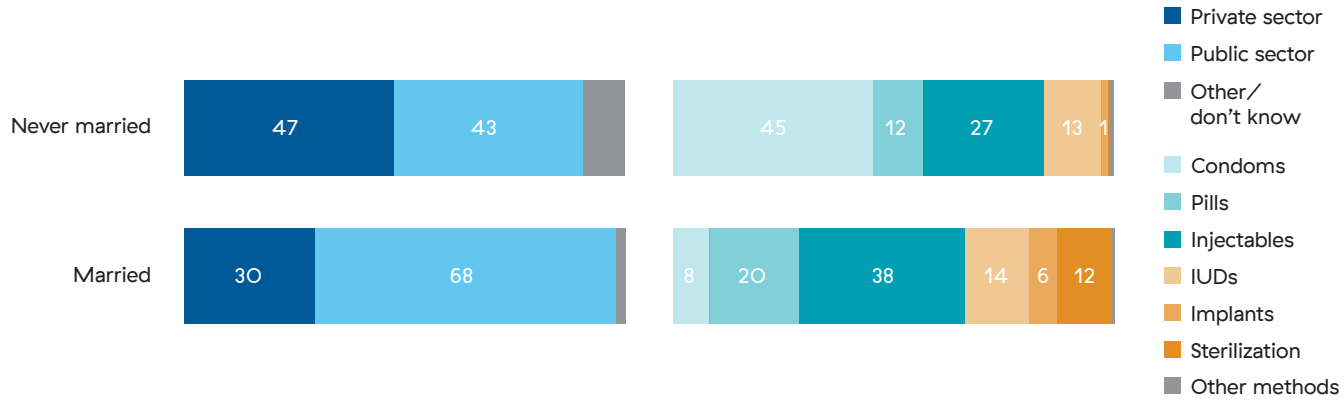


Note: Figures represent averages across all countries analyzed. Numbers may not add to 100 due to rounding.

Source and method mix patterns by marital status (Figure 12) mirror patterns by age, as older women are more likely to be married. On average across the 32 countries analyzed by marital status, unmarried users are far more likely than married users to obtain their method from private sector sources (47 versus 30 percent) and to use SAMs (84 versus 66 percent). The largest difference in method mix between unmarried and married contraceptive users is the level of condom use, which is nearly six times higher among unmarried users (45 versus 8 percent).

Figure 12. Unmarried users more likely than married users to obtain method from private sector

Percent of users by marital status who use each source (left) and use each method (right)

