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THE COMMERCIAL SECTOR'S ROLE IN PROVIDING LONG-ACTING AND PERMANENT METHODS

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ACRONYMS

CA/WA/NA/E	Central Asia/West Asia/North Africa/Europe
CDC	Centers for Disease Control
DHS	Demographic and Health Surveys
IUD	Intrauterine devices
LAPMs	Long-acting and permanent methods
PSP-*One*	Private Sector Partnerships-*One* project
NGO	Nongovernmental organization
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

The report provides information about the use of long-acting and permanent methods (LAPMs) and the role of the commercial sector in their provision. It examines changes in the use of LAPMs and the sources for acquiring them. Data from a few countries are used to examine how ability to pay affects the use of LAPMs in the commercial sector.

We obtained information on the use of LAPMs from 63 of the most recent reproductive health survey reports. Where possible, we divided the sources into commercial, nongovernmental organization (NGO), and public source categories. We also analyzed trends in method and source use for countries where we could obtain information on the use of the commercial sector. Lastly, we analyzed LAPM use and source by wealth quintiles.

LAPMs are used less often in sub-Saharan Africa than in other developing country regions worldwide, although there were large variations in the composition of LAPMs used in these different regions. In the Central Asia/West Asia/North Africa/Europe region, use of intrauterine devices (IUD) was high, but sterilization use was low. In contrast, use of sterilization was high in Latin America, but some countries in this region also had high usage of IUDs. In only one sub-Saharan African country was use of sterilization high (South Africa). Three South and Southeast Asian countries had high use of sterilization; only Vietnam had high use of the IUD.

The report finds that for the eight countries with high levels of IUD use where information on the commercial sector was available, the commercial sector share of the market ranges from 16 to 39 percent with use in five countries between 30 to 39 percent. However, use of the commercial sector for female sterilization reaches only 20 percent or better in four of eleven countries with use 30 percent or better in only two countries. The wide variation in patterns of commercial sector use among countries may occur because clients have trouble accurately reporting their source. An examination of trends in the use of the commercial sector for IUDs and sterilization showed that where the use of these methods increases, at best the commercial sector grows too, but its market share does not. In some cases it even decreases.

We examined how ability to pay affected LAPM use and source for a handful of countries. In four countries the public sector remained an important contributor to IUD use among those in the higher wealth groups. Only in Egypt and Jordan was the commercial sector a more-used provider in the highest ability-to-pay group. Findings were similar for sterilization: the commercial sector was the dominant source in only one of four countries in the highest ability-to-pay group. Thus, even among those with the greatest ability to pay, the role of NGOs and the public sector dwarfs that of the commercial sector.

The data makes clear that progressing from public to commercial provision is not a natural process. Unless there is concerted effort to segment consumers, upper-income women may not graduate to the commercial sector. While an opportunity exists, more knowledge is needed about the barriers to graduation and new strategies to work across sectors need to be developed.

Several research recommendations were also identified:

- The categorization of private sources should be differentiated between commercial and NGO.
- More information is needed to understand why consumers with the ability to pay do not use the commercial sector.
- Analysis of additional data sets needs to be conducted to better comprehend the impact of ability to pay on the use and source of LAPMs.

1. INTRODUCTION

The United States Agency for International Development (USAID) has been phasing out its provision of contraceptive commodities. Consequently, countries will need to purchase their own contraceptives or find new donors. If new donors are not forthcoming, countries may alter their method mix to favor cheaper and longer-acting methods or they may encourage the growth of the commercial sector for these and shorter-acting methods. This paper provides information on the importance of the commercial sector in providing long-acting and permanent methods (LAPMs). Such data are useful in designing and evaluating interventions to increase this role.

One strategy to reduce commodity costs is to shift the method mix to favor LAPMs. The one-time cost of these methods may be spread across a period of time. For example, the cost per couple year of protection for an intrauterine device (IUD) is low, as its commodity cost is $0.58 (weighted average of USAID and United Nations Population Fund prices, Ross, Stover, and Adelaja 2005) . In contrast, to gain the same protection from injectables, assuming they are used for the same time period as an IUD (3.5 years), it would cost almost $14. Clearly, an increase in the use of IUDs combined with a decrease in the use of injectables would reduce the financial burden on donors and ministries of health. However, the opposite trend is occurring in many developing countries—injectable use is rising while IUD use is decreasing.

During the last ten years, IUD prevalence has remained constant in Africa and Latin America/the Caribbean. However, in both of these regions, the prevalence of modern methods has risen so that the contribution of IUDs to the method mix has fallen (United Nations Population Division, Department of Economic and Social Affairs 1994, United Nations Population Division, Department of Economic and Social Affairs 2003). At the same time, the share of injectables in the method mix has increased. Changes in Kenya, for example, have been dramatic. According to Kenyan Demographic and Health Surveys (DHS), from 1984 to 2003 the IUD's contribution to the modern-method mix dropped from 31 to 8 percent while injectables' contribution increased from 5 to 45 percent.

Of course not all long-acting methods are low cost; hence, an increase in their use would not necessarily reduce financial requirements for contraceptives. Although a Chinese-made implant is available in Indonesia for a wholesale cost of $12 (Purdy 2005), contraceptive implants generally cost more than $20. And while there are no commodity costs for sterilization, there are costly supply needs for this procedure.[1]

A second strategy for reducing costs to donors and local governments is to strengthen the role of the commercial sector in contraceptive provision. The higher the percentage of methods the commercial sector provides, including LAPMs, the lower the burden the public sector faces if donors stop providing contraceptives. While this fact is true for both long- and short-acting methods, more emphasis has been placed in increasing the provision of short-acting methods (mostly pills and condoms) through the expansion of social marketing programs. Less progress, however, has been made in increasing the commercial market for LAPMs.

[1] WHO "Mother-Baby Package Costing Spreadsheet", Version 1.01, December 1999.

In discussing the commercial sector, it is important not to confuse it with the private sector. The private sector includes not just the commercial sector, but also nongovernmental organizations (NGOs). In some ways, NGOs are closer to the public sector in that clients' payments for services only partially cover the costs. However, NGOs rely on donor funds to cover costs while the public sector depends on tax revenues.[2] Commercial providers are different in that their survival depends on collecting sufficient revenue from their customers to cover their costs. Given the concern with financial sustainability and contraceptive security, this report addressses the growth of the commercial sector in providing LAPMs.

It is not always easy to determine whether a source is public or private, let alone NGO or commercial. For example, as Ross, Stover, and Adelaja (2005) note, "Definitions of *public* and *private* have varied, sometimes even in successive surveys in the same country." The report also notes that a respondent may be unclear about whether a source is public or private. Moreover, as we argue that the commercial and NGO sectors are different, we face the added task of dividing the private sector into these two components. It is important to make this distinction to understand the financial burden on donors and local governments of providing contraception. While a recent compilation of information about family planning use provides information on sources, it does not divide the private sector into commercial and NGOs (Ross, Stover, and Adelaja 2005). This report fills that gap.

The first part of this report provides information on the use of LAPMs and the commercial sector's role in their provision. It also looks at changes in the use and source of these methods, while paying attention to the changing role of the public, NGO, and commercial sectors. We are interested in determining whether there are consistent patterns in different countries in the commercial sector's importance and its growth.

The second part of the report uses data from a few countries to examine how ability to pay affects use of the commercial sector to obtain LAPMs. Market segmentation analysis allows for a better understanding of the needs of consumers with different life circumstances and demonstrates people's different reproductive-health needs to policymakers and encourages partnerships between the private and public sectors (Berg 2000). Through market segmentation, we expect to find that the commercial sector is a more-used service provider among households with higher ability to pay, while NGOs—and especially the public sector—would be more used in the poorest households. Moreover, market segmentation also should result in a small number of women with high ability to pay using the public sector.

Policymakers and program planners need information to determine the potential to increase the role of the commercial sector as a provider of LAPMs. This report shows both trends in LAPM use and its provision by the commercial sector, as well as how use varies by ability to pay. Such information demonstrates where commercial-sector use has lagged. Most importantly, this report shows where there is potential to increase the commercial sector's role as a provider of LAPMs.

[2] Some NGOs in Latin America cover a high percentage of their costs. For example, ProSalud in Bolivia covers about 80 percent of its costs.

2. METHODOLOGY

We obtained information on the use of LAPMs by currently married or in-union women from 63 of the most recent reproductive health survey reports (1996 and later): 51 from the Monitoring and Evaluation to Assess and Use Results project's Demographic and Health Surveys (DHS) and 12 from the Centers for Disease Control's (CDC) International Reproductive Health Surveys. Both groups conduct surveys of women of reproductive age and collect information about contraceptive use and sources, among other topics. LAPMs are defined as "methods that can prevent pregnancy for at least one year." This definition includes IUDs, implants, and female and male sterilization. Private sector sources that were categorized as commercial were listed, in most cases, under the heading of private source and include hospitals, doctors and clinics, family planning centers, dispensaries, community centers, midwives, nurse midwives, health promoters, health providers, nursing homes, maternity homes, and pharmacies.

There were 29 surveys where NGOs could be identified as providing LAPMs. For six of these surveys, the source of the LAPMs was directly identified as being an NGO. For the remaining 23 surveys, we divided the category of "source" into the categories of "commercial source" or "NGO", based on the information provided within the survey. Only sources coded as NGO in the survey, that specifically identified the name of an NGO, or that were described as a church/mission or NGO facility were coded as NGOs for the purposes of our analysis, and any sources that could not be coded to the NGO or the commercial sector with certainty were classified as "other private". For example, one code in the Jordan 2002 survey listed under the "private medical" heading was the Jordanian Association of Family Planning and Protection and we coded this as an NGO. In another example, in the Bolivia 2003 survey, NGO- and church-affiliated hospitals and clinics were listed under the "public sector" heading, but we reclassified them as NGOs. In some cases, not enough information was provided to make a distinction between commercial and NGO entities. For example, while "Sociedade Civil de Bem Estar Familiar no Brasil" is a well-known NGO in Brazil, it is not identified as a source. Thus, while codes such as "family planning clinic" and "post/community agent" are likely to be NGOs in Brazil, they were not included as an NGO since we could not be certain. Furthermore, there were some variations from one survey to another and for specific countries, although these cases accounted for only a small percentage of users.

Even when there is no indication that NGOs provide services, other data may indicate that the contribution of the commercial sector may be overestimated. For example, data from the 2003 Indonesia DHS report indicates that 23 percent of IUD users characterized as private sector did not pay for their method (Badan Pusat Statistik—Statistics Indonesia (BPC) and ORC Macro 2003). This raises the concern that some private sector users may have gotten the IUD at an NGO or through the public sector.

The first set of tables in this report is organized according to location of countries using the classification system of the DHS, which was modified to accommodate the CDC's classification system: countries in Central Asia/North Africa/West Asia/Europe (CA/WA/NA/E) were placed in one group. Other tables focus on trends in the use of IUDs and sterilization, as well as sources for obtaining the method. For countries with high IUD or sterilization use in at least one year, these tables show the trend in the use of the particular LAPM and the method's source.

Both the share of each sector for a method and the contribution of that sector to total use of a method are presented in the tables. While market share is useful in understanding whether the commercial sector's percentage of the market is high, it provides no information on the size of the market. Share may be high, but the market itself may be small; shares may be falling, but the market may be growing, so that the commercial sector actually provides more services. Therefore, the contribution of each sector (commercial, NGO, and public) to total use of a method is shown. It is calculated by multiplying the use of a particular method among women in union by the market share. Summing up each sector's contribution to total use gives a method's prevalence.[3]

In the second part of the report, further analysis was conducted of six datasets (Colombia, Peru, Egypt, Jordan, the Dominican Republic, and Guatemala) from the DHS to focus on market segmentation. The population in Colombia, Peru, and Egypt was divided according to wealth quintiles to examine the relationship between use and source for LAPMs. As described in the *DHS+ Dimensions* newsletter, the wealth index is based on ownership of assets where the population is divided into five categories—from the poorest 20 percent to the richest 20 percent. The division is made using information on items the household owns, such as bicycles, cars, and furniture and on the condition of the dwelling unit such as flooring material, drinking water source, and type of toilet (DHS Dimensions Newsletter, 2002). Utilization of the wealth quintiles allows us to compare the use of contraception and access to services of the poor to those of higher wealth status. For Jordan, the Dominican Republic, and Guatemala, we examined the relationship between education and contraceptive source.[4]

[3] Consider this example: The percentage of women using IUDs increases from 10 to 20 percent, but market share for commercial sector IUDs falls from 30 to 20 percent. The contribution of the commercial sector or the percentage of women using the IUD and obtaining it from the commercial sector, however, increases from 3 to 4 percent.

