The Private Sector's Contributions to Family Planning Market Growth

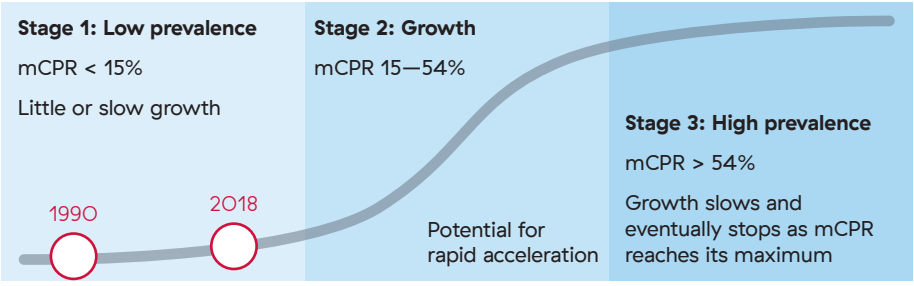
Nigeria

The Nigerian family planning market experienced substantial private sector contributions from 1990 to 2018; however, the modern contraceptive prevalence rate among married women remained in Stage 1—increasing from 3.5 to 12.0 percent. A SHOPS Plus analysis revealed several economic, sociocultural, policy, and programmatic factors that facilitated or inhibited the private sector's contributions to increase the modern contraceptive prevalence rate. Understanding these factors can help donors and country governments better consider appropriate private health sector investments and interventions in their family planning programs.

A review of trends in the modern contraceptive prevalence rate (mCPR) across low- and middle-income countries has led stakeholders to develop a normative S-shaped pattern for growth (Figure 1). In this model, low prevalence and little growth occur on one end, with high prevalence and low growth on the other, and a period of potentially rapid growth in between (Track20 2017). While country growth patterns can vary substantially, the S-curve model serves as a framework to categorize countries to one of these three stages based on their mCPR (Feyisetan et al. 2017). The model can assist stakeholders in assessing the appropriate level of investment, type, and timing of interventions to help their countries' mCPR growth better mirror the S-curve, enabling more men and women to achieve their reproductive intentions.

Figure 1. The S-curve for family planning markets

Nigeria's mCPR is marked in red



Program focus

Stage 1: Change norms to increase demand and provide services

Stage 2: Reduce barriers to access, improve quality, sustain demand generation

Stage 3: Sustain gains

Note: The mCPR percentages listed in this figure are among currently married women.
Source: Track20 (2017)

This is one in a series of briefs that examines family planning market growth since 1990.

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Understanding the types of interventions that work best at each stage of the S-curve is necessary to create optimal family planning outcomes. The USAID-funded Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project sought to identify those interventions that could best harness the private health sector within each stage of the S-curve. The project examined countries where (1) the private sector has played a significant role in the family planning market and (2) the private sector role has increased as mCPR grew. This analysis revealed economic, sociocultural, policy, and programmatic factors that facilitated increased private sector contributions. Understanding these factors can help donors and country governments better consider appropriate private health sector investments and interventions in their family planning programs.

Between 1990 and 2018, despite significant contributions from the private sector and stronger growth in the southern regions of the country, Nigeria stayed within Stage 1. To take the country to Stage 2, family planning stakeholders will need to continue mobilizing political and policy support for family planning, increase perceived value of contraceptive methods, and sustain regionally tailored product and service delivery strategies as Nigeria moves from Stage 1 to Stage 2. This brief recommends strategies for stakeholders to leverage the private sector's contributions to growth.

