

**REPRODUCTIVE INTENTIONS AND ABILITY TO UPTAKE MODERN
CONTRACEPTIVE METHODS AMONG URBAN POOR WOMEN OF
REPRODUCTIVE AGE IN NIGERIA**

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REPRODUCTIVE INTENTIONS AND ABILITY TO UPTAKE MODERN CONTRACEPTIVE METHODS AMONG URBAN POOR WOMEN OF REPRODUCTIVE AGE IN NIGERIA.

A thesis submitted in partial fulfilment of the requirement for the degree of Master of Public Health

By

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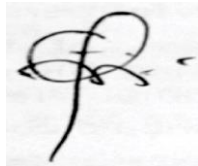
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The thesis **Reproductive Intentions and Ability to Uptake Modern Contraceptive Methods among Urban Poor Women of Reproductive Age in Nigeria** is my work.

Signature:



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Glossary

Unmet Needs for Contraceptive: Unmet need for family planning is defined as fecund women who are not using contraception but who wish to postpone their next birth (spacing) or stop childbearing altogether (limiting)(1).

Contraceptive Prevalence: Contraceptive prevalence is the percentage of women who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method used. It is usually reported for married or in-union women aged 15 to 49(2).

Family Planning: Family planning refers to a conscious effort by a couple to limit or space the number of children they want to have through the use of contraceptive methods (1).

Modern Methods: Female and male sterilization, the pill, injectables, intrauterine devices (IUDs), male and female condoms, implants and other modern methods (1).

Reproductive Intention: This refers to individuals personal attitude towards reproduction, i.e. does she want to have another child soon, does she wish to postpone the next birth for some time or does she want no more children at all (3)

Rumours, Myths and Misconceptions: about modern methods, such as exaggerated or erroneous reports about side effects, misconceptions about short- or long-term health problems and negative stereotypes about persons who practice family planning (4).

Unintended Pregnancy: Unintended pregnancies consist of unplanned births, induced abortions, and miscarriages resulting from unintended pregnancies (5).

Urban Poor: A slum household consists of one or a group of individuals living under the same roof in an urban area, lacking one or more of the following five amenities: (1) durable housing (a permanent structure providing protection from extreme climatic conditions); (2) sufficient living area (no more than three people sharing a room); (3) access to improved water (water that is sufficient, affordable and can be obtained without extreme effort); (4) access to improved sanitation facilities (a private toilet, or a public one shared with a reasonable number of people); and (5) secure tenure (*de facto* or *de jure* secure tenure status and protection against forced eviction)(6).

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CPR	Contraceptive Prevalence Rate
DFID	Department for International Development
DHS	Demography Health Survey
DMPA	Depo Medroxyprogesterone Acetate
ECP	Emergency Contraceptives
FBOs	Faith Based Organizations
FCT	Federal Capital Territory
FGON	Federal Government of Nigeria
FMOH	Federal Ministry of Health
FP	Family Planning
FP2020	Family Planning 2020
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Counselling
IUDs	Intra Uterine Contraceptive Devices
LARC	Long Acting Reversible Contraceptives
LGAs	Local Government Areas
LMICs	Low Middle Income Countries
MCH	Maternal and Child Health
NARHS	National AIDS and Reproductive Health Survey
NDHS	National Demographic Health Survey
NHIS	National Health Insurance Scheme
NURHI	Nigerian Urban Reproductive Health Initiative
OCPs	Oral Contraceptive Pills
OPP	Out of Pocket Payment
PHCs	Primary Health Centres
PPMVs	Private Patent Medicine Vendors
RH	Reproductive Health
SDGS	Sustainable Development Goals
SDPs	Service Delivery Points
SMOH	State Ministry of Health
SRH	Sexual Reproductive Health
SSA	Sub-Sahara Africa
STIS	Sexually Transmitted Infections
TFR	Total Fertility Rate
THE	Total Health Expenditures
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	Women within Reproductive Age (15-49 years)

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Abstract

Despite series of investments in FP programs, Nigeria is yet to make any significant progress when compared to some SSA countries. The modern CPR remains low at 10% while unmet need for contraceptives is 16%. An average woman in Nigeria is expected to have at least 5.5 children in her lifetime. Nigeria contribute significantly to rapid urbanization in West Africa and sub-Sahara Africa. Rapid urbanization in Nigeria has been linked to natural population growth. A large number of urban births are either unplanned or unwanted. Recent evidence also revealed inequalities exist among the poor and rich in urban settings, as the urban poor are more vulnerable and neglected sometimes more than rural women. To effectively address this, there is need to explore why urban women especially the urban poor are not using modern methods despite high need.

This thesis reviewed relevant and peer reviewed articles systematically adapting the Levesque et al conceptual framework to explore the demand and supply side determinants, i.e., "paired dimensions" of reproductive intentions and modern contraceptive uptake in Nigerian urban poor settings.