[4] For two of these countries, information on wealth quintiles was not available at the time this report was written. For the third country, Jordan, analysis problems prevented us from using that data.

3. RESULTS: ROLE OF THE COMMERCIAL SECTOR IN PROVISION OF LAPMS

3.1 CONTRACEPTIVE USE

Table 1 provides summary information on contraceptive use (Appendix Table 1 provides more detailed information on all LAPMs by country). Contraception use is lowest overall in sub-Saharan Africa, although it is greater than 50 percent in South Africa and Zimbabwe. The use of modern methods is much lower than total method use in some sub-Saharan African countries indicating that traditional method use is high. There are also variations in the use of LAPMs among regions; LAPM use is lowest in the sub-Saharan Africa region where the highest use in any country is 19.7 percent (South Africa), accounting for less than 40 percent of modern method use. In Zimbabwe, LAPMs account for only 8 percent of modern method use. Conversely, in some Latin American countries, where modern method use is high, such as the Dominican Republic (66 percent), LAPMs account for almost three-quarters of the contraceptives used in this category. In every region, however, there is at least one country in which the use of LAPMs does not exceed five percent.

TABLE 1: RANGES BY REGION OF THE PERCENTAGE OF CURRENTLY MARRIED AND IN-UNION WOMEN WHO ARE USING ANY CONTRACEPTIVE METHOD, ANY MODERN METHOD, AND ANY LAPM

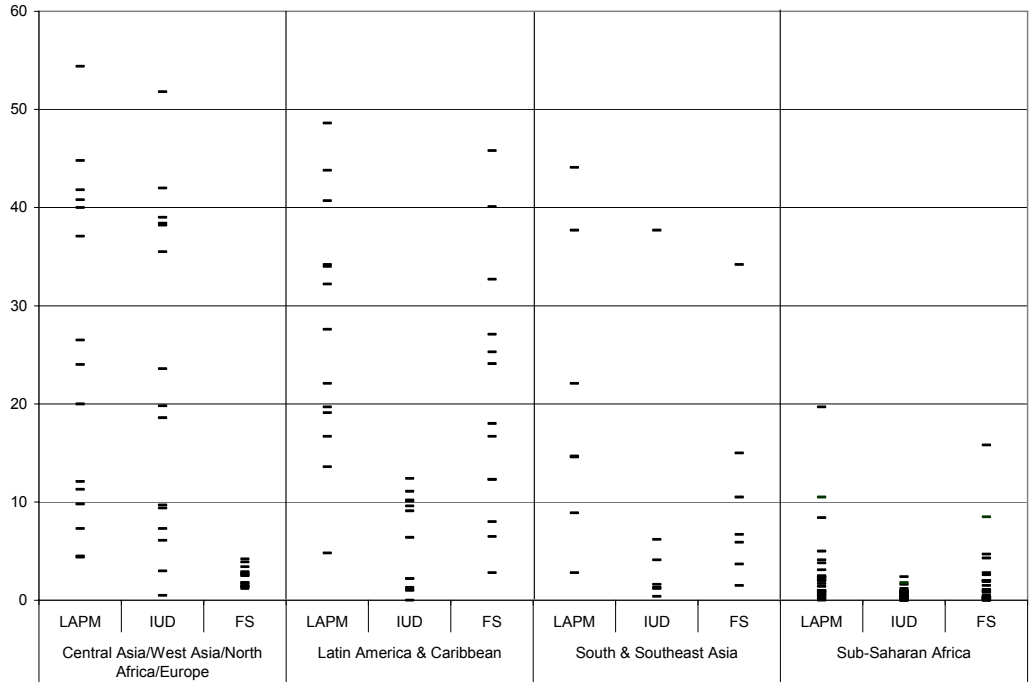
Category (number of countries)	Sub-Saharan Africa (28)	Latin America and the Caribbean (13)	South and Southeast Asia (7)	Central Asia/West Asia/North Africa/Europe (15)
Using any method	4.1 to 56.3	28.1 to 76.9	23.8 to 78.5	20.8 to 75.1
Using any modern method	1.2 to 55.1	22.3 to 70.3	18.5 to 56.7	7.9 to 62.8
Using any LAPM	0 to 19.7	4.8 to 48.6	2.8 to 44.1	4.4 to 54.4

An examination of LAPMs shows that the two main methods are IUDs and female sterilization, with low use of implants and male sterilization. Indonesia has the highest use of implants (4.3 percent), while male sterilization use is highest in Nepal (6.1 percent) with use around two percent in Brazil, India, and South Africa.

3.2 LAPM USE

As shown in Figure 1 and Tables 2 and 3, although there are some regional similarities in the use of LAPMs (with the exception of sub-Saharan Africa), there are wide variations in the methods used. IUD use is highest in the CA/WA/NA/E region, while use of female sterilization is highest in Latin America and the Caribbean.

FIGURE 1: USE OF ANY LAPM, IUDS, AND FEMALE STERILIZATION BY REGION



There are eleven countries in the CA/WA/NA/E region that have IUD use of nine percent or higher (Table 2). In contrast, there are only six countries in the Latin America and the Caribbean, one in the South and Southeast Asia and no counties in the Sub-Saharan African regions with IUD use as high as nine percent. This cut-off point is arbitrary; it was chosen to examine source patterns for countries in which use was high. Originally we wanted to use a cut off point of ten percent but this did not provide enough countries for subsequent analysis, so we lowered the cut off to nine percent. Thus, we examine source only for countries in which the commercial sector has the potential to make an important contribution to contraceptive prevalence.

TABLE 2: COUNTRIES WHERE IUD USE IS MORE THAN NINE PERCENT

Central Asia/West Asia North Africa/Europe		Latin America and the Caribbean		South and Southeast Asia		Sub-Saharan Africa
Uzbekistan	51.8	Colombia	12.4	Vietnam	37.7	
Kazakhstan	42.0	Paraguay	11.1			
Turkmenistan	39.0	Bolivia	10.2			
Kyrgyz Republic	38.2	Ecuador	10.1			
Moldova	38.4	Honduras	9.6			
Egypt	35.5	Peru	9.1			
Jordan	23.6					
Turkey	19.8					
Ukraine	18.6					
Georgia	9.7					
Armenia	9.4					

In contrast to the findings for IUDs, there are ten countries in Latin America and the Caribbean and none in CA/WA/NA/E with female sterilization use above nine percent (Table 3). Only four countries outside Latin America and the Caribbean have female sterilization use as high as nine percent. Four Latin American countries are on both lists: Colombia, Ecuador, Honduras, and Peru. Thus, it is not common to find countries in which both IUD and female sterilization use is as high as nine percent.

TABLE 3: COUNTRIES WHERE USE OF FEMALE STERILIZATION IS MORE THAN NINE PERCENT

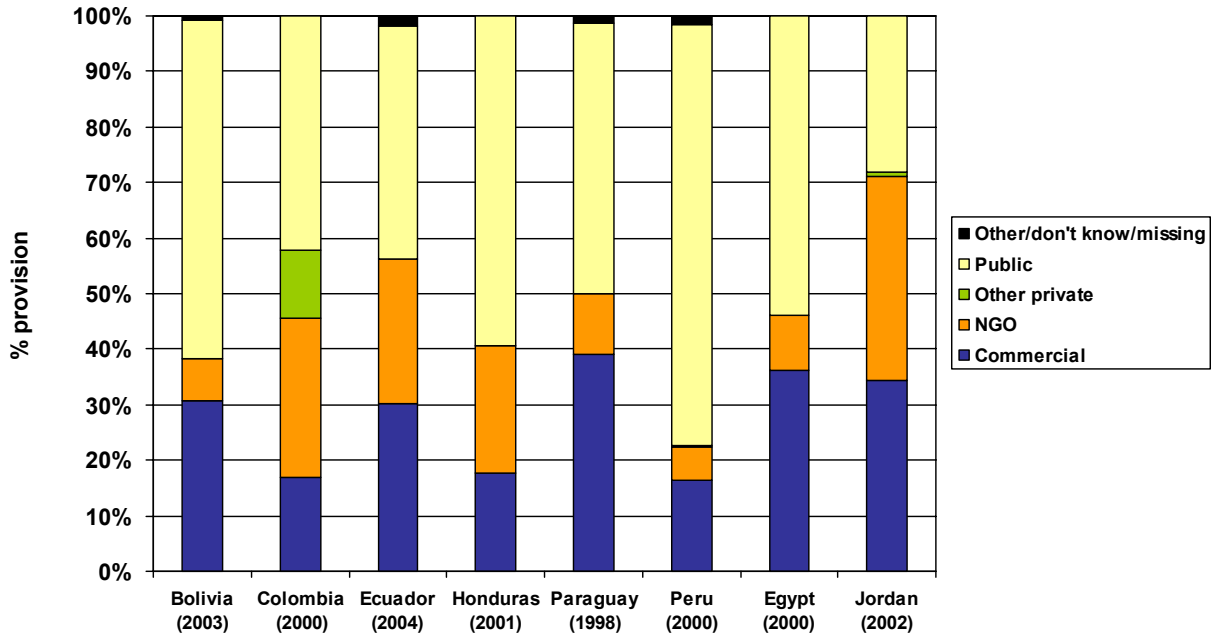
Central Asia/West Asia North Africa/Europe	Latin America and the Caribbean		South and Southeast Asia		Sub-Saharan Africa	
	Dominican Republic	45.8	India	34.2	South Africa	15.8
	Brazil	40.1	Nepal	15.0		
	El Salvador	32.7	Philippines	10.5		
	Colombia	27.1				
	Nicaragua	25.3				
	Ecuador	24.1				
	Honduras	18.0				
	Guatemala	16.7				
	Jamaica	12.3				
	Peru	12.3				

3.3 SOURCE OF METHOD PROVISION

Appendix Table 2 provides information on the percent of IUD users who obtained the method from the public and private sectors. In some cases, the private sector is broken down according to whether the source was an NGO or a commercial sector one. As previously mentioned, the division according to commercial or NGO is not always clear. Accordingly, use of these data may overstate the provision of IUDs in the commercial sector if it is assumed that private sector refers solely to the commercial sector. In many countries, including places where IUD is both high and low, NGOs are a highly used source for providing the method.

Figure 2 shows the source of the IUD for selected countries where use is more than nine percent and the private sector[5] sources are designated as commercial or NGO. In three countries, use of the commercial sector was less than 20 percent and in the other five countries, use of the commercial sector was between 30 and 40 percent. For those countries included in Table 2 but not Figure 2, the contribution of the private sector is small. Furthermore, in only one of these countries (Turkey) does use of the private sector reach 20 percent or more (see Appendix Table 2). Thus, the countries in Figure 2 have both the highest IUD use and the highest shares for the commercial sector.