Methods

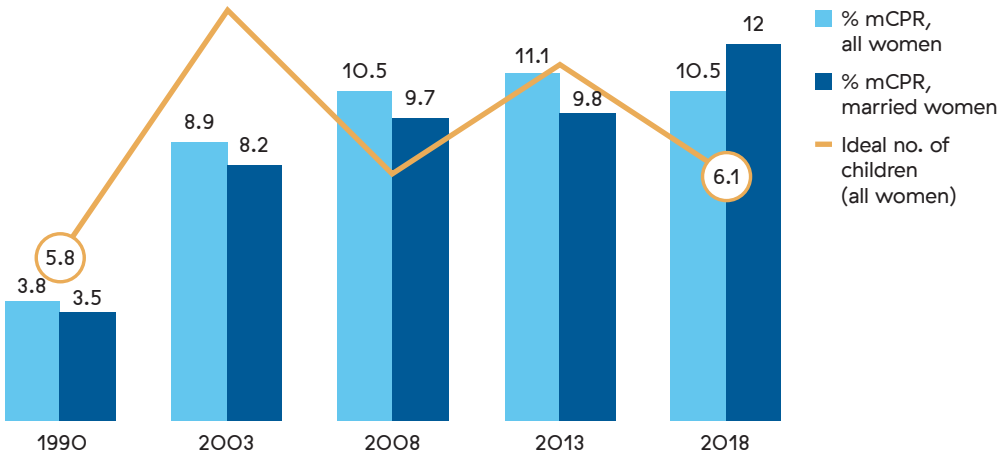
This is one in a series of briefs that examines the family planning markets in six countries since 1990. Five countries in Stages 2 and 3 (Bangladesh, Cambodia, Kenya, the Philippines, and Tanzania) saw increases in mCPR and private sector contributions. One country (Nigeria) saw substantial private sector contributions, but low growth in mCPR, and remained in Stage 1. Examining all six countries helps identify what factors are necessary for leveraging the private sector's contributions to growth.

SHOPS Plus conducted extensive secondary analysis of Demographic and Health Survey (DHS) data to examine trends in the use of modern contraceptive methods by reported sources of supply, translating use rates into absolute numbers of women using United Nations Development Programme's World Population Prospects (2019 Revision) projections. The project conducted country-specific literature reviews and key informant interviews with experts who worked in Nigeria's family planning market between 1990 and 2018 to explain the trends revealed through the DHS data analysis. The goal was to better understand factors that enabled or inhibited the private sector's contributions to mCPR growth.

Persistent demand-side challenges to family planning growth

The Nigerian family planning market experienced slow growth during the 25-year period from 1990 to 2018. The mCPR among all women—married and unmarried—has historically been slightly higher than that of only married women, although that trend reversed in 2018. Between 1990 and 2018, mCPR among *married* women increased from 3.5 percent to 12.0 percent (STATcompiler 2019). The mCPR among *all* women similarly increased from 3.8 percent to 10.5 percent. In that same period, the ideal number of children a woman desired to have in her lifetime remained relatively unchanged, increasing slightly from 5.8 to 6.1, indicating little changes in the proportion of women desiring to delay or limit pregnancies (Figure 2).

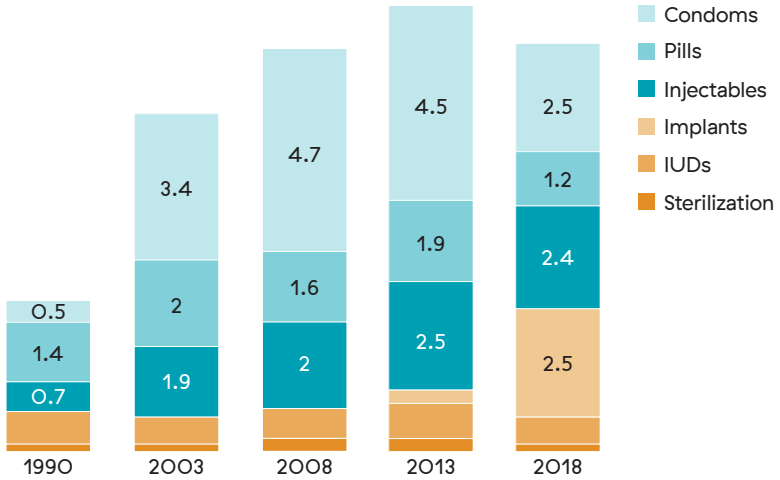
Figure 2. Changes in family planning use and childbearing preferences, 2000—2014



As mCPR among all women increased gradually, the method mix shifted (Figure 3).[1] From 1990 to 2008, short-acting methods (SAMs)—condoms, pills, and injectables—grew the fastest. Between 2008 and 2018, while growth in use of SAMs began to plateau and then decline, uptake of implants increased substantially. However, the increased uptake of implants between 2013 and 2018 was insufficient to mitigate the decline in use of SAMs, resulting in an overall decline in mCPR among all women.