Findings confirmed that high level of awareness on modern methods, different types and benefits of FP has not translated to increase in use among urban poor. Factors driving use include myths and misconceptions, fear of side effects, sociocultural factors, poverty, social boundaries of living environment, provider bias, poor response from the public health system and high informal sector patronage. Effective interventions include SRH policies and political commitment, strengthened public-private partnership, community engagement, community service provision and improving the quality of FP counselling.

To increase uptake of modern methods among urban Nigerian women especially the poor, recommendations include SRH policies and political/stakeholder's commitment, effective demand generation activities, community service provision and meaningful private sector engagement, further research and improving the quality of FP counselling. These recommendations are evidenced based and are crucial for Nigeria to achieve her target of 36% CPR increase in 2018, contribute her quota in achieving FP2020, demographic dividends and SDGs by 2030.

Key words: Reproductive intentions, Utilization, modern contraceptives, women of reproductive age, urban poor, Nigeria.

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Introduction

Globally, approximately 200 million girls and women lack access to contraceptives and voluntary family planning (FP) services, majority of who are in the poorest countries. Less than 20% of women within reproductive age (WRA) (15-49 years) in sub-Saharan Africa (SSA) are using modern contraceptives. About 89 million women will have unintended pregnancy in 2017 out of which 84 million will be caused by unmet need for modern contraceptives. At least 1 out of 4 unintended pregnancies end in an unsafe abortion (7-9). The implication is that, girls and women are at risk of death or disability during pregnancy, childbirth or unsafe abortion especially in the face of poor quality care (8).

In many low and middle income countries (LMICs), Nigeria inclusive, majority of the girls and women are not able to afford sexual reproductive (SRH) services and supplies, available services are not appropriate thus their needs are not met and majority lack adequate information about contraception. In addition to these, male partners and communities are not fully equipped with the required information to support the rights of girls and women to choose when and what method to use. If these barriers remains without being adequately addressed, women and children's health and survival are at risk while communities and nations might not likely achieve demographic dividends (7,10,11).

Without significant and sustainable progress in FP, achieving the target of sustainable development goals (SDGs) which is guiding global development agenda till 2030 might not be feasible. SDGs are set of development paradigm to ensure no one is left behind (12). Achieving the FP2020 goal of increasing modern contraceptive access to additional 120million girls and women is crucial to meeting the SDGs 3 and 5 (13), but also vital to the remaining 15 goals as FP is essential in speeding up progress in all aspects of development (14).

I am a professional nurse/midwife who until I came to KIT has been involved in various FP program/projects in two major urban settings (Ibadan and Lagos) South West, Nigeria. Service delivery has been my focus and recently before KIT, I was the quality improvement system strengthening officer (QISSO) for Nigerian Urban Reproductive Health Initiative (NURHI), a project sponsored by Bill and Melinda Gates Foundation, where I was coordinating activities to improve the quality of family planning (FP) services provided in Lagos through training, monitoring, supportive supervision, on the job training for skilled and unskilled service providers in the public and private sectors.

As a public health professional, I have witnessed the inequalities that exists in urban settings. Despite the high level of awareness on modern methods and contraceptive needs among women in urban settings. Majority of the women I met confirmed the need to limit family size or delay pregnancy especially in Lagos slums because of the cost of living, cost of education, the fact that most of their male partners or husband hardly make a significant contribution to run the home and they want their children to live the kind of life lived by Lagosians in the highbrow areas. Despite the reasons provided by women during FP outreaches, the uptake of modern method remains poor. This serves as the basis for my thesis topic.

In the urban Nigerian setting, women have various reproductive intentions which include either to postpone or limit childbirth. So many factors are responsible for their decision. For women who are not ready to be pregnant, what steps or actions are they taking to ensure they are not pregnant? What factors (demand and supply sides) in the settings where they have found themselves are influencing their decision to use modern contraceptives? Are these women aware of where to source for modern methods, do they have sufficient information to make an informed choice, are the services readily available and are service providers at each level able to help women use a method of choice? This thesis is set to explore factors influencing the ability to use modern contraceptives in response to my question "why are women not using modern contraceptives despite the high level of awareness and need" and what evidence based interventions can be applied in the urban poor settings to increase modern contraceptive use?

CHAPTER 1: BACKGROUND INFORMATION ON NIGERIA

This chapter describes the background information about the Nigeria.

1.1 Geographical and Governance Profile

The Federal Republic of Nigeria is a West African country divided into 6 geopolitical zones¹. Nigeria has 36 states and Abuja is the Federal Capital Territory. Each state is divided into 774 constitutionally recognised local government areas (LGAs) (1). State governments are led by governors who strongly influence budgets, wield significant political power and control 50% of all government revenue. As a result, the implementation of many health policies, including family planning, benefits significantly from the support of state governors while the local government council is led by a chairman (the chief executive) and councillors (15).

1.2 Demographic Profile

Table 1 Demographic profile of Nigeria at a glance (16–19)

7 th most populous nation in the world with an estimated current population of 190,886 million
Year 2030 - 264,068 million
Year 2050 - 410,638 million (third most populous nation by 2050 after China and India)
Most populous African and indigenous black nation in the world
Makes up 47% of West African population
Nigeria is a predominantly young population with one of the largest youth population in the world
49% of the population are urban dwellers while 51% lives in the rural areas

Nigeria is a multi-ethnic, religious and culturally diverse society with the Hausa, Yoruba, and Igbo as the major groups. These diversities influence the experiences and outcomes of women and girls throughout their lifecycle in Nigeria (1,20).

