Sources of Family Planning

Nigeria

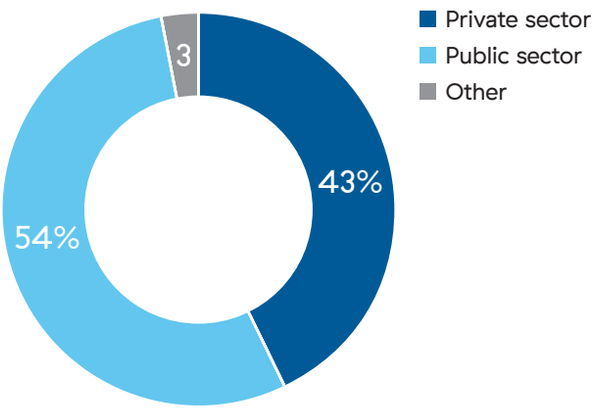
Photo: KC Nwakalor

Understanding where women obtain their family planning methods can help programs to better target their resources and increase overall access to modern contraception. This brief is one in a series of country briefs that examines where women obtain modern contraception by method, geography, marital status, age, and socioeconomic status. Through a secondary analysis of the 2018 Nigeria Demographic and Health Survey, the brief explains where modern contraceptive users obtain their method and examines the contribution of the private sector to family planning in Nigeria.

Key Findings

- Four in ten modern contraceptive users rely on the private sector for their method (43%), a decrease from 61% in 2013.
- Over the last five years, public sector use has increased among women using implants (from 65 to 93%).
- The private sector is the primary source for condom (87%) and pill (67%) users.
- More than three-fourths of unmarried users and 80% of adolescent users obtain their method from the private sector.
- Nigeria's modern contraceptive prevalence rate among all women has remained unchanged over the last five years at 10%, with large inequities in use by socioeconomic status and geography.

Source of modern contraceptives in Nigeria



This is one in a series of briefs that examines sources of family planning methods in USAID priority countries. View the data at PrivateSectorCounts.org.

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Modern contraceptive prevalence rate and method mix

Among all women of reproductive age in Nigeria, just one in ten use modern contraception. Among married women, the modern contraceptive prevalence rate (mCPR) is 12 percent. This brief focuses on all women, married and unmarried, to accurately portray contraceptive sources among all users. Nigeria's mCPR did not change substantially from 2013 to 2018 (from 10.4 to 9.6 percent).

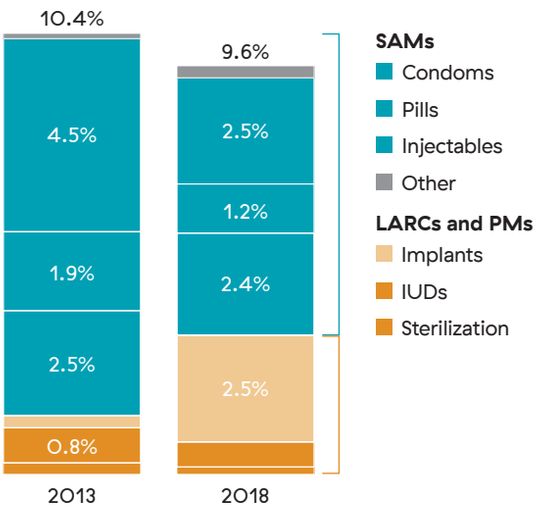
The largest change has been an increase in the use of long-acting reversible contraceptives and permanent methods (LARCs and PMs, from 1.4 to 3.3 percent), specifically implants, from 0.3 to 2.5 percent. There was a corresponding decrease in the use of short-acting methods (SAMs, from 9 to 6.4 percent).[1]

Sources for family planning methods

The public sector has become the primary source of modern contraceptives in Nigeria (54 percent), a substantial change from 2013 when just 29 percent of users obtained their method from the public sector. Forty-three percent of modern contraceptive users now go to the private sector, down from 61 percent in 2013. Less than 3 percent of users go to other sources, a decrease from 10 percent in 2013.[2]