Figure 3. Modern contraceptive use by method

All women (%)

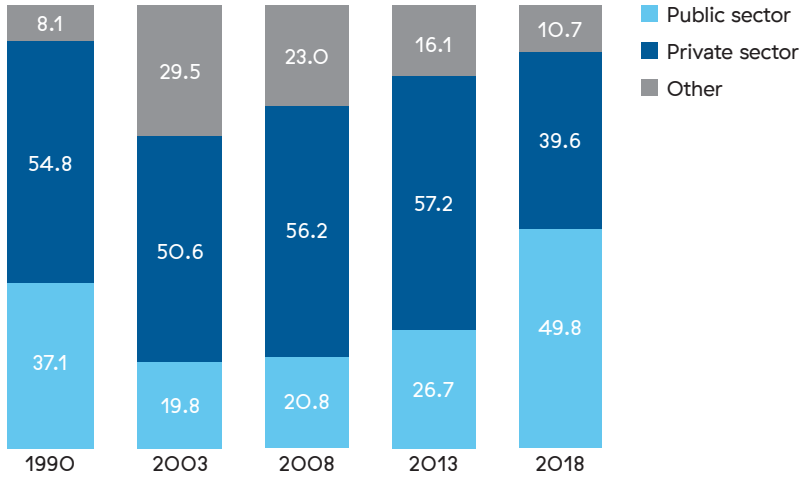


[1] Diaphragms, contraceptive foam or jelly, female condoms, and emergency contraception are included in graphs that show all modern contraceptives combined, but are not shown separately due to small sample sizes. This analysis excludes the lactational amenorrhea method, Standard Days Method, other fertility awareness methods, and DHS's category of other modern methods, as surveys do not systematically ask for sources of these methods.

Overall, the private sector has traditionally been the largest source of modern contraceptives in Nigeria (Figure 4). Between 1990 and 2013, its market share ranged between 51 and 57 percent of modern method users. The public sector's share steadily grew from 20 percent of modern method users in 2003 to 27 percent in 2013. In 2018, the share of the public sector increased substantially to 50 percent of modern method users while the share of the private sector declined to just 40 percent. The private sector's decline between 2013 and 2018 resulted from a drop in use of SAMs. These methods, globally and in Nigeria, are mainly obtained from private sources. Similarly, changes in the method mix explain the steady increase in the public sector's contribution. As use of injectables and implants—methods primarily accessed from public sources—increased, the share of public sector sources among users of modern contraceptives increased.

Figure 4. Sources of contraceptives among all users of modern contraceptives

All users (%)



The private sector's contributions to the family planning market have largely come from private pharmacies, including patent and proprietary medicine vendors (PPMVs) (Figure 5). Private pharmacies and PPMVs are major sources of SAMs, especially condoms and pills, two of the methods that have historically dominated the Nigerian family planning market.

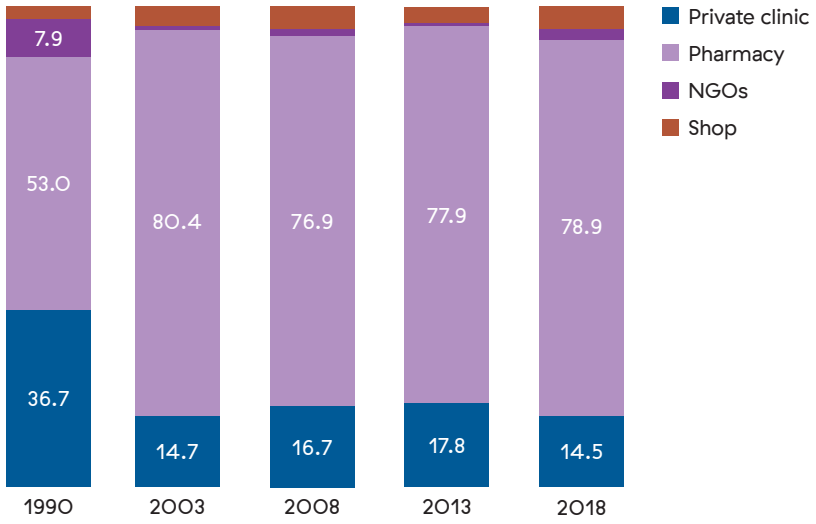
Performance of social marketing organizations and regional trends in mCPR offer insights

