Introduction

The key actors in Bangladesh’s Health, Population and Nutrition Sector Development Program (HPNSDP) are the public sector, nongovernmental organizations (NGOs), the non-profit private sector, and the for-profit private sector. The public health infrastructure is considered one of the largest in the health sector; RH providers and facilities are available at all levels. Several NGOs are active in Bangladesh’s health sector, including international organizations such as CARE, Save the Children and World Vision. Also involved in health delivery are large national NGOs, including BRAC, Concerned Women for Family Planning, and the Grameen Kalyan Health Program, and hundreds of small and local NGOs (Perry 2000).

The nongovernmental, the non-profit, and the for-profit private sectors are also engaged in the procurement and distribution of selected drugs and healthcare products targeting beneficiary groups in Bangladesh. For example, the Social Marketing Company (SMC) of Bangladesh is a pioneer in manufacturing oral rehydration solution (ORS), in distributing and marketing public health products such as oral contraceptives, condoms, and injectable, and in using for-profit channels to market its own brand of products in Bangladesh.

The private health sector in Bangladesh includes large and small for-profit companies, professionals such as doctors and individual providers, and informal unqualified health providers, including shopkeepers. The private sector provides health services at hospitals, nursing and maternity homes, at clinics run by doctors, nurses,
midwives, and paramedical workers, and at diagnostic facilities, for example, laboratories and radiology units. The private sector also sells drugs from pharmacies and unqualified static and itinerant drug sellers, including from general stores (Bangladesh Health Watch, 2008).

The potential of the public, private, and NGO sectors to collaboratively provide health services in Bangladesh requires further review, according to several studies (Bustreo et al. 2002, Rahaim et al. 2011). The Government of Bangladesh (GOB) considers all areas of development in its Vision 2021 plan. For the health sector, the Government is examining the role that each sector can play, particularly in service delivery for the poor. Understanding the extent of the private sector’s involvement in RH service provision is critical to ensuring quality RH services for all.

This study examines the private sector’s provision of RH services in order to assess the sector’s support of family planning (FP), delivery, and antenatal care (ANC) in Bangladesh. The public, private, and NGO sectors are defined as follows:

- **Public sector**: GOB-funded and GOB-managed health agencies, facilities, and providers.
- **Private sector**: For-profit providers and any other health system actors and/or facilities deriving revenue from their health services and products.
- **NGO sector**: Non-profit NGO health providers or facilities.

The study utilized data from multiple rounds of nationally representative cross-sectional surveys, including Bangladesh Demographic and Health Surveys (BDHS) and the Utilization of Essential Service Delivery Survey (UESD), which was carried out by the National Institute of Population Research and Training (NIPORT) under the Ministry of Health and Family Welfare. A multivariate binary logistic regression model is fitted on the BDHS and UESD datasets from 1994–2010 to determine the factors that significantly affect the utilization of the private sector over the public sector for selected RH services.

**Study Findings**

**RH SERVICES IN BANGLADESH BY SECTOR**

The private sector has gradually increased its market share of modern FP service delivery from 20 percent in 1993-94 to 43 percent in 2011, while the public sector’s market share of FP services has fallen 28 percent over the same period (Figure 1).

Among private sector sources for FP, the privately run drug stores and pharmacies are the dominant sources for obtaining FP methods, particularly the pill and condoms. The private sector has also increased its market share in the delivery of ANC services from 28 percent in 2006 to 43 percent in 2011, while the public sector share dropped from 49 percent in 2006 to 41 percent in 2011. Facility deliveries in private health facilities have increased by ten-fold in the past 18 years (Figure 2).
Socioeconomic characteristics play an important role in determining RH-seeking behavior. Wealthy, urban, and educated women rely significantly on the private sector for RH services. Nevertheless, while the poor and wealthy women’s reliance on public facilities for RH has decreased, the public sector remains the major source of RH services in Bangladesh.