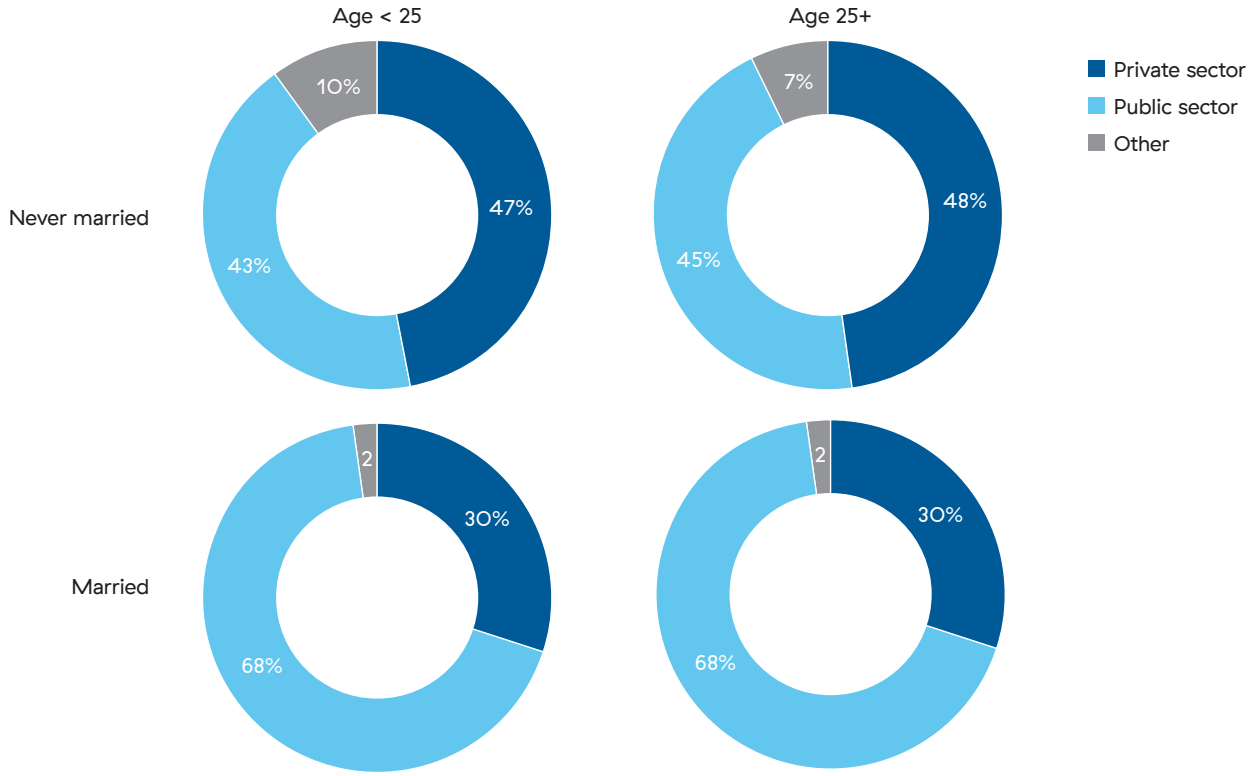


Note: Figures represent averages across 32 countries analyzed, excluding countries that did not collect contraceptive data from unmarried women.

When users are categorized by their marital status and age group (younger than 25 or 25 and older), it becomes clear that private sector use is more strongly related to marital status than age (Figure 13). Nearly one-half of unmarried users, both younger and older, rely on private sources for their method compared with just under one-third of married users—both younger and older.

Figure 13. Source patterns are more closely related to marital status than age

Sources among users by age and marital status combined



Note: Figures represent averages across 32 countries analyzed, excluding countries that did not collect contraceptive data from unmarried women.

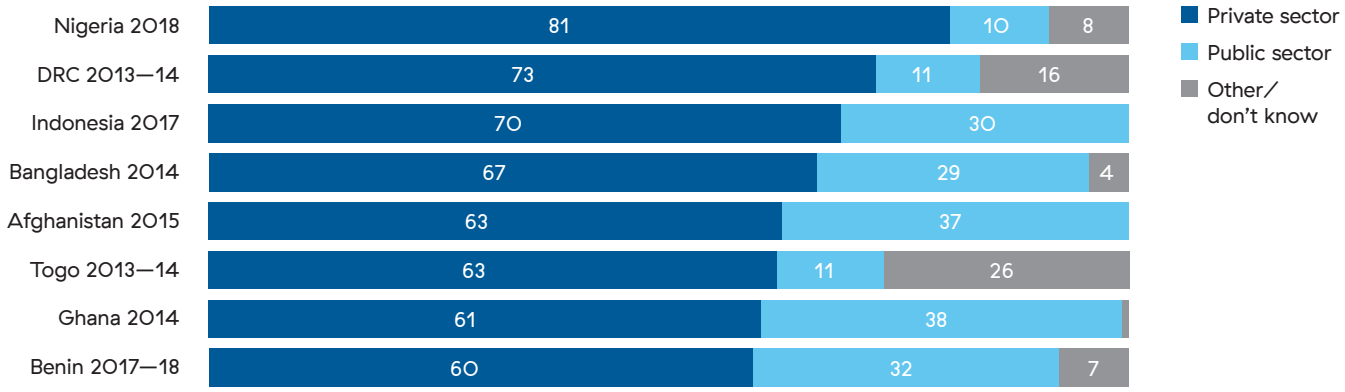
Many countries have stated goals to improve their family planning services that reach adolescents (Bryant-Comstock 2015). Given this focus in many countries, it is important to examine where adolescent users obtain contraception, regardless of their marital status.

Figure 14 shows the important role the private sector plays in reaching users age 15 to 19 in many countries. More than 80 percent of adolescent users in Nigeria rely on private sector sources for their contraception, along with 73 and 70 percent in DRC and Indonesia, respectively. In Bangladesh and Afghanistan, where only married women were interviewed, more than 60 percent of these

adolescent users obtained contraception from private sources. Private sector use among adolescents is also at or above 60 percent in Togo, Ghana, and Benin. In many of these countries, *other* informal sources—mostly partners, friends, and family members—supply a substantial portion of contraceptives. In DRC and Togo, adolescents use these informal sources at higher rates than the public sector.

Figure 14. The private sector is the dominant source for contraception for adolescents in several countries

Sources of contraception among adolescent users (ages 15—19) in selected countries



Note: Numbers may not add to 100 due to rounding.