FIGURE 2: SOURCE OF IUDS FOR COUNTRIES WHERE USE IS MORE THAN NINE PERCENT FOR THE MOST RECENT SURVEY AND INFORMATION ON PRIVATE SECTOR IS DISAGGREGATED INTO COMMERCIAL AND NGO SECTORS

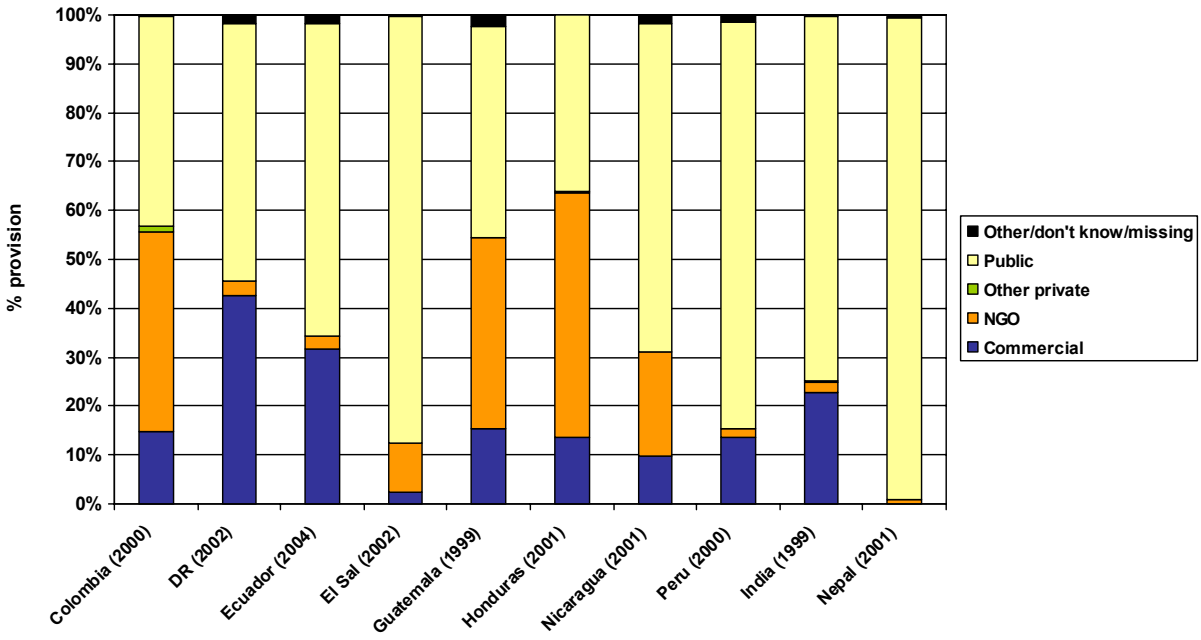


Appendix Table 2 also shows the percentage of women who received their sterilization from the private sector and whether the sterilization was obtained in an NGO or in the commercial sector. Although NGOs are generally a more used source of female sterilization in Latin America and the Caribbean than in other regions, they are also used in Cameroon, Egypt, Kenya, Malawi, Nepal, Tanzania, Zambia, and Zimbabwe, though in only one of these countries (Nepal) is use of female sterilization high.

[5] For more information concerning the "Other private" category for Colombia, see footnote 6.

Figure 3 shows source for ten countries in which use of sterilization is more than nine percent and private sources could be divided into the commercial and NGO sectors. These are the same countries that are listed in Table 3 for which this division of source was available. The share of the commercial sector reaches a maximum of just over 40 percent in the Dominican Republic and a minimum of about one percent in Nepal. Most countries (seven) have commercial sector shares less than 20 percent. Thus, the commercial sector share for sterilization is generally lower than the commercial sector share for IUDs. Moreover, there are also substantial differences in the share of the NGO sector. Finally, there is no apparent correspondence between a high commercial share and a high private sector share. It is also interesting to contrast the source mix of countries in Figure 3 with that of the remaining four countries in Table 2 that did not distinguish between commercial and NGO use (Brazil, Jamaica, the Philippines, and South Africa). In Brazil, the Philippines, and South Africa, use of the private sector is over 20 percent. In Jamaica it is only eight percent.

FIGURE 3: SOURCE OF FEMALE STERILIZATION FOR COUNTRIES WHERE USE IS MORE THAN NINE PERCENT FOR THE MOST-RECENT SURVEY AND INFORMATION ON PRIVATE SECTOR IS DISAGGREGATED INTO COMMERCIAL NGO SECTORS



3.4 TRENDS IN THE USE AND SOURCE OF THE IUD AND FEMALE STERILIZATION IN SELECTED COUNTRIES

What happens to the use of the commercial sector over time? Are changes in the role of the commercial sector related to changes in the use of LAPMs?

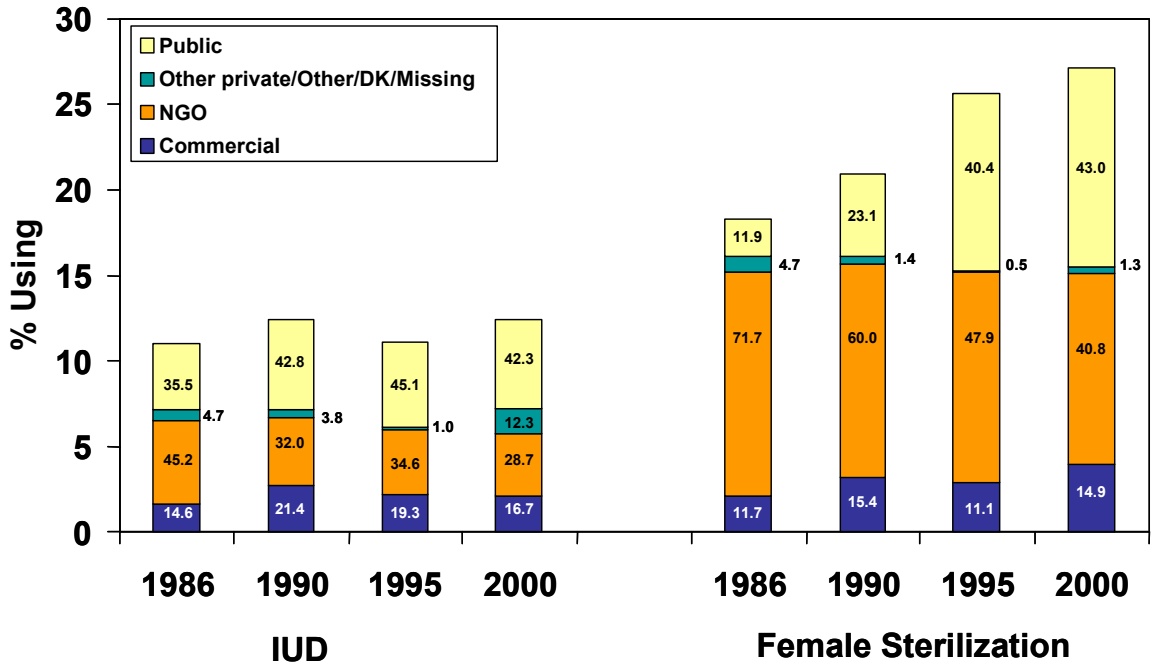
Appendix Tables 3a and 3b show the percent distribution of source as presented in the survey reports and the percent contribution of each source to the total use of the method. Tables are restricted to countries in which use was at least nine percent in one year.

There is no single pattern of change in method use. For example, IUD use has risen in Honduras, Paraguay, Egypt, and Jordan, while it has fallen in Nicaragua (since 1998) and Peru (since 1992)

(Appendix Table 3a). For female sterilization, use has increased in all countries included in Appendix Table 3b, dominated by those in Latin America and the Caribbean.

Using Colombia as an example, we examine how one country has met the increased demand for female sterilization and the demand for IUDs. Figure 4 shows trends in market share for the sources of IUDs and female sterilizations, as well as the contribution of each source to total use of the method. As for IUDs, the commercial sector's share has slightly increased, with NGOs (specifically Profamilia) playing a lesser role over time. Use of "Caja de CompensaciÓn" (labeled as "other private" in figures 4 and 5) to obtain IUDs in 2000 was much higher than in previous years. However, it is not apparent how this source should be classified[6]. In the expanding sterilization market, the market share of the commercial sector has not grown[7]. Also of interest are the changing roles of NGOs and the public sector as providers of sterilization. The share of NGOs in the sterilization market has decreased with the public sector playing an increasingly larger role as sterilization use increases.

FIGURE 4: COLOMBIA - PERCENT CONTRIBUTION OF VARIOUS SOURCES TO TOTAL USE OF IUDS AND FEMALE STERILIZATION AND MARKET SHARE FOR THE LAST FOUR DHS SURVEYS[8]



Percents in bars are market shares so that they add to 100 percent.

[6] The 2000 survey as well as the 1995 survey classified "Caja" as an NGO, but the 1986 survey classified "Caja" as a private source. In 2005 (survey data available after this report was mostly completed) the DHS notes that "Caja" were part of the Social Security System but were classified as private.

[7] Moreover, the 2005 survey indicates inconsistencies in source codes for sterilization making it difficult to compare sources over time. The survey report warns that many persons perceive Profamilia as a public entity and therefore reported they received services at a public source.

[8] The numbers shown within the bars are market shares and add up to 100 percent. The percentages shown by the height of the bars refer to the contribution of each source, with the total equalling the contraceptive prevalence rate for the method.

As shown in Appendix Table 3a, the commercial sector's contribution to IUD use increased in five countries (Colombia, Honduras, Paraguay, Egypt, and Jordan), and slightly decreased in three (Ecuador, Nicaragua, and Peru). With regard to market share, we can see that in only one country (Colombia) has the share of the commercial sector increased only slightly, peaking in 1990, but having its role decrease since. Thus, in the four countries in which IUD use was increasing, even though the commercial sector provided more IUDs, in none of these countries did its share of the market increase.[9]

Despite use of female sterilization (Appendix Table 3b) having increased in all countries, in only four of them (Colombia, Ecuador, Guatemala, and Nicaragua) has the contribution of the commercial sector increased. In fact, the commercial sector's role actually decreased in one of these countries (Honduras).[10] In no country did the share of the commercial sector increase. To sum up, even where IUD and female sterilization use is growing, at best the commercial sector grows too, but its share of the market either does not increase or actually declines.

3.5 THE ROLE OF ABILITY TO PAY IN USE AND CHOICE OF SOURCE

This section presents findings for a handful of countries on how choice of method and source use vary by ability to pay for the few countries where information on the wealth index (described in the methods section) and on use of the commercial sector is available.[11] In a few countries where information on the wealth index was not available, we show source use cross-tabulated by the woman's education level on the assumption that education is a reasonable proxy for ability to pay. However, as older women are more likely to have lower levels of education and to use LAPMs, it is misleading to examine the impact of education on LAPM use without controlling for age. The findings, although based on a limited number of countries, are suggestive of the penetration of the commercial sector in serving the needs of women with the highest ability to pay for family planning services. Extension of the analysis to other countries could be useful in determining whether there were common patterns.

As shown in Appendix Table 4a, the percentage of women using IUDs dramatically increases with wealth in Peru and Egypt, but is less strongly related to wealth in Colombia. Moreover, it is clear that in all three of these countries as well as in Jordan the share of the commercial sector increases with ability to pay.

Not surprisingly the contribution of the commercial sector increases with wealth, but so too does that of other sectors. For example, as shown for Colombia in Figure 5, while the percentage of women that use the commercial sector for IUDs increases with wealth, what is really striking is the large role played by other providers in the higher ability-to-pay groups. The importance of NGOs (Profamilia) increase with wealth, and Profamilia serves almost twice as many IUD users in the highest wealth quintiles as does the commercial sector. "Other private" sector sources serve about as high a proportion of women as does the commercial sector in the middle quintile groups, and far fewer women in the three

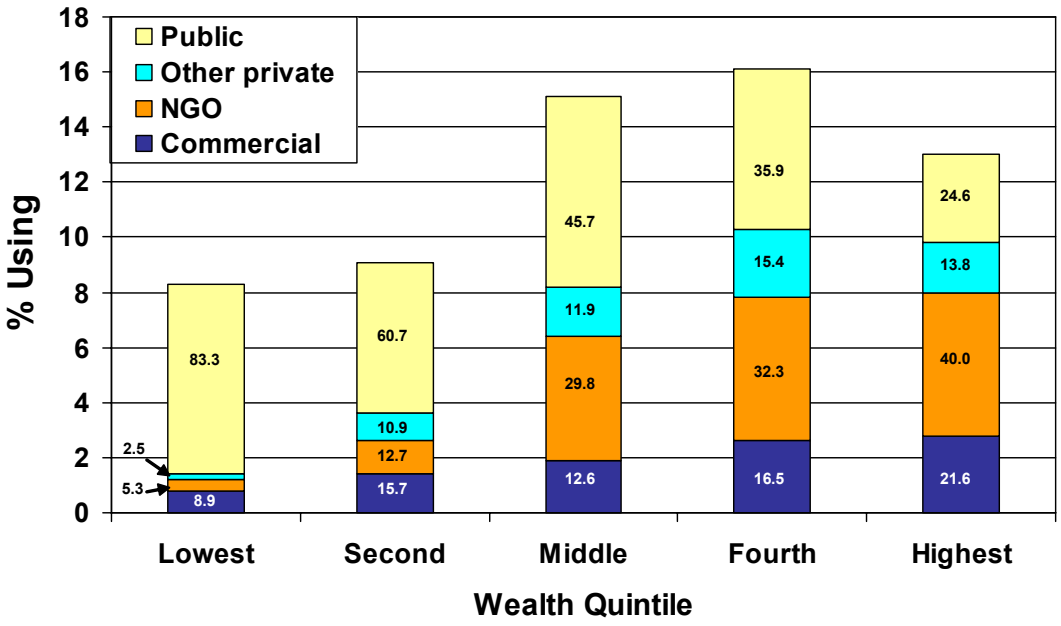
[9] Some of the changes in the source mix are large and may be the result of misclassification. For example, the sharp changes recorded for Ecuador (1999–2004), Jordan (1990–1997), and Paraguay (1990–1996) may be due to misclassification of source in the surveys.