Overall trends in use of SAMs among all women (Figure 3) mirror trends in sales of these products by the social marketing sector (Figure 6). Couple years of protection (CYPs) generated from social marketing sales of SAMs[2] exhibited an annual growth rate of more than 10 percent between 1990 and 2008, corresponding to the period when use of these

[2] As reported in Contraceptive Social Marketing Statistics, published by DKT International, 1991—2018

Figure 5. Sources of contraceptives among private sector users of modern contraceptives

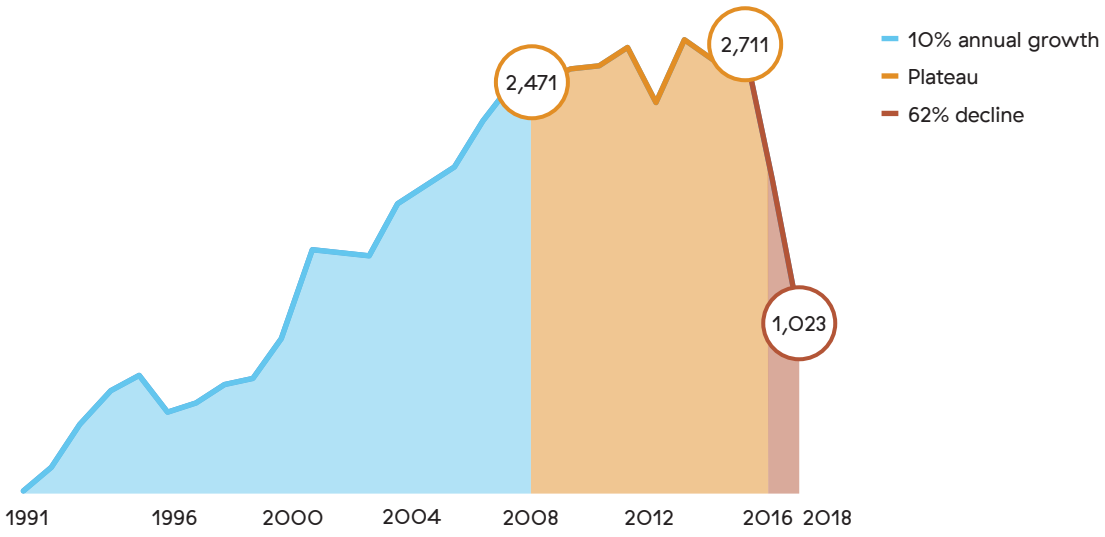
Private sector users (%)



methods among all women increased rapidly. Similarly, between 2008 and 2016, CYPs from social marketing sales of SAMs leveled off as did the use of these methods among all women. In the third period between 2016 and 2018, CYPs from sales of SAMs exhibited a 62 percent decline corresponding to a decline in use of SAMs among all women. The trends in CYPs from sales of SAMs are heavily influenced by the performance of Society for Family Health, the leading social marketing organization in Nigeria.

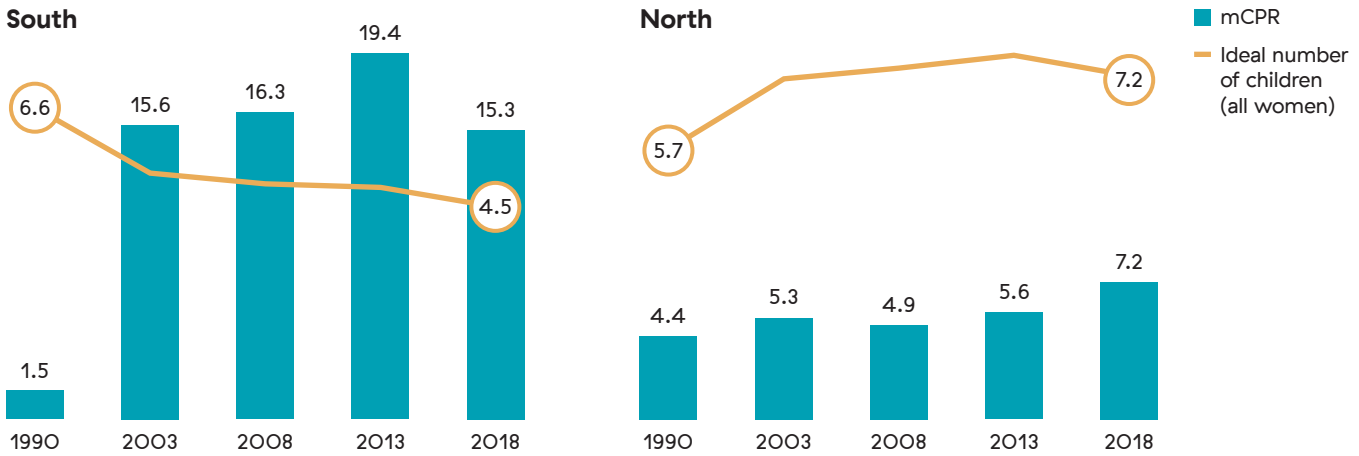
Figure 6. Couple years of protection from social marketing organization sales of short-acting methods