Contraceptive source by geography

Use of modern contraception is slightly higher in urban areas of analyzed countries than in rural areas (27 versus 24 percent). On average, 45 percent of urban contraceptive users go to private sector sources. While private sector use is lower in rural areas, more than 1 in every 4 rural contraceptive users (27 percent) obtains her method from a private source, on average across the 36 countries analyzed. Like all global patterns, this conceals substantial country-level variation. For example, more than half of all rural contraceptive users rely on private sources in Indonesia, and nearly 50 percent of rural users rely on private sources in DRC, Pakistan, and Cambodia. On average across the 36 countries analyzed, the method mix is largely consistent in urban and in rural areas. The two methods that differ in their use by geography are condoms, which are more common in urban areas (17 versus 9 percent), and injectables, which are more common in rural areas (37 versus 27 percent).

On average across the 36 countries analyzed, the private sector is an important source of contraception for urban and rural areas

On average across the 36 countries analyzed, 93 percent of women in the bottom wealth quintile in their country also live in rural areas. Likewise, 83 percent of women in the top wealth quintile in their country live in urban areas. Therefore, the findings on contraceptive sources by urbanity largely align with those by socioeconomic status in the next section.

Contraceptive source by socioeconomic status

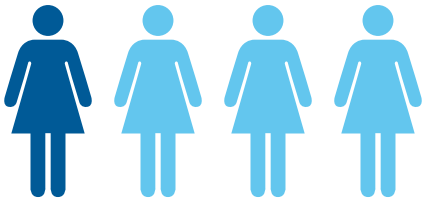
A total market approach aims to provide all women with access to their choice of contraceptive method and to allocate limited resources where they are needed most. In some markets, this may mean that users with the ability to pay for contraception buy their methods from private sources, enabling the public sector to use their resources to serve those without the ability to pay. This section compares contraceptive sources used by women in the wealthiest 20 percent (quintile) of each country's population with those in the poorest 20 percent. Comparing wealth quintiles across countries is challenging because quintiles are a relative measure of wealth within each country. For example, households in the wealthiest quintile of the population in Zimbabwe likely have higher incomes than households in the wealthiest quintile in DRC. Women in the poorest quintile in Mali might be much poorer than women in the same quintile in Tajikistan. The authors examined the average source patterns across the 36 countries by looking at the poorest and wealthiest women in each country, noting that women across countries are not all equally wealthy or equally poor.

On average across countries analyzed, nearly one out of every four of the poorest contraceptive users obtains her method from a private source (22 percent). Just over three-fourths (76 percent) of the poorest users, averaged across countries analyzed, visit public sector sources for their contraception. Contraceptive sources among the wealthiest women in each country are more evenly split: 46 percent of the wealthiest women go to public sources and 50 percent to private sources.

Method mix varies by wealth quintile as well. On average across countries analyzed, condoms—which are primarily sourced from the private sector—are much more popular among the wealthiest than poorest users (19 versus 6 percent). Conversely, injectables—largely obtained from public sector sources—make up a larger share of the method mix among the poorest than the wealthiest users in analyzed countries (41 versus 24 percent).

On average across countries analyzed, both the poorest and wealthiest contraceptive users rely on the private sector

Nearly 1 in 4 of the poorest contraceptive users in each country obtains her method from the private sector



Nearly half of the wealthiest contraceptive users in each country rely on public sources