[10] It is possible that misclassification of source in the survey has occurred in Honduras, thereby making it difficult to determine changes in market size and share of the commercial sector.

[11] The wealth index can be calculated for other countries. However, in this preliminary analysis, only DHS data sets that had this information available were used. Wealth indexes for countries in which the CDC conducted surveys were not computed.

highest quintile groups as does Profamilia. Conversely the role of the public sector decreases with wealth but it still serves nearly 25 percent of IUD users in the highest quintile.

FIGURE 5: COLOMBIA - PERCENT CONTRIBUTION OF DIFFERENT SOURCES TO TOTAL USE OF IUDS AND MARKET SHARE BY WEALTH QUINTILE

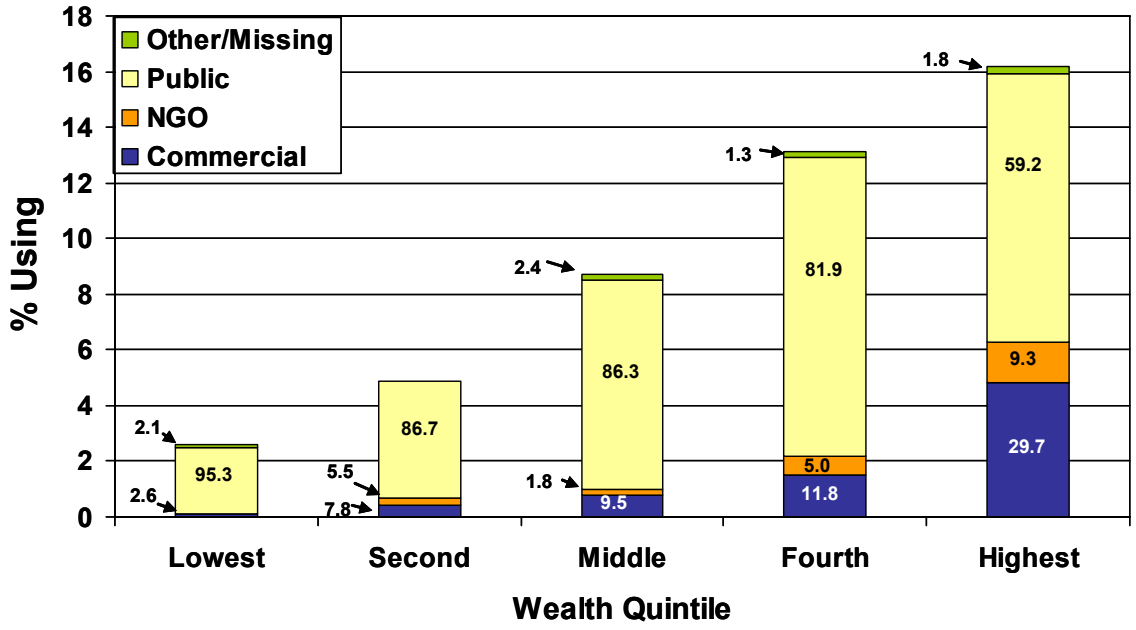


Percents in bars are market shares so that they add to 100 percent.

A different picture is evident for Peru (Figure 6). Use of the IUD is strongly correlated with wealth, with IUD use being more than six times higher among those in the highest quintile compared with the lowest wealth quintile.[12] The contribution of the commercial sector increases considerably with wealth. It provides services to about as high a percentage of women in the highest quintile group as it does to women in the bottom four quintiles of the wealth distribution combined. What is most evident in the figure, however, is the domination of the public sector as a provider for all wealth groups. Its contribution to the provision of IUDs is strongly related to wealth, with provision to women in the third quintile (7.5 percent use of the public sector) being greater than provision in the two lowest quintiles (2.4 percent use for the lowest quintile and 4.2 percent use for the second quintile). Thus, even though the commercial sector is a more used provider among those with greater ability to pay, the public sector still plays the dominant role. Services are free in the public sector (Sharma, Subiria, Dayaratna 2005), and it is apparent that the free services are mostly used by women who can afford to pay. No data are yet available on what has happened to IUD provision as a result of the phase-out of contraceptive commodity donations.

[12] An extensive discussion of the role of ability to pay in affecting the method and source mix in Peru is in Sharma, Subiria, and Dayaratna 2005.

FIGURE 6: PERU - PERCENT CONTRIBUTION OF DIFFERENT SOURCES TO TOTAL USE OF IUDS AND MARKET SHARE BY WEALTH QUINTILE



Percents in bars are market shares so that they add to 100 percent.

The findings for Egypt are somewhat similar to those for Peru. The public sector plays a dominant role in providing services to women, although its role is reduced in the highest quintile group and the commercial sector is used far more in Egypt than in Peru.

In all four countries (Appendix Table 4a) the public sector remains an important contributor to IUD use among those in the higher ability-to-pay groups. Only in Egypt and Jordan is the commercial sector the dominant provider in the highest ability-to-pay group. Thus, even though the commercial sector is used more often in the higher ability to pay groups, there is still substantial room for growth.

This analysis covers only selected countries; we do not know if the same pattern will be evident in other countries that have a high prevalence of IUDs. However, a recent paper indicates that in Latin America and the Caribbean a significant proportion of contraceptive users in the two highest wealth quintiles get their contraceptives from the public sector (Policy Project 2004). Therefore it would not be surprising to find similar results regarding IUDs for other Latin American countries.

Turning to female sterilization, Appendix Table 4b shows that use of this method is unrelated to wealth in Colombia, but does increase with wealth in Peru. (We do not consider Egypt in this analysis as a low proportion of women use this method.) While commercial sector provision increases with wealth, even in the highest quintile, the commercial sector does not dominate. More women are using NGOs and the public sector in Colombia and Peru. The market share of the commercial sector does increase with ability to pay in all four countries (using education as a proxy for ability to pay in two countries as we have not computed the wealth index for them), but the commercial sector is the dominant provider in the highest group in only the Dominican Republic.

Summing up for both methods, we can see from Appendix Tables 4a and 4b that the commercial sector is the dominant provider in the highest ability-to-pay group in only one case for sterilization (Dominican Republic) and in two cases for the IUD (Egypt and Jordan). Even among those with greatest ability to pay, the role of NGOs and the public sector dwarfs that of the commercial sector.

4. DISCUSSIONS AND CONCLUSIONS

There are wide variations in the use of LAPMs across countries and regions, with some countries having virtually no use and others having use of 40 percent or more. Moreover, the mix of LAPMs differs across countries and regions, with the IUD being the most prevalent LAPM in CA/WA/NA/E while female sterilization is prevalent in Latin America and the Caribbean. There are two countries, both in Latin America, where the prevalence of each of the methods is 10 percent or higher.

The role of the commercial sector also varies. For countries with high use of the IUD, there was some consistency in the share of the commercial sector across the few countries for which the surveys clearly labeled private sources as commercial vs. NGO, with provision of the method being in the range of 30 to 40 percent in five of eight countries, but under 20 percent in the remaining three countries. For female sterilization, however, use of the commercial sector was lower with only three of ten countries having a commercial sector share greater than 20 percent and only two countries having a share over 30 percent.

The lack of a consistent pattern of commercial sector use raises the question of whether the variation is as high as reported or whether there are reporting errors resulting from difficulties in classifying source. For example, in many countries providers in the public sector are poorly paid and have their own practices to supplement their income. Clients may not be able to report accurately the source. Moreover, large swings in the categorization of source indicate there is some misreporting. For example, the changing classification of "Caja" makes it difficult to determine trends in commercial and NGO use in Colombia.

The commercial sector has not fared well. With regard to market share for both the IUD and female sterilization, in only one country (Colombia) has the share of the commercial sector increased and in that country IUD use has remained fairly steady and the increase in the commercial share was small. In no country has the market share of the commercial sector for female sterilization increased. Why is the commercial sector not keeping pace with the growth in method use? Perhaps the most important factor is the dominance of the public sector. It may be that efforts to support and improve the public and NGO sectors have resulted in wealthier clients preferring these less costly sources. Fueled by heavy reliance on donated commodities, as was the case in Peru, the public sector was able not to charge for contraception, thus making commercial-sector prices uncompetitive with the result that the share of the public sector increased (Sharma, Gribble, Menotti, 2005).

Turning to the question of ability to pay and source, we found different patterns for the few countries where we had analyzed data. In only one country and for only female sterilization was use constant across wealth groups. In all other cases, use was strongly correlated with ability to pay.

Although the commercial sector's share of the market increases with ability to pay, it is the dominant provider in the highest ability-to-pay group in only one case for female sterilization (the Dominican Republic) and in two cases for IUDs (Egypt and Jordan). The public sector and NGOs remain important providers among women who can best afford to use the commercial sector. Competition from NGOs, Social Security Institutes and the public sector may discourage women from using the commercial

sector. The lower prices of NGOs and the public sector may encourage wealthier women to use these sources and discourage the commercial sector from increasing its provision.

4.1 PROGRAMMATIC AND POLICY IMPLICATIONS

Many countries are going to face a phase-out of donor-provided contraceptives. They need to prepare for this change by devoting more public sector resources to family planning and to encouraging growth of the commercial sector. There is a lot of scope to increase the role of the commercial sector as a provider of LAPMs. Even among those best able to afford commercially priced services, their use is low. Therefore PSP-*One* has an opportunity to expand commercial sector provision of quality and affordable services. This opportunity depends on the cooperation of all sectors (public, NGO, and commercial) if it is to be realized. Commercial providers cannot segment the market if the public and NGO sectors pursue all consumers. Moreover, even if upper-income consumers are left to commercial providers, it is not certain that the pool will be large enough or consistent enough to generate adequate profits.

The data make clear that the progression from public to commercial providers is not a natural process. Unless there is an effort to segment consumers, upper-income women may not graduate to the commercial sector. They may be unwilling to spend some of their money to avoid the inconvenience of the public sector and they may not be convinced that services in the commercial sector are of sufficient quality to be worth any extra cost. Thus, while a potential opportunity exists, it is also apparent that we need to know more about the barriers to graduation and to develop new strategies to work across sectors.

Therefore, it is apparent that expanding the commercial sector is going to require a set of policy and program changes to make it a more attractive alternative for obtaining reproductive health services. For example, these might include:

- vouchers to pay up-front costs of LAPMs
- contracting out of services
- policies that do not encourage public sector use among those who can pay

4.2 RECOMMENDATIONS FOR RESEARCH

1. The categorization of sources should be differentiated between commercial and NGO sectors. This classification may not be easy to achieve because attribution of source is not always straightforward. For example, as indicated previously, the same provider may work in different sectors. Nevertheless, if efforts to expand the use of the commercial sector are to be evaluated, it is imperative that surveys improve their classification of source. This clarification is important regarding countries like Indonesia that are held up as examples of increasing self-sufficiency as evidenced by a growing private sector. We need to determine if a growing private sector is synonymous with a growing commercial sector and increasing financial sustainability.