In thousands



Overall national trends in Nigeria mask significant variation at the regional level. The mCPR among all women is much higher in the southern regions of the country than in the north, largely due to diverging trends in the ideal number of children women desire (Figure 7). In 1990, mCPR was higher and desired fertility lower among women in the northern parts of the country. Since then, though desired fertility levels have continually decreased among women in the south, among all women in the north, levels have seen an overall increase of 1.5 children between 1990 and 2018. In line with these trends, mCPR grew quickly in the south, reaching Stage 2 of the S-curve by 2003 and continued to grow further until 2013. However, mCPR in the north did not increase between 2003 and 2013, keeping the national mCPR in Stage 1 of the S-curve. While mCPR showed a modest increase in the north between 2013 and 2018, it declined by four percentage points in the south, resulting in the overall decline seen at the national level. Importantly, at the 2018 desired fertility levels in the south—comparable to Tanzania, which has an mCPR of 27 percent among all women—modeling by the Track20 program indicates that there is an opportunity for continued increase in mCPR. In the north, due to much higher levels of desired fertility, there is little to no room for continued increases without corresponding changes in norms regarding ideal family size and decreases in under-5 mortality.

Figure 7. Regional trends in family planning use and childbearing preferences, 1993—2018

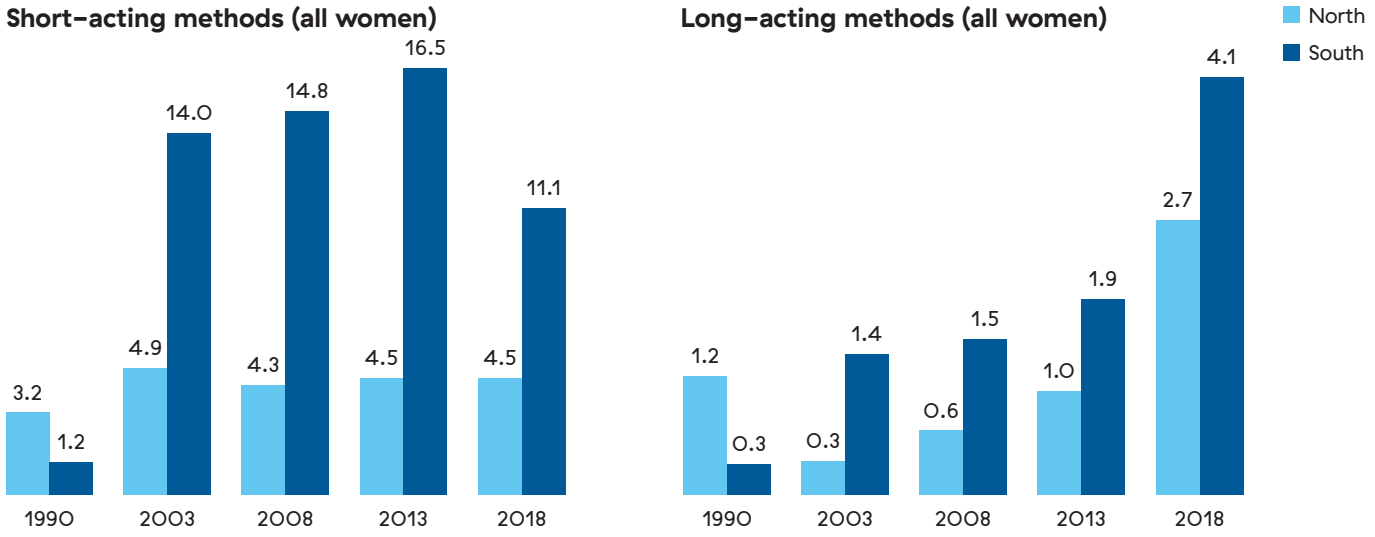