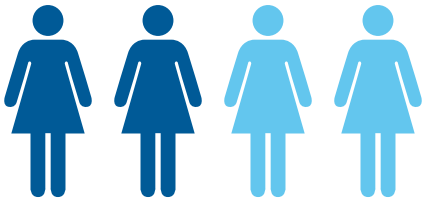


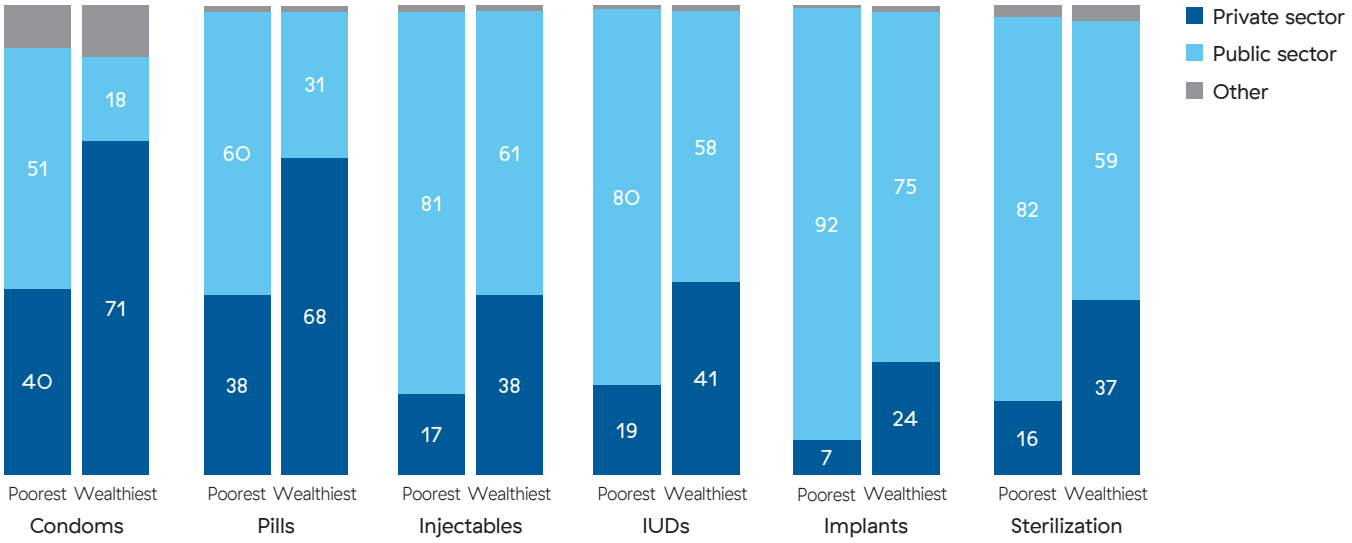
Figure 5 showed that women obtain different contraceptive methods from different sources. Figure 15 demonstrates that contraceptive sources for the same method vary depending on women's socioeconomic status. Sources among the poorest (left bar) and wealthiest (right bar) users of each contraceptive method are averaged across women in the poorest and wealthiest quintiles in each country analyzed. For each method, the wealthiest users in each country are, on average, more likely to go to a private source than the poorest users, as expected. Also as expected, women from both the poorest and wealthiest quintiles in each country rely primarily on public sources for LARCs and PMs, especially implants, given that these clinical methods are often more available in public than private facilities (Ali et al. 2018).

It is more surprising to see that on average across the 36 countries, 31 percent of pill users from the wealthiest quintile in each country and 61 percent of injectable users from the wealthiest quintile in each country get these methods from public sources. Reasons behind this high public sector use for short-term resupply methods vary in each country. Frequently, there are high levels of public sector reliance even among the wealthy in countries where regulatory barriers prevent private providers from delivering certain methods, for example, where pharmacists cannot provide pills or injectables without prescriptions (Riley, Callahan, and Dalious 2017). Additionally, in some

countries, the "wealthiest" women are not wealthy enough to be able to pay for contraceptives, especially those that are not subsidized. These patterns also likely reflect that women and couples make decisions about where to access contraception not only based on affordability, but also on preferences for convenience, privacy, and choice. These data show potential opportunities for improved resource allocation using a total market approach. However, the patterns must be examined and interpreted at the country level with an understanding of multiple factors including service and product availability, mCPR, development status and market maturity, government regulatory policies, and individual preferences.

Figure 15. Sources among the poorest and wealthiest users of each contraceptive method

Percentage of users in the poorest and wealthiest quintiles who obtain contraception from each sector



Note: Figures represent pooled averages across all countries analyzed.

Figures 16 and 17 showcase these variations in source patterns among the poorest and wealthiest contraceptive users at the country level. Figure 16 shows that in more than one-third of the 36 countries analyzed, the majority of the wealthiest users rely on public sector sources. Figure 17 shows sources among users in the poorest quintile. While public sector use among the poorest women is much higher than among the wealthiest, many poor women are served by the private sector. More than one-third of the poorest contraceptive users in DRC, Indonesia, Cambodia, Yemen, Haiti, Pakistan, Afghanistan, and Myanmar obtain their method from private sector sources.

Box 4. Relative and absolute measures of wealth and income

Wealth quintiles are a measure of *relative* wealth that enables comparisons of poorest and wealthiest households within a single country at one point in time (Rutstein and Johnson 2004). In some countries, however, women in the wealthiest quintile may actually have very little disposable income to use for commodities such as contraception. Absolute measures of wealth, such as World Bank poverty headcount data, is another useful tool to understand income and ability to pay. For more information on absolute measures of income at the country level, please see FPMarketAnalyzer.org and a SHOPS Plus report by Bellows, Reidy, and Weinberger (2019).