2. More information is needed to understand why consumers with an ability to pay do not use the commercial sector. This information is critical to identify interventions for PSP-*One* or other stakeholders of a total-market approach to maximize commercial sector provision.

3. We have analyzed data from few countries on how use of the commercial sector varies with wealth. Analysis of data from a larger number of countries, including those from CDC surveys, would allow us to determine the impact of wealth on use of LAPMs and on the contribution of the commercial sector to use of LAPMs.

   The wealth index should be used to categorize women in all surveys. One way to evaluate efforts to expand the commercial sector is to determine how well it provides services to women who can afford to pay. At a minimum, the commercial sector should be serving a high proportion of users in the highest ability to pay groups. Efforts need to be made to expand this role, especially as countries face the phase-out of donor-provided contraceptives.

ANNEX A: TABLES

APPENDIX TABLE 1: CURRENT CONTRACEPTIVE USE OF SELECTED METHODS FOR WOMEN IN UNION, 15–49 YEARS OF AGE

Country (year)	Source	Category of union	n	Using any method	Using any modern method	Using any LAPM	IUD	Implant	Female steril	Male steril	Ratio: modern to any method use	Ratio: LAPM to modern method use
Central Asia/West Asia/North Africa/Europe												
Albania (2002)	CDC	Married women	3965	75.1	7.9	4.4	0.5	0	3.9	0	11%	56%
Armenia (2000)	DHS	Currently married women	4125	60.5	22.3	12.1	9.4	0	2.7	0	37%	54%
Azerbaijan (2001)	CDC	Currently married & in union	5146	55.4	11.9	7.3	6.1	0	1.2	0	21%	61%
Egypt (2000)*	DHS	Currently married women	14382	56.1	53.9	37.1	35.5	0.2	1.4	0	96%	69%
Georgia (2000)	CDC	Currently married women	5117	40.5	19.8	11.3	9.7	0	1.6	0	49%	57%
Jordan (2002)	DHS	Currently married women	5706	55.8	41.2	26.5	23.6	0	2.9	0	74%	64%
Kazakhstan (1999)	DHS	Currently married women	3018	66.1	52.7	44.8	42.0	0	2.8	0	80%	85%
Kyrgyz Republic (1997)	DHS	Currently married women	2675	59.5	48.9	40.0	38.2	0	1.8	0	82%	82%
Moldova (1997)	CDC	Currently in union	4023	73.7	50.0	41.8	38.4	0	3.4	0	68%	84%
Romania (1999)	CDC	Currently married women	4846	63.8	29.5	9.8	7.3	0	2.5	0	46%	33%
Turkey (1998)	DHS	Currently married women	5921	63.9	37.7	24.0	19.8	0	4.2	0	59%	64%
Turkmenistan (2000)	DHS	Currently married women	4892	61.8	53.1	40.8	39.0	0	1.8	0	86%	77%
Ukraine (1999)	CDC	In union	4794	67.5	37.6	20.0	18.6	0	1.4	0	56%	53%
Uzbekistan (2002)	DHS	Currently married women	3720	67.7	62.8	54.4	51.8	0	2.6	0	93%	87%
Yemen (1997)	DHS	Currently married women	9786	20.8	9.8	4.5	3.0	0	1.4	0.1	47%	46%
* Egypt 2003 survey not included in order to have comparability with data in Appendix Table 4a.												
Latin America & Caribbean												
Bolivia (2003)	DHS	Currently in union	10569	58.4	34.9	16.7	10.2	0	6.5	0	60%	48%
Brazil (1996)	DHS	Currently married women	7584	76.7	70.3	43.8	1.1	0	40.1	2.6	92%	62%
Colombia (2000)	DHS	Currently in union	5935	76.9	64.0	40.7	12.4	0.2	27.1	1.0	83%	64%
Dominican Republic (2002)	DHS	Currently in union	13996	69.8	65.8	48.6	2.2	0.5	45.8	0.1	94%	74%
Ecuador (2004)	CDC	Married/in union	7180	72.7	57.7	34.2	10.1	0	24.1	0	79%	59%
El Salvador (2002)	CDC	Married/in union	6188	67.3	61.9	34.0	1.3	0	32.7	0	92%	55%
Guatemala (1999)**	DHS	Currently in union	3964	38.2	30.9	19.7	2.2	0	16.7	0.8	81%	64%
Haiti (2000)	DHS	Currently in union	5958	28.1	22.3	4.8	0	2.0	2.8	0	79%	22%
Honduras (2001)	CDC	Married women	5347	68.1	50.8	27.6	9.6	0	18.0	0	75%	54%
Jamaica (1997)	CDC	In union	4648	65.9	62.8	13.6	1.0	0.1	12.3	0.2	95%	22%
Nicaragua (2001)	CDC	Currently in union	7424	68.6	66.1	32.2	6.4	0	25.3	0.5	96%	49%
Paraguay (1998)***	CDC	Married/in union	2386	57.4	47.7	19.1	11.1	0	8.0	0	83%	40%
Peru (2000)	DHS	Currently in union	15628	68.9	50.4	22.1	9.1	0.2	12.3	0.5	73%	44%
** Guatemala 2002 survey not included in order to have comparability with data in Appendix Table 4b.												
*** Paraguay 2004 survey not included because source data not yet available.												

Country (year)	Source	Category of union	n	Using any method	Using any modern method	Using any LAPM	IUD	Implant	Female steril	Male steril	Ratio: modern to any method use	Ratio: LAPM to modern method use
South & Southeast Asia												
Bangladesh (2000)	DHS	Currently married women	9720	53.8	43.4	8.9	1.2	0.5	6.7	0.5	81%	21%
Cambodia (2000)	DHS	Currently married women	9071	23.8	18.5	2.8	1.3	0	1.5	0	78%	15%
India (1999)	DHS	Currently married women	83649	48.2	42.8	37.7	1.6	0	34.2	1.9	89%	88%
Indonesia (2003)	DHS	Currently married women	27857	60.3	56.7	14.6	6.2	4.3	3.7	0.4	94%	26%
Nepal (2001)	DHS	Currently married women	8342	39.3	35.4	22.1	0.4	0.6	15.0	6.1	90%	62%
Philippines (2003)	DHS	Currently married women	8671	48.9	33.4	14.7	4.1	0	10.5	0.1	68%	44%
Vietnam (2002)	DHS	Currently married women	5338	78.5	56.7	44.1	37.7	0	5.9	0.5	72%	78%
Sub-Saharan Africa												
Benin (2001)	DHS	Currently in union	4563	18.6	7.2	1.4	0.8	0.3	0.3	0	39%	19%
Burkina Faso (2003)	DHS	Currently in union	9655	13.8	8.6	1.7	0.4	1.2	0.1	0	62%	20%
Cameroon (1998)	DHS	Currently in union	3676	19.3	7.1	2.1	0.6	0	1.5	0	37%	30%
Chad (1997)	DHS	Currently married women	5832	4.1	1.2	0.2	0	0	0.2	0	29%	17%
Comoros (1997)	DHS	Currently married women	1634	21.0	11.4	3.1	0.3	0	2.8	0	54%	27%
Eritrea (2002)	DHS	Currently married women	5733	8.0	5.1	0.6	0.4	0	0.2	0	64%	12%
Ethiopia (2000)	DHS	Currently married women	9789	8.1	6.3	0.4	0.1	0	0.3	0	78%	6%
Gabon (2000)	DHS	Currently in union	3348	32.7	11.8	1.0	0	0	1.0	0	36%	8%
Ghana (2003)	DHS	Currently married women	3549	25.2	18.7	3.8	0.9	1	1.9	0	74%	20%
Guinea (1999)	DHS	Currently in union	5561	6.2	4.2	0.2	0.2	0	0	0	68%	5%
Ivory Coast (1999)	DHS	Currently in union	1863	15.0	7.3	0.5	0.4	0	0.1	0	49%	7%
Kenya (2003)	DHS	Currently married women	4919	39.3	31.5	8.4	2.4	1.7	4.3	0	80%	27%
Madagascar (2003)	DHS	Currently in union	5140	27.1	18.3	2.0	0.6	0.3	1.1	0	68%	11%
Malawi (2000)	DHS	Currently married women	9452	30.6	26.1	5.0	0.1	0.1	4.7	0.1	85%	19%
Mali (2001)	DHS	Currently in union	10723	8.1	5.7	0.6	0.2	0.1	0.3	0	70%	11%
Mauritania (2001)	DHS	Currently married women	4541	8.0	5.1	0.8	0.8	0	0	0	64%	16%
Mozambique (2003)	DHS	Currently married women	8736	16.5	11.7	1.0	0.1	0	0.9	0	71%	9%
Namibia (2000)	DHS	Currently married women	2610	43.7	42.6	10.5	1.2	0	8.5	0.8	97%	25%
Niger (1998)	DHS	Currently in union	6382	8.2	4.6	0	0	0	0	0	56%	0%
Nigeria (2003)	DHS	Currently married women	5336	12.6	8.2	0.9	0.7	0	0.2	0	65%	11%
Rwanda (2000)	DHS	Currently in union	5052	13.2	4.3	0.8	0	0	0.8	0	33%	19%
Senegal (1997)****	DHS	Currently in union	5851	12.9	8.1	2.3	1.6	0.2	0.5	0	63%	28%
South Africa (1998)	DHS	Currently married women	5077	56.3	55.1	19.7	1.8	0	15.8	2.1	98%	36%
Tanzania (1999)	DHS	Currently married women	2653	25.4	16.9	2.4	0.4	0	2.0	0	67%	14%
Togo (1998)	DHS	Currently in union	5819	23.5	7.0	2.0	1.0	0.6	0.4	0	30%	29%
Uganda (2001)	DHS	Currently married women	4881	22.8	18.2	2.5	0.2	0.3	2.0	0	80%	14%
Zambia (2002)	DHS	Currently married women	4694	34.2	22.6	2.4	0.1	0.3	2.0	0	66%	11%
Zimbabwe (1999)	DHS	Currently married women	3609	53.5	50.4	4.1	0.9	0.5	2.6	0.1	94%	8%

**** Senegal 1999 survey not included because source data not yet available.

APPENDIX TABLE 2: PERCENT DISTRIBUTION OF SOURCE OF LAPMS

Country (year)	Source	IUD	Implant	Female sterilization	Male sterilization
Central Asia/West Asia/North Africa/Europe					
Albania (2002)		*n=28*	-	*n=168*	-
	Private	9.2	-	0	-
	Public	90.8	-	100	-
	Total	**100**	-	**100**	-
Armenia (2000)		*n=391*	-	*n=117*	-
	Private	2.2	-	1.2	-
	Public	97.2	-	98.8	-
	Other/don't know/missing	0.6	-	0	-
	Total	**100**	-	**100**	-
Azerbaijan (2001)		*n=370*	-	*n=52*	-
	Private	6.1	-	5.5	-
	Public	93.8	-	94.5	-
	Total	**100**		**100**	-
Egypt (2000)*		*n=5112*	-	*n=217*	-
	Commercial	36.1	-	49.9	-
	NGO	9.9	-	3.5	-
	Public	54.0	-	46.6	-
	Total	**100**	-	**100**	-
Georgia (2000)**		*n=794*	-	*n=91*	-
	Private	6.2	-	0.3	-
	Public	93.8	-	99.7	-
	Total	**100**	-	**100**	-
Jordan (2002)		*n=1349*	-	*n=173*	-
	Commercial	34.3	-	32.0	-
	NGO	36.7	-	0	-
	Other private	1.0	-	0	-
	Public	28.0	-	68.0	
	Total	**100**	-	**100**	
Kazakhstan (1999)		*n=1462*	-	- -	
	Private	13.6	-	-	-
	Public	85.6	-	-	-
	Other/don't know/missing	0.8	-	-	-
	Total	**100**	-	- -	
Kyrgyz Republic (1997)		*n=1063*	-	- -	
	Private	0.2	-	-	-
	Public	98.9	-	-	-
	Other/don't know/missing	0.9	-	-	-
	Total	**100**	-	- -	
Moldova (1997)**		*n=1556*	-	- -	
	Private	18.2	-	-	-
	Public	80.6	-	-	-
	Other/don't know/missing	1.2	-	-	-
	Total	**100**	-	- -	
Romania (1999)**		*n=364*	-	*n=129*	-
	Commercial	38.0	-	0.3	-
	NGO	0.1	-	0	-
	Other private	0.7	-	0	-
	Public	61.2	-	99.7	-
	Total	**100**	-	**100**	-