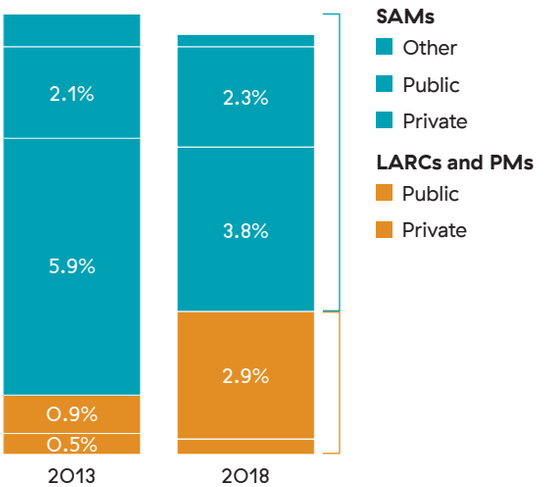
The shift in sources is largely but not entirely due to method mix changes, primarily a shift toward implants, now the second most common method behind condoms. Implants are almost exclusively sourced from the public sector (93 percent), an increase from 65 percent in 2013. The prevalence of injectable use remained stable, but the source mix changed substantially: in 2013, 40 percent of injectable users obtained their method from private sources; in 2018, this dropped to 23 percent. The private sector is still the dominant source for pill and condom users—methods that now have decreased prominence in Nigeria's method mix. The majority of condom users (87 percent) and pill users (67 percent) obtain their method from the private sector.

Nigeria's modern contraceptive prevalence rate has not changed substantially since 2013



Percent of women using each method

The private sector is the primary source for SAMs in Nigeria



Percent of women using SAMs or LARCs and PMs by source

[1] SAMs include injectables, contraceptive pills, male condoms, female condoms, emergency contraception, and fertility awareness methods. LARCs and PMs include IUDs, implants, and female sterilization. The lactational amenorrhea method and "other modern" methods are excluded from this analysis, as the Demographic and Health Survey does not systematically ask women about sources for these methods. This analysis shows which methods women use. It does not reflect which methods women might choose if they had access to all methods.

[2] Public sector sources include hospitals, health centers, family planning clinics, mobile clinics, and field workers. Private sector sources include hospitals, clinics, and doctors; NGOs including mobile clinics, field workers, and churches; and pharmacies, chemists, patent medicine sellers, and shops. Other sources include friends and relatives. This analysis shows where women obtained their most recent method. It does not reflect where women might choose to go if they had access to all sources of care.

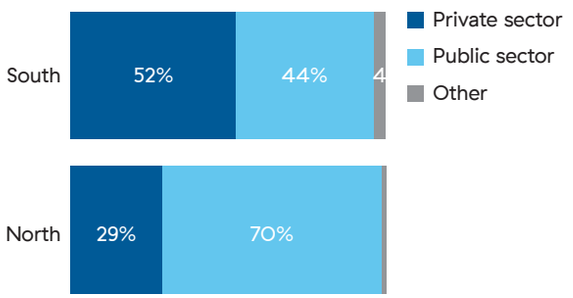
Private sector sources

Among women using contraception from private sources, 83 percent go to pharmacies, patent and proprietary medicine vendors (PPMVs), or shops. Another 15 percent go to hospitals or clinics, and 2 percent go to NGOs. Nearly all private sector condom and pill users (both 92 percent) obtain their method from a pharmacy or PPMV, and the majority use brands promoted through social marketing.

Contraceptive source by geography

The mCPR is higher in urban (16 percent) than in rural (7 percent) areas. Nevertheless, urban and rural contraceptive users are almost equally likely to obtain their method from the private sector (44 and 40 percent). The mCPR and contraceptive source vary substantially between northern and southern Nigeria. Women who live in the south are twice as likely to use modern contraception (14 percent) as those in the north (7 percent). Women who use contraception in the south are also more likely to go to the private sector than those in the north (52 versus 29 percent).

Private sector use is higher in southern than northern Nigeria



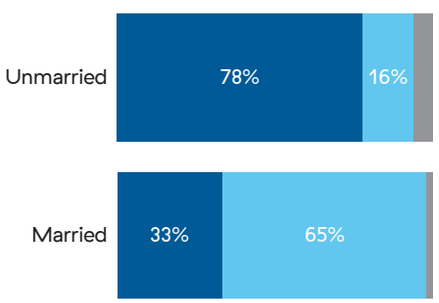
Percent of users in each group who obtain modern contraception from each source

Contraceptive source by marital status and age

Unmarried contraceptive users are far more likely than married users to go to private sources (78 versus 33 percent). This is related to differences in the method mix: condoms are the dominant method among unmarried users (67 percent of their method mix), whereas implants are the most common method among married users (31 percent), followed by injectables (30 percent).