Demographic differences between the two regions help explain the diverging trends in desired fertility levels. In the south, the population tends to come from Yoruba and Igbo ethnic groups and belong to Christian religions. In the north, the population comes from Hausa and Fulani and Islam is the majority religion. Extensive research has demonstrated links between ethnic and religious norms that influence desired fertility and acceptance of modern family planning (Adedini 2018, Babalola 2018, and Obasohan 2015). This research has highlighted preferences for larger families among Muslim communities and widespread belief that family planning is anti-Islam as key constraints to demand in the

north. Additionally, stakeholders indicate that lower education levels and gender-based constraints in the north contribute to less access to information about family planning and more widespread myths and misconceptions about modern methods.

mCPR trends also reflect regional differences in use of specific family planning methods (Figure 8). In the south, use of SAMs increased dramatically, peaking at 16.5 percent of all women in 2013. In the north, use of SAMs has remained stagnant at 2003 levels. In contrast to the regional differences in uptake of SAMs, use of long-acting reversible contraceptives (LARCs) increased slowly yet consistently in both regions between 2003 and 2018. These differences suggest that factors impacting lower uptake of SAMs in the north are another contributing factor to low mCPR growth in Nigeria.

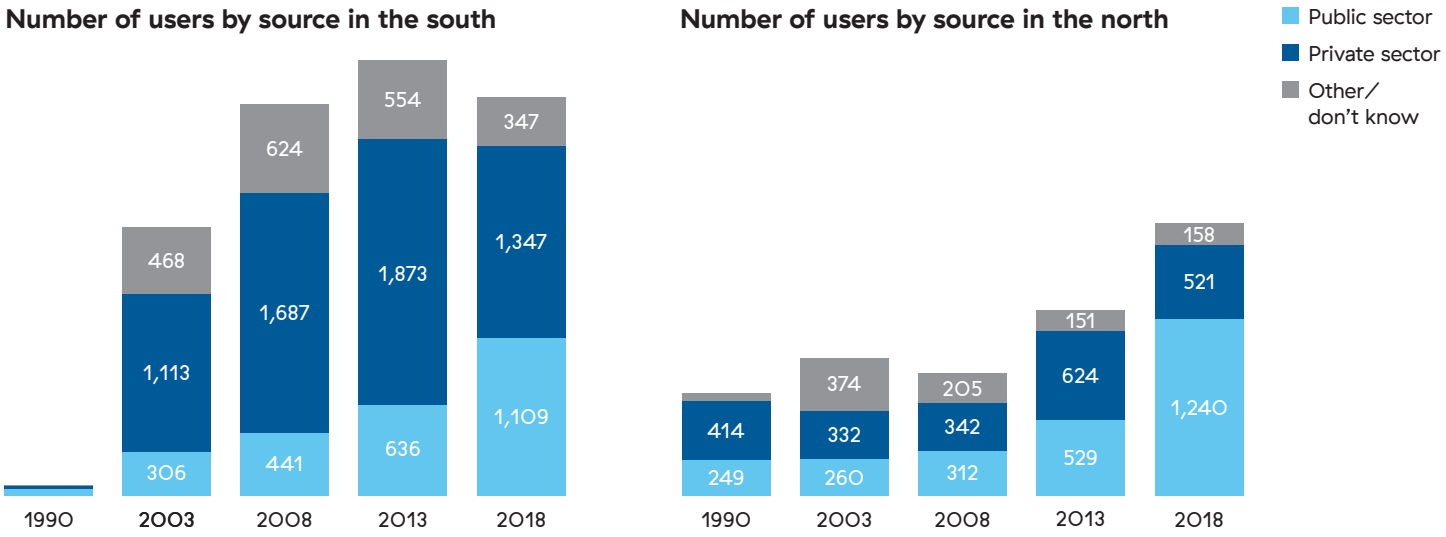
Figure 8. Regional trends in use of short- and long-acting methods