APPENDIX TABLE 2: PERCENT DISTRIBUTION OF SOURCE OF LAPMS

Country (year)	Source	IUD	Implant	Female sterilization	Male sterilization
Turkey (1998)		*n=1173*	-	*n=257*	-
	Private	27.9	-	21.2	-
	Public	71.9	-	76.9	-
	Other/don't know/missing	0.2	-	1.9	-
	Total	**100**	-	**100**	-
Turkmenistan (2000)		*n=1971*	-	*n=104*	-
	Private	0.6	-	0	-
	Public	99.3	-	100	-
	Other/don't know/missing	0.1	-	0	-
	Total	**100**	-	**100**	-
Ukraine (1999)		*n=1005*	-	-	-
	Private	4.1	-	-	-
	Public	91.5	-	-	-
	Other/don't know/missing	4.4	-	-	-
	Total	**100**	-	-	-
Yemen (1997)		*n=293*	-	*n=142*	-
	Commercial	50.2	-	20.5	-
	NGO	4.9	-	1.1	-
	Other private	0.3	-	0	-
	Public	44.3	-	73.7	-
	Other/don't know/missing	0.3	-	4.7	-
	Total	**100**	-	**100**	-
Latin America & Caribbean					
Bolivia (2003)^		*n=1189*	-	*n=758*	-
	Commercial	30.6	-	27.6	-
	NGO	7.6	-	1.3	-
	Public	60.9	-	69.0	-
	Other/don't know/missing	0.9	-	2.1	-
	Total	**100**	-	**100**	-
Brazil (1996)		*n=105*	-	*n=3460*	*n=201*
	Private	51.5	-	27.2	66.9
	Public	47.4	-	70.9	31.3
	Other/don't know/missing	1.1	-	1.9	1.8
	Total	**100**	-	**100**	**100**
Colombia (2000)		*n=939*	-	*n=2029*	*n=59*
	Commercial	16.8	-	14.9	11.3
	NGO	28.7	-	40.8	74.1
	Other private	12.3	-	1.1	1.5
	Public	42.2	-	43.0	11.6
	Other/don't know/missing	0	-	0.2	1.5
	Total	**100**	-	**100**	**100**
Dominican Republic (2002)		*n=411*	*n=86*	*n=7773*	-
	Commercial	38.2	2.4	42.7	-
	NGO	10.9	8.4	2.8	-
	Other private	0	0.6	0	-
	Public	48.3	79.6	52.7	-
	Other/don't know/missing	2.6	9.0	1.8	-
	Total	**100**	**100**	**100**	-
Ecuador (2004)		*n=716*	-	*n=1579*	-
	Commercial	30.1	-	31.7	-
	NGO	26.1	-	2.7	-
	Public	42.0	-	63.9	-

APPENDIX TABLE 2: PERCENT DISTRIBUTION OF SOURCE OF LAPMS					
Country (year)	**Source**	**IUD**	**Implant**	**Female sterilization**	**Male sterilization**
	Other/don't know/missing	1.8	-	1.7	-
	Total	**100**	-	**100**	-
El Salvador (2002)		*n=62*	-	*n=1857*	-
	Commercial	2.7	-	2.5	-
	NGO	0.9	-	9.9	
	Public	94.0	-	87.3	-
	Other/don't know/missing	2.4	-	0.3	-
Guatemala (1999)		*n=92*	-	*n=721*	-
	Commercial	33.3	-	15.4	-
	NGO	39.8	-	39.1	-
	Public	26.9	-	43.2	-
	Other/don't know/missing	0.0	-	2.3	-
	Total	**100**	-	**100**	-
Haiti (2000)		-	*n=119*	*n=186*	-
	Private	-	77.8	41.4	-
	Public	-	22.2	58.6	-
	Total	-	**100**	**100**	-
Honduras (2001)		*n=515*	-	*n=930*	-
	Commercial	17.8	-	13.5	-
	NGO	22.7	-	50.2	-
	Other private	0	-	0.1	-
	Public	59.5	-	36.2	-
	Total	**100**	-	**100**	-
Jamaica (1997)		-	-	*n=590*	-
	Private	-	-	8.4	-
	Public	-	-	89.9	-
	Other/don't know/missing	-	-	1.7	-
	Total	-	-	**100**	-
Nicaragua (2001)		*n=537*	-	*n=2368*	-
	Commercial	15.5	-	9.7	-
	NGO	20.4	-	21.5	-
	Other private	1.8	-	0	-
	Public	60.5	-	67.0	-
	Other/don't know/missing	1.8	-	1.8	-
	Total	**100**	-	**100**	-
Paraguay (1998)		*n=290*	-	*n=210*	-
	Commercial	39.1	-	41.9	-
	NGO	11.0	-	4.3	-
	Public	48.7	-	41.3	-
	Other/don't know/missing	1.2	-	12.5	-
	Total	**100**	-	**100**	-
Peru (2000)		*n=1620*	*n=40*	*n=2100*	*n=83*
	Commercial	16.3	14.2	13.7	3.9
	NGO	6.1	4.0	1.8	0
	Other private	0.3	0	0	0
	Public	75.8	81.8	83.0	87.1
	Other/don't know/missing	1.5	0	1.5	9.0
	Total	**100**	**100**	**100**	**100**

APPENDIX TABLE 2: PERCENT DISTRIBUTION OF SOURCE OF LAPMS

Country (year)	Source	IUD	Implant	Female sterilization	Male sterilization
South & Southeast Asia					
Bangladesh (2000)		*n=121*	*n=45*	*n=651*	*n=50*
	Commercial	3.1	1.8	4.0	0
	NGO	6.0	11.6	5.3	6.7
	Other private	0.7	0	0	2.5
	Public	89.8	83.3	89.8	83.7
	Other/don't know/missing	0.4	3.3	0.9	7.1
	Total	**100**	**100**	**100**	**100**
Cambodia (2000)		*n=77*	-	*n=141*	-
	Private	56.1	-	6.5	-
	Public	43.9	-	92.0	-
	Other/don't know/missing	0	-	1.5	-
	Total	**100**	-	**100**	-
India (1999)		*n=765*	-	*n=7887*	*n=398*
	Commercial	51.9	-	22.9	19.1
	NGO	2.4	-	1.9	0.8
	Other private	0.3	-	0.3	0.8
	Public	45.4	-	74.7	79.1
	Other/don't know/missing	0	-	0.2	0.2
	Total	**100**	-	**100**	**100**
Indonesia (2003)		*n=1738*	*n=1209*	*n=1070*	*n=125*
	Private	54.0	35.4	33.8	6.5
	Public	42.9	64.6	66.2	91.6
	Other/don't know/missing	3.1	0	0	1.9
	Total	**100**	**100**	**100**	**100**
Nepal (2001)		*n=34*	*n=54*	*n=1252*	*n=528*
	Commercial	18.5	6.1	1.1	0.6
	NGO	11.0	42.3	6.8	11.2
	Public	64.4	51.6	85.9	80.9
	Other/don't know/missing	6.1	0	6.2	7.3
	Total	**100**	**100**	**100**	**100**
Philippines (2003)*		*n=359*	-	*n=947*	-
	Commercial	0	-	0	-
	NGO	0	-	0	-
	Other private	18.0	-	23.2	-
	Public	80.1	-	75.8	-
	Other/don't know/missing	1.9	-	1.0	-
	Total	**100**	-	**100**	-
Vietnam (2002)		*n=2015*	-	*n=317*	*n=25*
	Private	5.9	-	0	0
	Public	94.0	-	99.8	100
	Other/don't know/missing	0.1	-	0.2	0
	Total	**100**	-	**100**	**100**
Sub-Saharan Africa					
Benin (2001)		*n=36*	-	-	-
	Commercial	2.7	-	-	-
	NGO	5.6	-	-	-
	Other private	2.2	-	-	-
	Public	89.6	-	-	-
	Total	**100**	-	-	-
Burkina Faso (2003)		-	*n=125*	-	-
	Private	-	3.7	-	-
	Public	-	96.3	-	-
	Total	-	**100**	-	-
Cameroon (1998)*		*n=25*	-	*n=65*	-
	Commercial	25.2	-	6.3	-
	NGO	10.8	-	28.5	-
	Public	64.0	-	64.4	-
	Other/don't know/missing	**0**		**0.8**	
	Total	**100**	-	**100**	-
Comoros (1996)		-	-	*n=49*	-
	Private	-	-	2.0	-
	Public	-	-	98.0	-
	Total	-	-	**100**	-

APPENDIX TABLE 2: PERCENT DISTRIBUTION OF SOURCE OF LAPMS

Country (year)	Source	IUD	Implant	Female sterilization	Male sterilization
Ethiopia (2000)		-	-	*n=33*	-
	Commercial	-	-	1.9	-
	NGO	-	-	12.3	-
	Public	-	-	85.8	-
	Total	-	-	**100**	-
Gabon (2000)		-	-	*n=51*	-
	Private	-	-	30.7	-
	Public	-	-	69.3	-
	Total	-	-	**100**	-
Ghana (2003)^		*n=35*	*n=37*	*n=72*	-
	Commercial	18.7	5.9	29.3	-
	NGO	3.1	2.1	0	-
	Public	78.2	92.0	68.9	-
	Other/don't know/missing	0	0	1.8	
	Total	**100**	**100**	**100**	-
Kenya (2003)*^		*n=129*	*n=95*	*n=238*	-
	Commercial	33.5	20.8	26	-
	NGO	17.0	18.0	18.8	-
	Public	49.5	61.2	54.7	-
	Other/don't know/missing	0	0	0.5	
	Total	**100**	**100**	**100**	-
Madagascar (2003)		*n=34*	-	*n=57*	-
	Commercial	34.2	-	31.3	-
	NGO	31.8	-	0	-
	Public	34.0	-	66.9	-
	Other/don't know/missing	0	-	1.8	
	Total	**100**	-	**100**	
Malawi (2000)*		-	-	*n=504*	-
	Commercial	-	-	0.8	-
	NGO	-	-	56.5	-
	Other private	-	-	0.3	-
	Public	-	-	42.4	-
	Total	-	-	**100**	-
Mali (2001)		-	-	*n=31*	-
	Private	-	-	3.8	-
	Public	-	-	78.1	-
	Other/don't know/missing	-	-	18.1	-
	Total	-	-	**100**	-
Mauritania (2001)		*n=37*	-	-	-
	Private	31.2	-	-	-
	Public	68.8	-	-	-
	Total	**100**	-	-	-
Namibia (2000)		*n=49*	-	*n=291*	-
	Private	43.9	-	24.8	-
	Public	53.2	-	71.8	-
	Other/don't know/missing	2.9	-	3.4	-
	Total	**100**	-	**100**	-
Nigeria (2003)		*n=45*	-	-	-
	Private	32.4	-	-	-
	Public	65.5	-	-	-
	Other/don't know/missing	2.1	-	-	-
	Total	**100**	-	-	-
Rwanda (2000)		-	-	*n=51*	-
	Private	-	-	6.3	-
	Public	-	-	93.7	-
	Total	-	-	**100**	-
Senegal (1997)		*n=117*	-	*n=30*	-
	Private	32.1	-	33.2	-
	Public	66.7	-	66.8	-
	Other/don't know/missing	1.2	-	0	-
	Total	**100**	-	**100**	-

APPENDIX TABLE 2: PERCENT DISTRIBUTION OF SOURCE OF LAPMS

Country (year)	Source	IUD	Implant	Female sterilization	Male sterilization
South Africa (1998)		*n=143*	-	*n=1020*	*n=108*
	Private	48.0	-	22.2	48.1
	Public	51.3	-	76.4	31.0
	Other/don't know/missing	0.7	-	1.4	20.9
	Total	**100**	-	**100**	**100**
Tanzania (1999)*		-	-	*n=62*	-
	Commercial	-	-	1.5	-
	NGO	-	-	25.4	-
	Public	-	-	69.8	-
	Other/don't know/missing	-	-	3.3	-
	Total	-	-	**100**	-
Togo (1998)		*n=70*	*n=37*	*n=24*	-
	Commercial	8.7	0	9.7	-
	NGO	8.4	14.2	0	-
	Other private	0	0	2.6	-
	Public	82.9	85.8	87.7	-
	Total	**100**	**100**	**100**	-
Uganda (2001)		-	-	*n=105*	-
	Private	-	-	29.6	-
	Public	-	-	67.6	-
	Other/don't know/missing	-	-	2.8	-
	Total	-	-	**100**	-
Zambia (2002)*		-	-	*n=112*	-
	Commercial	-	-	36.2	-
	NGO	-	-	22.2	-
	Public	-	-	40.1	-
	Other/don't know/missing	-	-	1.5	-
	Total	-	-	**100**	-
Zimbabwe (1999)*		*n=42*	-	*n=109*	-
	Commercial	44.2	-	22.6	-
	NGO	29.9	-	13.4	-
	Other private	2.4	-	6.4	-
	Public	23.5	-	55.4	-
	Other/don't know/missing	0	-	2.2	-
	Total	**100**	-	**100**	-

Note: Source information not available for Chad, Eritrea, Guinea, Ivory Coast, Niger and Uzbekistan.