Figure 16. Contraceptive sources among users in the wealthiest quintile

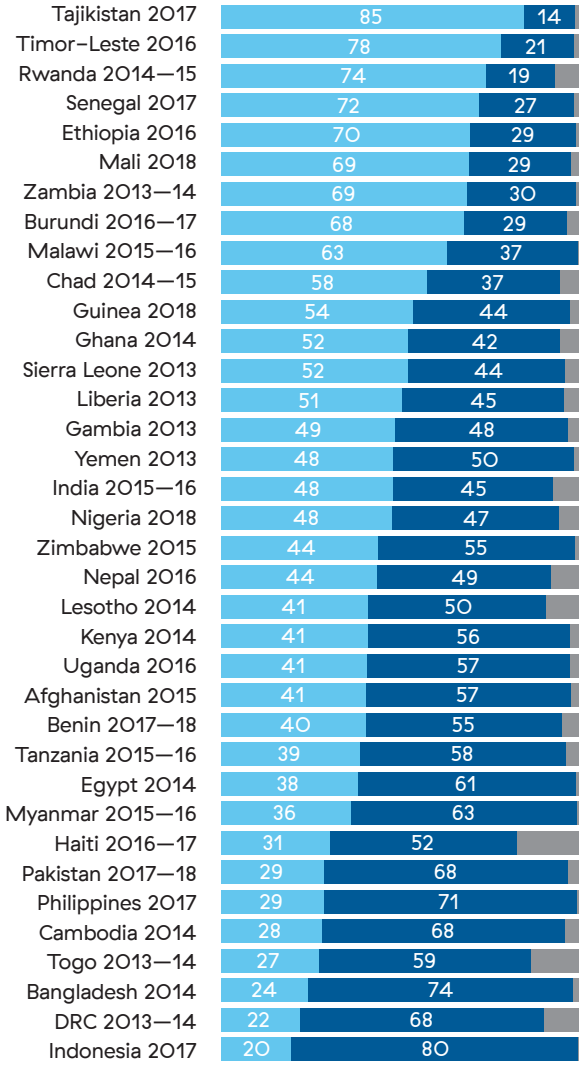
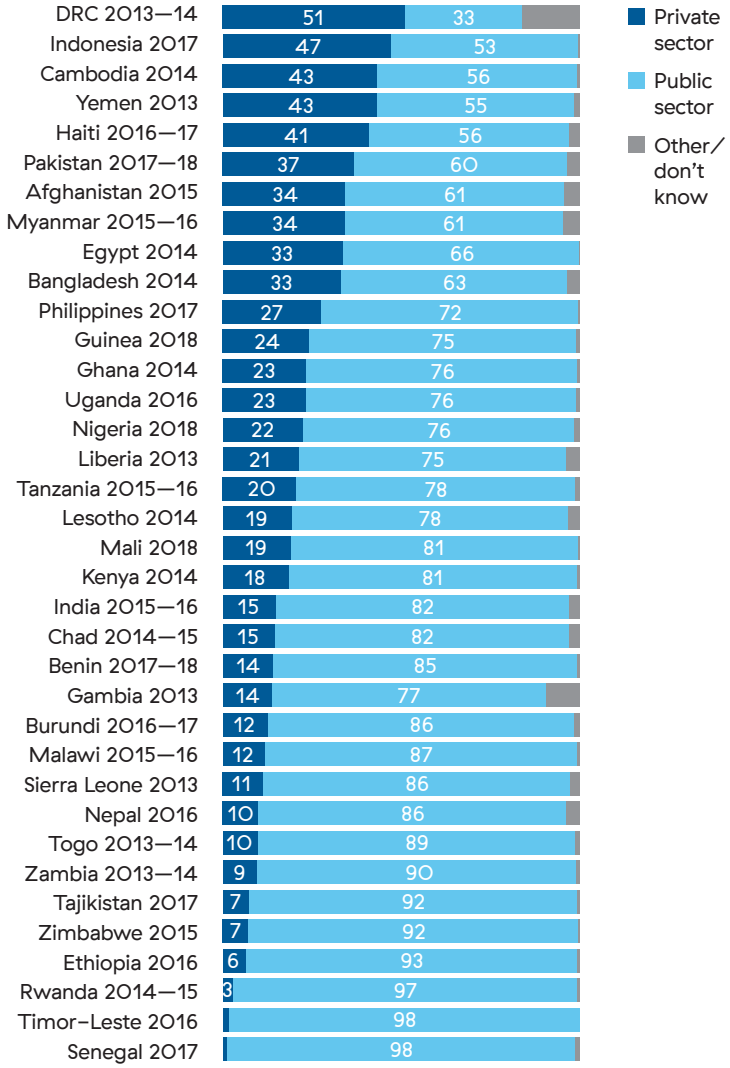