In line with the different method mix patterns across the two regions, the private sector's role in the market varied as well (Figure 9). With a heavier reliance on SAMs, private sources tend to dominate in the south. With much lower levels of use of SAMs in the north, the private sector serves a smaller proportion of users in the region. As expected, based on the method mix, the private sector also saw much larger increases in use in the south until 2013. After 2013, the decline in use of SAMs and increase in use of LARCs saw a shift toward public sector growth in the south. In the north, the number of users accessing family planning from the public sector has consistently increased since 1990, and the number of users accessing from private sources has fluctuated.

Figure 9. Trends in absolute number of users

In thousands, by source and region



All absolute numbers of users presented in this brief are derived from a secondary analysis of DHS data applied to United Nations Development Programme's World Population Prospects (2019 Revision) projections.

Factors explaining trends in family planning provision

The private sector has historically played an active role in Nigeria's family planning market and while it has helped increase use in specific methods and geographic areas, overall mCPR has remained low. SHOPS Plus shared these trends with local family planning experts and conducted in-depth interviews to understand the underlying economic, sociocultural, policy, and programmatic factors that influenced these trends. The interviews surfaced several insights into factors that shaped the family planning market during this time.

Demand challenges in both sectors

Demand for family planning has remained relatively low in Nigeria, especially in the northern parts of the country. While there are many factors that contribute to this trend, stakeholders highlighted two as especially relevant for the private sector.

First, there is limited political and policy support from the government. Without strong government support, significant investments have not been made to change norms and behaviors that currently limit uptake of modern family planning methods and to reduce child mortality as an underlying factor of higher levels of desired fertility.

Second, even in the south where demand is higher, the family planning market in Nigeria is very price sensitive. Despite growing income and ability to pay, Nigeria is one of the most price-sensitive markets in the region. Market research reveals that Nigerian consumers prioritize price over other access and quality factors in determining their purchases (Fiorini et al. 2013). As a result, there is a limited price range in which family planning products can be sold, disincentivizing new private commercial actors from making investments needed to enter the market.

Facilitating factors for the private sector in the south

The private sector was able to facilitate increased mCPR in the south for many years due to three main factors:

- **Increased demand**: While desired fertility remained high in the north, the average number of desired children has continuously declined in

the south between 1990 and 2018. This decline has helped drive an increase in the demand for modern family planning methods and helped expand the market until 2013.

- **Existing infrastructure**: The private sector is heavily concentrated in the south, with a robust set of drug shops and private clinics. Southern states have five times as many private clinics and twice as many community pharmacies and PPMVs per capita as northern states (Makinde et al. 2018). This widespread private sector footprint helped private actors rapidly scale up supply and meet the growing demand for family planning.
- **Supportive donor investments**: In the 1990s and 2000s, donors invested heavily in social marketing programs and broader private sector approaches. While these investments were national in scope, the private sector's stronger presence in the south translated into more rapid progress than the north. Organizations like the Society for Family Health were able to leverage these investments to increase their distribution of SAMs, especially in PPMVs and community pharmacies.

Premature transition to the private market

While supportive factors helped the private sector to increase mCPR in the south, these factors were not widespread enough to benefit the entire country. Additionally, while the private sector has always had limited infrastructure in the northern states, security challenges in recent years have further weakened its presence, thereby further limiting the effectiveness of private sector approaches. Countries where the private sector contributions to mCPR have grown have attempted to overcome limitations in countrywide or subnational gaps in private sector infrastructure. Strategies that these countries have employed include formalizing and supporting growth of previously informal private health care providers (e.g., accredited drug shops), or implementing alternate models such as community-based distribution. Nigeria has not implemented these options to address infrastructure gaps in the northern states. As a result of the continued lower levels of uptake of modern contraceptives in the north and the lower proportion of women and families being able to meet their reproductive intentions, donors have shifted their investments in three ways:

- **Geographic shift** that pulled resources from southern states to increase investments in northern states to try to address the greater needs there
- **Strategic shift** by donors from leveraging the private sector to strengthening the public sector to better align with available resources in the north
- **Method shift** from SAMs, which are more prevalent in the private sector, to LARCs