Factors Affecting the Use of Private Sector RH Services

FAMILY PLANNING
A step-wise logistic regression analysis was carried out to assess the effect of selected differentials on an individual’s choice of the private sector as the source for FP methods. The results show that women in urban areas are 76 percent more likely to obtain FP methods from the private sector compared to women in rural areas. Women’s education level is another significant factor in determining reliance on the private sector for FP methods. Married women with a higher education level are significantly more likely to obtain FP methods from the private sector. For example, women with a primary level education are 57 percent more likely to obtain contraceptives from the private sector, and women with secondary or higher education levels are three times more likely to seek private sector services than women with no education. Exposure to mass media, such as TV, radio and/or newspapers is another significant predictor linking contraceptive access to the private sector. Women with regular exposure to mass media are 22 percent more likely to use the private sector compared to women with none or irregular exposure to mass media. Women with higher socioeconomic status are more likely to obtain contraceptives from the private sector than the poorest are. Women with the highest socioeconomic status are 2.6 times more likely to obtain FP methods from the private sector than the poorest women are.

ANTENATAL CARE
The result of the logistic regression analysis shows that women in urban areas are 10 percent less likely to receive ANC services from private sector facilities compared to women in rural areas. A household’s socioeconomic status—expressed in the form of wealth quintiles—is also linked suggestively to private sector ANC services. Women from higher socioeconomic status are more likely to receive ANC services from private facilities than their poorest counterparts.

DELIVERY
Women in urban areas are 18 percent more likely to deliver at a private facility than women in rural areas, based on the effect of selected differentials. Women’s education level is a significant factor relative to the selection of private facilities for deliveries. Mothers with secondary or higher levels of education are 49 percent more likely to deliver at private health facilities compared to women with no education. Women with higher socioeconomic status are more likely to give birth in private health facilities than their poorest counterparts. Each year women become 8 percent more likely to deliver at private facilities in Bangladesh, according to this study.

Conclusion
The results of this study suggest that the private health sector plays a larger role in providing RH services in Bangladesh than was known previously. Even though the public sector remains an important source of RH services, its market share has decreased over time. Wealthier and educated women mostly rely on the private sector for RH services, while a majority of the poorer and uneducated women rely on the public sector for RH services. Access to RH services whether in the public or private sectors has implications for the poor.

Recommendations
Based on the study’s findings and discussions with different stakeholders, the following policy recommendations are proposed to support better access to RH services in Bangladesh:

- The Government of Bangladesh should strengthen its stewardship by improving the legal and regulatory framework as well as its supervision and monitoring of the private health sector.
- RH services should be provided through public-private partnerships by contracting private organizations and/or NGOs to provide RH services at the community level.
- Government should take steps to improve and strengthen its capacity to engage in public-private partnerships.
- Devise a pro-poor RH health services delivery strategy to reduce the existing inequity.
- Conduct research to understand (i) the dynamics of the private sector’s delivery of RH services, especially by the private for-profit and informal health care providers; (ii) to test alternative strategies to more effectively engage the public and private sectors in complementary service delivery.
End Notes

1 Unqualified health providers have no formal qualification and yet are considered village doctors, kabiraj (traditional providers using herbal and faith based healing), quack (providers pretending to be doctors and selling medicine), and spiritual healers. They provide alternative treatments such as allopathic, homeopathic, ayurvedic and unani (a traditional medicine practiced in South Asia).

2 Shopkeepers and general stores are considered non-medical private sources, providing modern contraceptives, oral dehydration saline (ORS), etc.


4 Three waves of UESD were conducted: 2006, 2008, and 2010. For details see Al-Sabir et al. 2007 and 2009; NIPORT 2011.

References


This HNP Knowledge Brief highlights the key findings from a study by the World Bank on the “Role of the Private Sector in Accessing Reproductive Health Services in Bangladesh” written by Ahmed Al-Sabir and Bushra Binte Alam.