Figure 17. Contraceptive sources among users in the poorest quintile



Settings in which the private sector plays a larger role

The previous sections showed that there is a large variation in the roles the public and private sectors play in different countries. Even between countries in which the private sector plays a very large role, there is still great diversity. For example, Indonesia and DRC are two countries with the highest percentage of users who obtain their methods from private sector sources. Indonesia is an Asian upper-middle-income country in which 41 percent of women use modern contraception. In the Central African country of DRC, by contrast, the mCPR is 8 percent, and more than 60 percent of the population is estimated to live below the poverty line.

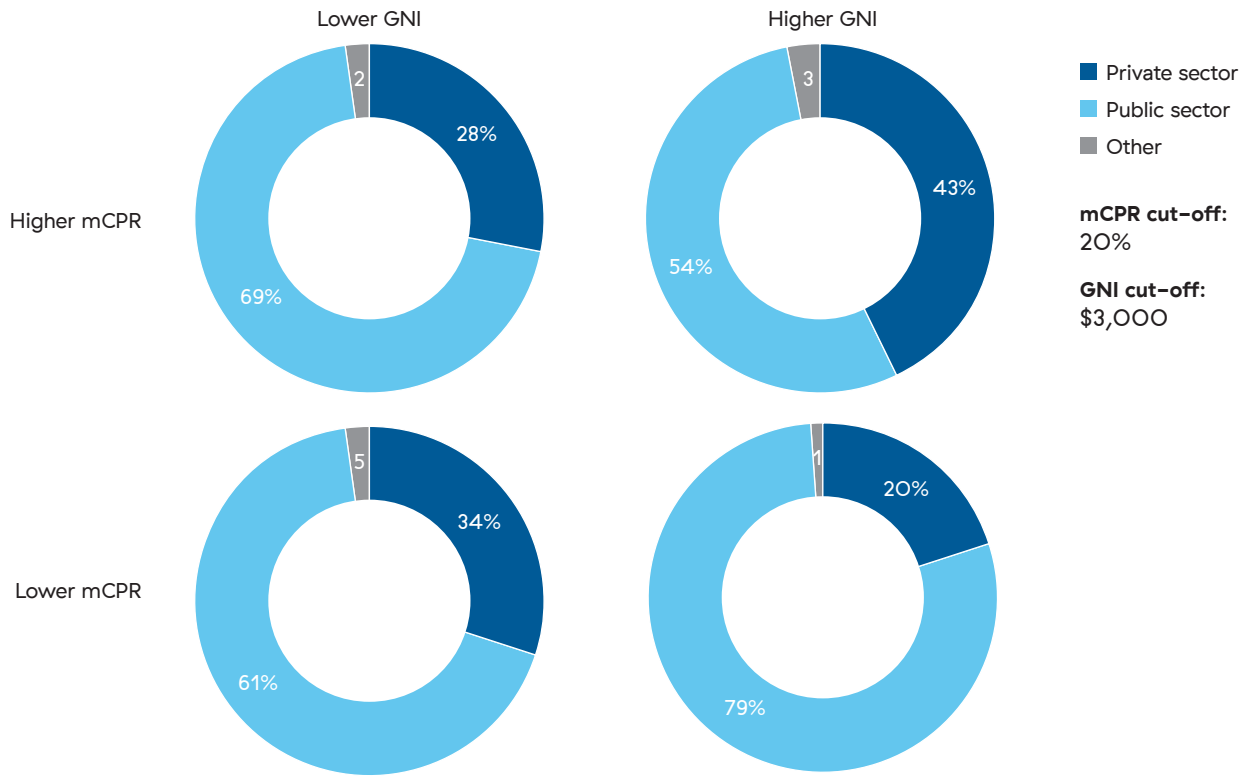
To explore settings in which the private sector plays a relatively larger role, the authors first looked for patterns by contraceptive prevalence. Family planning programs typically focus on different issues at different levels of contraceptive use. For example, many lower-mCPR countries focus on building infrastructure to deliver contraceptive supplies and services, while higher-mCPR countries may focus more on long-term sustainability. Because a healthy private sector is key to ensuring sustainability, the authors anticipated that the private sector would play a larger role in higher-mCPR countries. Yet as a percentage of users, the authors found the private sector plays a large role in several lower-mCPR countries, including Guinea and Afghanistan, where 6 percent of all women and 18 percent of ever-married women use modern contraception, respectively. The authors therefore examined the role of the private sector in countries according to additional contextual factors, including national-level income.