These shifts resulted in a decline of donor support for the private sector, which proved to be premature for the market to continue operating at its existing levels of both volume and value. Organizations like Society for Family Health that have historically dominated provision of SAMs have received less support from external donors to subsidize product social marketing. This decline in funding has contributed to some commodity disruptions, reduced investments in demand generation, and forced social marketing organizations to adopt higher prices, which present challenges to continued growth in such a price-sensitive market. With the shift in focus toward LARCs, there has not been a committed, sustained effort to include private clinics. While public-private partnership mechanisms exist that could distribute subsidized LARCs through private clinics, they are weak and scarcely used. Without donor financial support or significant government political and budgetary support to scale up and strengthen these mechanisms, private provision of LARCs is difficult to maintain. LARCs tend to be more expensive than the SAMs that the private sector currently provides. In price-sensitive markets like Nigeria, this extra cost can impose strict limits on demand. It can also impose a narrow price range that providers can charge for these services, thereby limiting their profit and thus their financial incentives to invest in the service. Donor subsidies can help lower the price and make the service more profitable. With the shift in geographic emphasis and the transition to public sector-focused intervention, these subsidies were reported to have been largely pulled from the marketplace before a sustainable private market for LARCs could emerge.

Conclusion

Examining the family planning landscape in Nigeria helps to understand why the private sector did not generate the significant increases in mCPR that other countries in this series saw. Time was a key factor. As a Stage 1 country, mCPR is expected to be slow and occur over a long period as demand builds to take the country to Stage 2. However, investments in demand creation and behavior change have not been significant or sustained enough to help the country move forward, especially in the northern region where desired family sizes remain high. In many countries where demand has increased, government and donor investments in sustained, large-scale community-based campaigns have been crucial components. Similar models have not been implemented at scale in Nigeria. Time has also limited the effect of private sector donor investments. In countries where the private sector has significantly contributed to mCPR growth, these investments have started in Stage 1, continued throughout Stage 2, and even into Stage 3. By decreasing these investments while Nigeria is still in Stage 1, private sector solutions have not been able to sustainably take root. In addition, private sector programming in Nigeria has not explicitly recognized private infrastructure gaps and aimed to address or circumvent them. And finally, the Nigeria case illustrates the need to look beyond just economic indicators as a marker for private sector potential. While per capita income has increased in the country—similar to many of the other countries in this series—willingness to use those financial resources for family planning has not grown commensurately. The continued price sensitivity of the Nigerian market speaks to the limited value that men and women continue to place on family planning and the need for increased investments in behavior change communication.

As stakeholders consider how to jump-start growth and finally move the country out of Stage 1, they need to consider what investments are best aligned with increasing demand and providing relevant services. Given that there are two drastically different markets in Nigeria's northern and the southern regions and further differences within these regions, these investments will need to be tailored to the subnational region. In the northern states, with their low demand and low private sector infrastructure, stakeholders should focus on sustained social behavior change communication campaigns to build normative support for family planning. As demand increases, donors and governments should focus on strengthening the existing public sector infrastructure in the region to offer quality family planning products and services to meet it. To address the low uptake of SAMs and limited private sector infrastructure in this region, blended financing models that support community-based distribution of these methods can be considered.

In areas with higher family planning demand and a strong private sector presence, donor and government investments should focus on sustaining improvements in physical and financial access to private sector sources. This includes strengthening the private sector supply chain for SAMs to mitigate supply chain disruptions for social marketing organizations and to fully leverage the potential of PPMVs to provide family planning products, counseling, and referrals for clinical methods. It also includes more strategic and significant engagement with private clinical outlets. To date, the private sector's contributions have largely come from products sold at retail outlets. As the market shifts to provider-dependent methods (i.e., injectables and LARCs), private clinics should be leveraged as a key influencer in supply and demand. Given the high levels of price elasticity, though, significant attention will need to be paid to financial barriers to access. Stakeholders should learn from successful models employed by countries like Kenya to train private providers, distribute free commodities, and build demand through private clinicians. With these differentiated approaches to increasing mCPR, Nigeria has the potential to reverse recent declines and accelerate growth in a more equitable manner going forward.

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