Percents are weighted, ns are unweighted

* Church/mission categorized as NGO

** Prescription to buy IUD at pharmacy categorized as commercial

^ Nursing/maternity center categorized as commercial

APPENDIX TABLE 3A: TRENDS IN IUD USE AND SOURCE

Change in percent using the IUD, percent distribution of sources and percent contribution of each source to total use of the method for women in union where use equals 9 percent or more in at least one year for a minimum of 3 surveys **

	Percent distribution of sources				Percent contribution of each source to total use			
Colombia	**1986**	**1990**	**1995**	**2000**	**1986**	**1990**	**1995**	**2000**
	n=2850	***n=4450***	***n=6097***	***n=5935***				
Method use	11.0	12.4	11.1	12.4				
Source	***n=360***	***n=632***	***n=819***	***n=939***				
Commercial	14.6	21.4	19.3	16.7	1.6	2.7	2.2	2.1
NGO	45.2	32.0	34.6	28.7	4.9	4.0	3.8	3.6
Other private	4.1	1.0	0.9	12.3	0.5	0.1	0.1	1.5
Public	35.5	42.8	45.1	42.3	3.9	5.3	5.0	5.2
Other/DK/Missing	0.6	2.8	0.1	0	0.1	0.3	<0.1	0
Total	**100**	**100**	**100**	**100**	**11.0**	**12.4**	**11.1**	**12.4**
Ecuador	**1989**	**1994**	**1999**	**2004**	**1989**	**1994**	**1999**	**2004**
	n=4776	***n=9146***	***n=9583***	***n=7180***				
Method use	11.9	11.8	10.1	10.1				
Source	***n=570***	***n=1173***	***n=1062***	***n=716***				
Commercial	30.9	29.4	30.6	30.1	3.7	3.5	3.1	3.0
NGO	42.6	48.7	40.9	26.1	5.1	5.7	4.1	2.6
Other private	0	0	0.9	0	0	0	0.1	0
Public	25.5	21.9	27.6	42.0	3.0	2.6	2.8	4.2
Other/DK/Missing	1.0	1.6	0	1.8	0.1	0.2	0	0.2
Total	**100**	**100**	**100**	**100**	**11.9**	**12.0**	**10.1**	**10.1**
Honduras	**1987**	**1991**	**1996**	**2001**	**1987**	**1991**	**1996**	**2001**
	n=6093	***n=4322***	***n=4693***	***n=5347***				
Method use	4.3	5.1	8.5	9.6				
Source	***n=286***	-	***n=404***	***n=515***				
Commercial	21.0	-	16.3	17.8	0.9	-	1.4	1.7
NGO	29.4	-	24.4	24.0	1.3	-	2.1	2.3
Other private	0	-	0.2	0	0	-	0	0
Public	49.6	-	59.1	58.2	2.1	-	5.0	5.6
Total	**100**	-	**100**	**100**	**4.3**	-	**8.5**	**9.6**
								- source data not available for 1991 survey
Nicaragua	**1993**	**1998**	**2001**		**1993**	**1998**	**2001**	
	n=4875	***n=8045***	***n=7424***					
Method use	9.3	9.1	6.4					
Source	***n=507***	***n=860***	***n=537***					
Commercial	17.0	8.9	15.5		1.6	0.8	1.0	
NGO	11.3	16.3	20.4		1.1	1.5	1.3	
Other private	3.4	2.2	1.8		0.3	0.2	0.1	
Public	68.3	71.2	60.5		6.4	6.6	3.9	
Other/DK/Missing	0	1.4	1.8		0	0.1	0.1	
Total	**100**	**100**	**100**		**9.3**	**9.2**	**6.4**	
Paraguay	**1990**	**1996**	**1998**		**1990**	**1996**	**1998**	
	n=3574	***n=4586***	***n=2386***					
Method use	5.7	7.6	11.1					
Source	***n=216***	***n=357***	***n=290***					
Commercial	50.3	35.5	39.1		2.9	2.7	4.3	
NGO	28.6	17.1	11.0		1.6	1.3	1.2	
Public	20.9	45.3	48.7		1.2	3.4	5.4	
Other/DK/Missing	0.2	2.1	1.2		0	0.2	0.1	
Total	**100**	**100**	**100**		**5.7**	**7.6**	**11.1**	
Peru	**1986**	**1992**	**1996**	**2000**	**1986**	**1992**	**1996**	**2000**
	n=2900	***n=8741***	***n=16885***	***n=15628***				
Method use	7.3	13.4	12.0	9.1				
Source	***n=3417***	***n=1246***	***n=2189***	***n=1620***				
Commercial	25.5	29.7	14.4	16.3	1.9	4.0	1.7	1.5
NGO	0	11.0	6.7	6.1	0	1.5	0.8	0.6
Other private	0	3.8	1.2	0.3	0	0.5	0	0
Public	66.4	55.4	77.7	75.8	4.8	7.5	9.3	6.9

APPENDIX TABLE 3A: TRENDS IN IUD USE AND SOURCE

Change in percent using the IUD, percent distribution of sources and percent contribution of each source to total use of the method for women in union where use equals 9 percent or more in at least one year for a minimum of 3 surveys **

	Percent distribution of sources				Percent contribution of each source to total use			
Other/DK/Missing	8.1	0.1	0	1.5	0.6	0	0	0.1
Total	**100**	**100**	**100**	**100**	**7.3**	**13.4**	**12.0**	**9.1**
Egypt	**1988**	**1992**	**1995**	**2000**	**1988**	**1992**	**1995**	**2000**
	n=8221	***n=9153***	***n=13710***	***n=14382***				
Method use	15.8	27.9	30.0	35.5				
Source	***n=1295***	***n=2555***	***n=4108***	***n=5112***				
Commercial	61.6	39.0	37.8	36.1	9.7	10.9	11.3	12.8
NGO	0	13.7	17.3	9.9	0	3.8	5.2	3.5
Public	38.4	47.3	44.9	54.0	6.1	13.2	13.5	19.2
Total	**100**	**100**	**100**	**100**	**15.8**	**27.9**	**30.0**	**35.5**
Jordan	**1990**	**1997**	**2002**		**1990**	**1997**	**2002**	
	n=6168	***n=5337***	***n=5706***					
Method use	15.3	23.1	23.6					
Source	***n=942***	***n=1235***	***n=1349***					
Commercial	37.6	32.8	34.3		5.8	7.6	8.1	
NGO	0	41.5	36.7		0	9.6	8.7	
Other private	0	1.4	1.0		0	0.3	0.2	
Public	62.4	24.3	28.0		9.5	5.6	6.6	
Total	**100**	**100**	**100**		**15.3**	**23.1**	**23.6**	

Note: percentages may not add to 100.0 because of rounding errors.

** Source data refers to all women using the method. Calculations of the "contribution" therefore assume that source distribution is the same for women in union and all women.

APPENDIX TABLE 3B TRENDS IN FEMALE STERILIZATION USE AND SOURCE

Change in percent using female sterilization, percent distribution of sources and percent contribution of each source to total use of the method and where use equals 9 percent or more in at least one year for a minimum of 3 surveys

	Percent distribution of sources				Percent contribution of each source to total use			
Colombia	**1986**	**1990**	**1995**	**2000**	**1986**	**1990**	**1995**	**2000**
	n=2850	***n=4450***	***n=6097***	***n=5935***				
Method use	18.3	20.9	25.7	27.1				
Source	***n=590***	***n=1018***	***n=1880***	***n=2029***				
Commercial	11.7	15.4	11.1	14.9	2.1	3.2	2.9	4.0
NGO	71.7	60.0	47.9	40.8	13.1	12.5	12.3	11.1
Other private	4.7	0.2	0.4	1.1	0.9	0.1	0.1	0.3
Public	11.9	23.1	40.4	43.0	2.2	4.8	10.4	11.6
Other/DK/Missing	0	1.2	0.1	0.2	0	0.3	<0.1	0.1
Total	**100**	**100**	**100**	**100**	**18.3**	**20.9**	**25.7**	**27.1**
Dominican Republic	**1991**	**1996**	**1999**	**2002**	**1991**	**1996**	**1999**	**2002**
	n=4083	***n=4983***	***n=728***	***n=13996***				
Method use	38.5	40.9	43.5	45.8				
Source	***n=1858***	***n=2410***	***n=396***	***n=7773***				
Commercial	51.1	45.6	49.1	42.7	19.7	18.7	21.4	19.6
NGO	11.5	13.1	4.0	2.8	4.4	5.4	1.7	1.3
Other private	0	0	0.5	0	0	0	0.2	0
Public	36.6	41.1	46.4	52.7	14.1	16.8	20.2	24.1
Other/DK/Missing	0.8	0.2	0	1.8	0.3	0.1	0	0.8
Total	**100**	**100**	**100**	**100**	**38.5**	**40.9**	**43.5**	**45.8**
Ecuador	**1989**	**1994**	**1999**	**2004**	**1989**	**1994**	**1999**	**2004**
	n=4776	***n=9146***	***n=9583***	***n=7180***				
Method use	18.3	19.8	22.5	24.1				
Source	***n=884***	***n=1734***	***n=2037***	***n=1579***				
Commercial	31.1	32.1	32.6	31.7	5.7	6.4	7.3	7.6
NGO	0.9	3.7	3.8	2.7	0.2	0.7	0.9	0.7
Other private	0	1.1	0.3	0	0	0.2	0.1	0
Public	67.4	63.1	62.6	65.3	12.3	12.5	14.1	15.7
Other/DK/Missing	0.6	0	0.7	0.3	0.1	0	0.2	0.1
Total	**100**	**100**	**100**	**100**	**18.3**	**19.8**	**22.5**	**24.1**
El Salvador	**1988**	**1993**	**1998**	**2002**	**1988**	**1993**	**1998**	**2002**
	n=2786	***n=3659***	***n=7453***	***n=6188***				
Method use	29.6	31.5	32.4	32.7				
Source	***n=660***	***n=1157***	***n=2125***	***n=1857***				
Commercial	2.7	3.6	4.8	2.5	0.8	1.1	1.6	0.8
NGO	14.1	16.0	12.5	9.9	4.2	5.0	4.1	3.2
Public	82.8	79.9	82.0	87.3	24.5	25.2	26.6	28.5
Other/DK/Missing	0.4	0.5	0.7	0.3	0.1	0.2	0.2	0.1
Total	**100**	**100**	**100**	**100**	**29.6**	**31.5**	**32.4**	**32.7**
Guatemala	**1983**	**1987**	**1995**	**1999**	**1983**	**1987**	**1995**	**1999**
	n=2709	***n=3377***	***n=7984***	***n=3964***				
Method use	10.2	10.3	14.3	16.7				
Source	***n=266***	***n=384***	***n=1237***	***n=721***				
Commercial	17.3	17.7	22.2	15.4	1.8	1.8	3.2	2.6
NGO	23.5	38.0	38.6	39.1	2.4	3.9	5.5	6.5
Public	58.8	42.0	38.0	43.2	6.0	4.3	5.4	7.2
Other/DK/Missing	0.4	2.3	1.2	2.3	0.0	0.2	0.2	0.4
Total	**100**	**100**	**100**	**100**	**10.2**	**10.3**	**14.3**	**16.7**
Honduras	**1987**	**1991**	**1996**	**2001**	**1987**	**1991**	**1996**	**2001**
	n=6093	***n=4322***	***n=4693***	***n=5347***				
Method use	12.6	15.6	18.1	18.0				
Source	***n=859***	***n=792***	***n=800***	***n=930***				
Commercial	30.8	33.9	16.4	13.5	3.9	5.3	3.0	2.4
NGO	5.5	16.8	48.1	50.2	0.7	2.6	8.7	9.0
Other private	0	0	0	1.1	0	0	0	0
Public	63.7	49.3	35.5	35.2	8.0	7.7	6.4	6.3