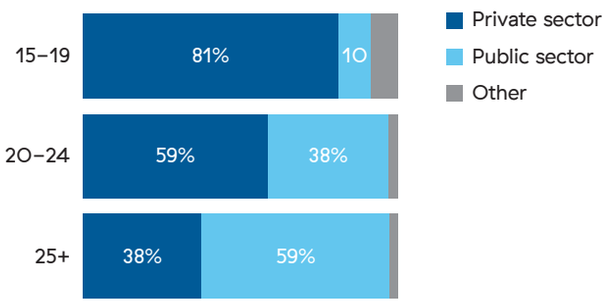
Similarly, there is substantially higher private sector use among adolescent contraceptive users age 15 to 19 (81 percent), decreasing slightly among women age 20 to 24 (59 percent), and lowest among users 25 and older, when the majority of women are married (38 percent). The method mix also varies by age. Condoms are the most popular method among adolescents while implants are the most popular method among users 25 and older. Injectables, a method more commonly sought from public sources in Nigeria, are more popular among users 25 and older (27 percent) compared with those age 20 to 24 (20 percent) or 15 to 19 (7 percent).

More than three-fourths of unmarried users go to private sources



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

Private sector use is highest among youth



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

Contraceptive source by socioeconomic status

The mCPR is more than three times higher among Nigeria's wealthiest than poorest[3] women (14 versus 4 percent). Among the poorest users, one-third obtain their method from private sources, primarily for SAMs. Two-thirds use public sources and obtain SAMs and LARCs in approximately equal shares. Half of the wealthiest users obtain their method from the private sector, almost exclusively for SAMs. The other half use the public sector to obtain LARCs (59 percent) as well as SAMs (41 percent).

Nearly 3 in 10 of the poorest contraceptive users go to the private sector

Half of the wealthiest contraceptive users go to public sources for both SAMs and LARCs

Implications

Nigeria's low mCPR has not substantially changed in the past five years and is driven largely by the use of SAMs, although implants are an increasingly popular method. Almost all implant and IUD users, and most injectable users, now obtain their method from public sources. The private sector share of the contraceptive market has decreased since 2013, though it continues to be the dominant source for condom and pill users. Potential reasons for this shift include the public sector's successful donor-supported implementation of the task shifting and task sharing policy that allows community health extension workers to provide injectables, implants, and IUDs, increasing women's access to a wider range of methods at primary health care facilities (Federal Ministry of Health 2014), while social marketing organizations have focused more on cost recovery (Purdy 2020). None of these shifts have increased the mCPR.

Nigeria's private sector is well positioned to increase contraceptive access and choice given the high use of the private sector among youth, Nigeria's largest population group, and the government's commitment to increasing access to family planning among youth (Federal Ministry of Health 2020). The government's updated strategic outcomes also include expanding the task shifting and task sharing policy to private providers, including pharmacies and PPMVs, updating regulations on private sector contraceptive provision, and improving mechanisms for private sector data reporting. These efforts, along with the government's intention to develop a private sector engagement strategic plan to increase domestic investment for family planning, could increase sustainability while strengthening the knowledge and skills of private providers to administer quality family planning services and increasing the availability of affordable products. This will expand women's access and choice and help Nigeria meet its voluntary family planning goals.

References

Federal Ministry of Health. 2014. "Task-Shifting and Task-Sharing Policy for Essential Health Care Services in Nigeria."

———. 2020. "Nigeria Family Planning Blueprint 2020—2024."

Purdy, C. 2020. "How One Social Marketing Organization Is Transitioning from Charity to Social Enterprise." *Social Marketing Quarterly*, 26 (2), 71—79.

[3] The poorest women are those in the lowest two wealth quintiles as defined by the Demographic and Health Survey's asset-based wealth index. The wealthiest women are those in the top two wealth quintiles.

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Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a fi e-year cooperative agreement (AID-OAA-A-15-00067) funded by the United States Agency for International Development. The project strategically engages the private sector to improve health outcomes in family planning, HIV, maternal and child health, and other health areas. Abt Associates implements SHOPS Plus in collaboration with the American College of Nurse-Midwives, Avenir Health, Broad Branch Associates, Banyan Global, Insight Health Advisors, Iris Group, Population Services International, and the William Davidson Institute at the University of Michigan. This brief is made possible by the support of the American people through USAID. The contents are the sole responsibility of Abt Associates and do not necessarily reflec the views of USAID or the United States government.

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