Figure 18 shows the roles of the private and public sectors among users in four groups of countries. Countries were split by mCPR and gross national income (GNI) per capita (purchasing power parity adjusted, World Bank 2019), based on the distribution of these two variables across the countries included in the analysis. The left column includes countries with GNI per capita lower than $3,000, and the right column includes countries above this cut point. The top row features countries with mCPRs above 20 percent, and lower-mCPR countries are featured in the bottom row.[6]

[6] *Lower mCPR* is classified as 20 percent or below in this analysis. *Higher mCPR* is classified as above 20 percent. GNI per capita (purchasing power parity adjusted) is classified as lower if it is below $3,000 USD and *higher* if it is equal to or above $3,000. Cutoff points were determined so that there are a relatively equal number of countries in each category. Countries in each category are: (1) Lower mCPR, lower GNI: Afghanistan, Benin, Burundi, Chad, Democratic Republic of the Congo, Gambia, Guinea, Mali, Togo; (2) Lower mCPR, higher GNI: Ghana, Nigeria, Senegal, Tajikistan, Timor-Leste; (3) Higher mCPR, lower GNI: Ethiopia, Haiti, Kenya, Liberia, Malawi, Nepal, Rwanda, Sierra Leone, Tanzania, Uganda, Zimbabwe; (4) Higher mCPR, higher GNI: Bangladesh, Cambodia, Egypt, India, Indonesia, Lesotho, Myanmar, Pakistan, Philippines, Yemen, Zambia.

Figure 18. Contraceptive sources by country mCPR and GNI per capita

Percent of modern contraception users in each country group who obtain contraception from each source



Note: Figures represent averages across countries analyzed in each group. Numbers may not add due to rounding.

The private sector's role is larger, on average, in countries with lower mCPRs and lower GNI per capita (34 percent) and in countries with higher mCPRs and higher incomes (43 percent). The lower-mCPR, lower-income group includes mostly West and Central African countries such as DRC and Guinea, but also includes Afghanistan. In these countries, there is often limited access to contraceptive supplies and services, and the private sector may be filling in gaps left by an underperforming public sector. The private sector in these countries is primarily made up of pharmacies, shops, and markets, and many contraceptive supplies are subsidized.

The lower-mCPR group with higher per-capita GNIs comprises several West African countries, such as Ghana, Nigeria, and Senegal, as well as Tajikistan and Timor-Leste. Levels of contraceptive use are higher, on average, than countries in the first group, including 18 percent among all women in Ghana and 19 percent in Senegal and Tajikistan. The third group of lower-income,

higher-mCPR countries includes several East and Southern African countries that have been noted for their strong family planning programs, either historically or recently, including Kenya, Rwanda, and Zimbabwe. In many of these countries, the government has created a public sector infrastructure that is able to meet the contraceptive needs of much of their population.

Countries in the higher mCPR and higher-income group represent more mature contraceptive markets, including countries like Bangladesh, Egypt, India, and the Philippines. A greater share of the private sector is clinical in these countries, often providing LARCs and especially PMs in South Asian countries. In many of these settings, the public and private sectors work together to create more sustainable service delivery. The higher mCPRs in these countries may, in part, reflect successful efforts by both public and private sectors that have expanded contraceptive access and choice, thereby growing the overall contraceptive market.

It is important to note that policy, governance, financing decisions, and preferences influence the source patterns seen in each country, and there is not necessarily one universal pattern relating contraceptive source to mCPR and GNI.

Photo: Sama Jahanpour

Implications

Across the low- and middle-income countries examined in this brief, both the public and private sectors have contributed to substantial family planning progress since the 2012 London Summit. Large increases in contraceptive prevalence through uptake of implants and injectables have primarily come through public sector sources. The private sector has kept pace with public sector growth, serving one out of every three modern method users. The authors' finding that the private sector serves, on average, 34 percent of contraceptive users is in line with earlier analyses examining pre-2012 data (Ugaz et al. 2015; Campbell et al. 2015). As contraceptive prevalence and population sizes continue to increase, the public and private sectors both serve millions of additional users each year.

This analysis demonstrates the importance of the private sector for specific groups of women: unmarried, adolescent, urban, and wealthier. The private sector does not only serve these populations, however. On average across countries analyzed, one in every four of the poorest contraceptive users, and more than one out of every four rural users, obtains her method from a private sector source.