APPENDIX TABLE 3B TRENDS IN FEMALE STERILIZATION USE AND SOURCE

Change in percent using female sterilization, percent distribution of sources and percent contribution of each source to total use of the method and where use equals 9 percent or more in at least one year for a minimum of 3 surveys

	Percent distribution of sources				Percent contribution of each source to total use			
Total	**100**	**100**	**100**	**100**	**12.6**	**15.6**	**18.1**	**18.0**
Nicaragua	**1993**	**1998**	**2001**		**1993**	**1998**	**2001**	
	n=4875	***n=8045***	***n=7424***					
Method use	18.5	26.1	25.3					
Source	***n=934***	***n=2540***	***n=2368***					
Commercial	9.3	5.9	9.7		1.7	1.5	2.5	
NGO	11.7	24.2	21.5		2.2	6.3	5.4	
Other private	1.3	0.6	0		0.2	0.2	0	
Public	77.7	67.5	67.0		14.4	17.6	17.0	
Other/DK/Missing	0	1.8	1.8		0	0.5	0.5	
Total	**100**	**100**	**100**		**18.5**	**26.1**	**25.3**	
Peru	**1986**	**1992**	**1996**	**2000**	**1986**	**1992**	**1996**	**2000**
	n=2900	***n=8741***	***n=16885***	***n=15628***				
Method use	6.1	7.9	9.5	12.3				
Source	***n=3621***	***n=742***	***n=1717***	***n=2100***				
Commercial	18.0	29.6	17.4	13.7	1.1	2.3	1.7	1.7
NGO	0	1.7	1.8	1.8	0	0.1	0.2	0.2
Other private	0	4.2	2.4	0	0	0.3	0.2	0
Public	77.8	64.0	78.3	83.0	4.7	5.1	7.4	10.2
Other/DK/Missing	4.2	0.5	0.1	1.5	0.3	0	0	0.2
Total	**100**	**100**	**100**	**100**	**6.1**	**7.9**	**9.5**	**12.3**
Nepal	**1991**	**1996**	**2001**		**1991**	**1996**	**2001**	
	n=24334	***n=7982***	***n=8342***					
Method use	11.0	12.1	15.0					
Source	***n=2676***	***n=963***	***n=1252***					
Commercial	2.4	3.0	1.1		0.3	0.4	0.2	
NGO	0	6.1	6.8		0	0.7	1.0	
Public	97.5	87.2	85.9		10.7	10.6	12.9	
Other/DK/Missing	0.1	3.7	6.2		0.0	0.4	0.9	
Total	**100**	**100**	**100**		**11.0**	**12.1**	**15.0**	

Note: percentages may not add to 100.0 because of rounding errors.

APPENDIX TABLE 4A: IUD USE AND SOURCE BY WEALTH QUINTILE

Percent distribution of source and contribution of each sourse to total use of the IUD by wealth quintile or source by education level

	Percent distribution of source by wealth quintile					Percent contribution of each source to total use of method by wealth quintile				
	Lowest Q	**Second Q**	**Middle Q**	**Fourth Q**	**Highest Q**	**Lowest Q**	**Second Q**	**Middle Q**	**Fourth Q**	**Highest Q**
Colombia (2000)										
	n=1158	***n=1348***	***n=1324***	***n=1166***	***n=1030***					
Method use	8.3	9.1	15.1	16.1	13.0					
Source	***n=86***	***n=119***	***n=190***	***n=173***	***n=135***	***n=86***	***n=119***	***n=190***	***n=173***	***n=135***
Commercial	8.9	15.7	12.6	16.5	21.6	0.8	1.4	1.9	2.6	2.8
NGO	5.3	12.7	29.8	32.3	40.0	0.4	1.2	4.5	5.2	5.2
Other private	2.5	10.9	11.9	15.4	13.8	0.2	1.0	1.8	2.5	1.8
Public	83.3	60.7	45.7	35.9	24.6	6.9	5.5	6.9	5.8	3.2
Total	**100**	**100**	**100**	**100**	**100**	**8.3**	**9.1**	**15.1**	**16.1**	**13.0**
Peru (2000)										
	n=4050	***n=3998***	***n=3633***	***n=2886***	***n=1951***					
Method use	2.6	4.9	8.7	13.1	16.2					
Source	***n=94***	***n=165***	***n=258***	***n=319***	***n=290***	***n=94***	***n=165***	***n=258***	***n=319***	***n=290***
Commercial	2.6	7.8	9.5	11.8	29.7	0.1	0.4	0.8	1.5	4.8
NGO	0	5.5	1.8	5.0	9.3	0	0.3	0.2	0.7	1.5
Public	95.3	86.7	86.3	81.9	59.2	2.4	4.2	7.5	10.7	9.6
Other/Missing	2.1	0	2.4	1.3	1.8	0.1	0	0.2	0.2	0.3
Total	**100**	**100**	**100**	**100**	**100**	**2.6**	**4.9**	**8.7**	**13.1**	**16.2**
Egypt (2000)										
	n=2498	***n=2589***	***n=2883***	***n=3025***	***n=3398***					
Method use	22.7	31.3	34.6	40.0	45.6					
Source	***n=525***	***n=767***	***n=928***	***n=1152***	***n=1472***	***n=525***	***n=767***	***n=928***	***n=1152***	***n=1472***
Commercial	25.7	30.6	32.4	31.0	50.0	5.8	9.5	11.2	12.4	22.8
NGO	4.9	8.5	8.1	10.9	13.0	1.1	2.7	2.8	4.4	5.9
Public	69.4	60.9	59.5	58.1	37.0	15.7	19.1	20.6	23.2	16.9
Total	**100**	**100**	**100**	**100**	**100**	**22.6**	**31.3**	**34.6**	**40.0**	**45.6**
Jordan (2002)										
		None/ Primary	**Second**	**Higher**						
Source		***n=153***	***n=715***	***n=303***						
Commercial		34.7	38.2	47.6						
NGO		36.9	31.7	29.4						
Public		28.5	30.2	23.0						
Total		**100**	**100**	**100**						

Note: percentages may not add to 100.0 because of rounding errors.

APPENDIX TABLE 4B: FEMALE STERILIZATION USE AND SOURCE BY WEALTH QUINTILE

Percent distribution of source and contribution of each source to total use of female sterilization by wealth quintile or source by education level

	Percent distribution of source by wealth quintile					Percent contribution of each source to total use of method by wealth quintile				
	Lowest Q	Second Q	Middle Q	Fourth Q	Highest Q	Lowest Q	Second Q	Middle Q	Fourth Q	Highest Q
Colombia (2000)										
	n=1158	***n=1348***	***n=1324***	***n=1166***	***n=1030***					
Method use	26.1	27.2	24.1	28.7	29.8					
Source	***n=302***	***n=366***	***n=331***	***n=347***	***n=302***	***n=302***	***n=366***	***n=331***	***n=347***	***n=302***
Commercial	5.2	8.9	11.9	20.1	27.3	1.4	2.4	2.8	5.8	8.1
NGO	33.5	39.2	44.9	41.4	37.9	8.7	10.7	10.8	11.9	11.3
Public	60.4	50.5	43.0	37.1	33.0	15.8	13.7	10.4	10.6	9.8
Other/Missing	0.9	1.4	0.3	1.3	1.8	0.2	0.4	0.1	0.4	0.6
Total	**100**	**100**	**100**	**100**	**100**	**26.1**	**27.2**	**24.1**	**28.7**	**29.8**
Peru (2000)										
	n=4050	***n=3998***	***n=3633***	***n=2886***	***n=1951***					
Method use	7.3	12.1	13.6	13.1	15.0					
Source	***n=278***	***n=496***	***n=506***	***n=412***	***n=331***	***n=278***	***n=496***	***n=506***	***n=412***	***n=331***
Commercial	3.7	7.3	7.5	16.4	31.2	0.3	0.9	1.0	2.2	4.7
NGO	0.9	1.9	1.4	1.8	2.5	0.1	0.2	0.2	0.2	0.4
Public	95.4	90.8	90.4	80.9	60.9	6.9	11.0	12.3	10.6	9.1
Other/Missing	0	0	0.7	0.9	5.4	0	0	0.1	0.1	0.8
Total	**100**	**100**	**100**	**100**	**100**	**7.3**	**12.1**	**13.6**	**13.1**	**15.0**
Dominican Republic (2002)										
	None	**Primary**	**Second**	**Higher**						
Source	***n=469***	***n=4121***	***n=1450***	***n=773***						
Commercial	30.7	36.7	48.2	67.3						
NGO	0.7	2.7	3.5	4.5						
Public	65.8	58.9	46.3	25.8						
Other/Missing	2.8	1.6	2.0	2.4						
Total	**100**	**100**	**100**	**100**						
Guatemala (1999)										
	None	**Primary**	**Second/Higher**							
Source	***n=119***	***n=287***	***n=124***							
Commercial	9.4	11.0	25.5							
NGO	44.8	43.0	29.3							
Public	42.4	45.8	41.6							
Other/Missing	3.4	0.2	3.7							
Total	**100**	**100**	**100**							

Note: percentages may not add to 100.0 because of rounding errors.

ANNEX B: REFERENCES

Badan Pusat Statistik—Statistics Indonesia (BPC) and ORC Macro. 2003. *Indonesia Demographic and Health Survey 2002–2003*. Calverton, MD: BPS and ORC Macro.

Berg, R. 2000. *Initiating Public/Private Partnerships to Finance Reproductive Health: The Role of Market Segmentation Analysis*. Washington, DC: POLICY Project.

Demographic and Health Surveys Dimensions Newsletter. Volume 4, Number 2, Fall 2002. http://www.measuredhs.com/pubs/pdf/NL42/Vol4no2.pdf.

POLICY Project. 2004. *Regional Contraceptive Security Report. Latin America and the Caribbean*. Washington, DC: POLICY Project.

Purdy, C. Personal communication, DKT International Indonesia, 2005.

Ross, J., J. Stover, and D. Adelaja. 2005. *Profiles for Family Planning and Reproductive Health Programs: 116 Countries*. 2nd ed. Glastonbury, CT: Futures Group.

Sharma, S., G. Subiria, and V. Dayaratna. 2005. *Family Planning Market Segmentation in Peru*. Draft paper. Washington, DC: POLICY Project.

Sharma, S., J.N. Gribble, and E.P. Menotti. 2005. Creating options in family planning for the private sector in Latin America. *Rev Panam Salud Pubmica*. 18(1): 37–44.

United Nations Population Division, Department of Economic and Social Affairs. 1994. *World Contraceptive Use Wall Charts*. New York: United Nations.

United Nations Population Division, Department of Economic and Social Affairs. 2003. *World Contraceptive Use Wall Charts*. New York: United Nations.

World Health Organization "Mother-Baby Package Costing Spreadsheet", Version 1.01, December 1999. Reproductive Health and Research, World Health Organization. [Online] Available at http://www.who.int/reproductive-health/economics/intro.html