Quantitative data like those analyzed here can explain a great deal about where women access contraception. Equally important, though less easy to determine quantitatively, are the reasons why women access contraception from certain sources, or use certain methods. Use of the private sector, particularly among poorer women, could indicate a lack of access to public sources in their geographic area (World Bank 2015). It may also indicate a preference for the private sector, for reasons of convenience, perceived quality, or to ensure their privacy (Keesara, Juma, and Harper 2015; Hutchinson, Do, and Agha 2011). Women may prefer to access contraception from private sources, but may not be able to access all methods there. Even the wealthiest women may not be able to afford the costs of unsubsidized LARCs in the private sector. To increase method choice in the private sector, governments should consider strategic purchasing to increase LARC availability and affordability, as well introducing new methods as they become available (e.g., DMPA-SC, which has the potential to increase affordability by eliminating service provision costs). Regardless of why women access the private sector for their family planning method, it

Photo: Jessica Scranton

is essential that all sectors offer a choice of the full range of contraceptive options, to the extent possible and in line with global guidelines (WHO/RHR and CCP 2018).

A strong public sector is an essential asset in family planning service delivery to ensure that most users—particularly the poorest and most vulnerable—can access family planning commodities and services for free or for a minimal fee. The private sector can complement public sector approaches—as many of the higher mCPR/higher GNI countries are doing—to help expand contraceptive access and choice, increasing the number of women and couples family planning programs can serve. Depending on the country context, the private sector can offer additional product brands (subsidized and commercial) and provide services through an increased number of outlet types (including pharmacies and shops, which may be more convenient) to create more options for users. These options ultimately enhance the likelihood that each woman's contraceptive needs and preferences are met. Reducing policy and regulatory barriers to align country and international standards will maximize the potential impact of the private sector in family planning and help facilitate a total market approach to drive countries' contraceptive markets toward increased sustainability, efficiency, and equity. With a supportive enabling environment, the public and private sectors can provide complementary approaches to expand method choice, access, and availability (Weinberger and Callahan 2017).

In addition to examining general patterns, this analysis highlights stark differences in contraceptive source patterns across countries. It is critical to interpret findings in the context of each country's policy and programmatic landscape—as SHOPS Plus did in its country briefs—to more comprehensively understand and make recommendations to improve family planning programs and markets. Each country's contraceptive market is shaped by a myriad of factors including its market development (e.g., GNI per capita, percent of national budget allocated to health and to family planning, sources of health financing), national and subnational policies (e.g., task-sharing, approval of new contraceptive methods like the Levoplant implant and DMPA-SC), contraceptive policy regulations and restrictions, health system capacity (e.g., availability of public and private sources of care, quality of care), and governance (e.g., public-private partnerships, leadership and commitment to improving contraceptive access and choice).

A total market approach will look different within each country context. This analysis indicates that there are often opportunities for improved resource allocation, strategically targeting public and private sector resources toward

Photo: Sharbendu De

specific population segments to optimize the comparative advantages of each sector. For example, countries with less mature markets that are just beginning their journey to self-reliance may require strategies to reach underserved populations such as through social marketing with subsidized family planning products. In contrast, countries with more advanced markets and stronger governance may benefit from the development of public-private partnerships to expand the role of the commercial private sector and allow public resources to be targeted to the poorest and most vulnerable communities. Such improved resource allocation will result in more efficient, equitable, and sustainable programs and markets.

Despite considerable progress toward FP2020 goals, stark gaps and inequities in contraceptive access and choice remain (FP2020 2019). Further, as low- and middle-income countries progress on their journeys to self-reliance, much work is needed to realize contraceptive market sustainability. Both the public and private sectors are important sources of modern contraception in nearly every low- and middle-income country. Indeed, many women will rely on both the public and private sectors as they progress through their reproductive life courses. Harnessing the power and potential of all market actors—government and nongovernmental, social marketing and franchising, and private commercial—is key to accelerating progress toward countries' family planning goals. Together, these actors can expand contraceptive access and choice and meet the needs and preferences of all current and potential future contraceptive users.

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Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a five-year cooperative agreement (AIDOAA-A-15-00067) funded by the United States Agency for International Development. The project strategically engages the private sector to improve health outcomes in family planning, HIV, maternal and child health, and other health areas. Abt Associates implements SHOPS Plus in collaboration with the American College of Nurse-Midwives, Avenir Health, Broad Branch Associates, Banyan Global, Insight Health Advisors, Iris Group, Population Services International, and the William Davidson Institute at the University of Michigan.

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