The Nigerian society is largely patriarchal with men in control of decision making in all spheres of life. Despite the existence of some powerful female entrepreneurs, unequal economic power exist between men and women. The societal structure relegates majority of women to certain gender roles and restrict access to cash and properties, and decision making (20).

1.3 Socio-Economic Situation

Despite her petroleum wealth, Nigeria is classified as a lower middle income country, has a poverty rate of 62.2%, life expectancy at birth is 52.3 years, human development index is poor at 0.47 and per capital income is 1280 USD. More than half of the population lives on less than 1.90USD per day. Poverty in Nigeria is fuelled by corruption and violence in the oil-producing region in the Niger Delta and the Boko Haram sect in North East Nigeria (21). Economic growth in Nigeria has not been equitable. About 54% lives below poverty line: 43% in urban cities and 64% in rural areas. 90% of the poorest lives in northern Nigeria. Northerners and Nigerians from the poorest wealth quintile are consistently deprived of social services. Food insecurity in the urban cities is 27% and 44% in the rural areas (22).

1.4 Health System

From a reproductive health perspective, the Federal Government is charged with developing policies, strategies, guidelines, and plans that provide direction for the Nigerian

¹ 6 geopolitical zones- north central, north east, north west, south east, south south, and south west.

healthcare system. However, implementation of these guidelines ultimately falls on the State Ministry of Health (SMOH). Each SMOH is responsible for health programme direction and coordination in its state. The State Ministry of Local Government (SMOLG) is responsible for hiring, managing, and paying health workers at the primary healthcare level (as part of the civil service). Each state has a FP coordinator who helps facilitate commodity ordering and transportation as well as advocacy. LGAs ultimately are responsible for managing and implementing the primary healthcare system, which is the most extensive channel for healthcare in the country. Ward development committees and other community groups often support their primary healthcare centres (PHCs). As a result, there are disparities in the way PHCs are funded, staffed, and stocked across the country (15).

Healthcare system in Nigeria is structured into three tiers; primary, secondary and tertiary. (23). Health services are provided by the public and private providers, although the government does not have a complete and accurate database for private providers. Nigeria's health sector is characterised by wide regional disparities in status, service delivery, and resource availability. Majority (88%) of public sector health care is provided by primary health care and an average of 22 health facilities per 100,000 population. The private sector plays a crucial role in health care delivery in Nigeria. It meets the health needs of 65% of the total population and 72% for the poorest Nigerians. The private sector includes pharmacies, private patent medicine vendors (Chemist), drug shops and private clinics (1,23).

Universal Health Coverage (UHC) through national health insurance system (NHIS) has been ineffective since it was launched in 1999. 2% of women age 15-49 years are covered. Coverage is employer-based and higher among the educated, wealthy and Nigerians living in urban settings in the South-West, South-South and North-Central (1). Health care allocation in 2014 budget is 3.7% compared with the agreed 15% allocation for health spending in the annual budget as agreed by African presidents during the 2001 Abuja declaration (24).

1.5 Overview of Sexual Reproductive Health and Family Planning in Nigeria

Maternal mortality and pregnancy related deaths remains important indicators for women related and development programs globally (25). Maternal mortality ratio of 576 per 100,000 live births in Nigeria is one of the highest in the world far below the SDG target of 70. Wide health variations exist among the poor and rich (1,26). The leading causes and drivers of preventable maternal deaths are postpartum haemorrhage, eclampsia, sepsis, obstructed labour and complications from unsafe abortion(27).

The country has the 3rd highest burden of HIV globally at a prevalence of 3.4% (28).The rural areas have a prevalence of 3.6% while the urban has 3.2%. Prevalence is driven by wealth, education, age, marital status and transactional sex. 80% of Nigerians are aware of the dual protection from male condom. Female condom in Nigeria remains unpopular. Despite the percentage of interest in screening for HIV (male-77%, female-78%), only a quarter reported screened (1,26).

Nigeria is yet to record a significant improvement in modern contraceptive uptake despite various programs in family planning (28–30). Women in Nigeria are expected to have at least 5.5 children at the end of their reproductive years with variations across age, regions, place of residence and states (1,29). Total fertility rate in urban settings is 4.7 while rural is 6.2 (1).

Available modern methods in Nigeria are OCPs, injectables, IUDs, implants, male and female condoms, lactational amenorrhoea (LAM), male and female sterilization (1,26,31). Male condoms, injectables and pills are the most frequently used modern methods. LAM, IUDs, implants and sterilization are the least used methods. 5% of current users are on traditional methods (1,26). Social marketing is thought to have influenced increased male condom use(32). Users seek for services from both public and private health facilities,

though the private health facilities² provides 59.9% of services while the public sector provides 28.9%³ (15).

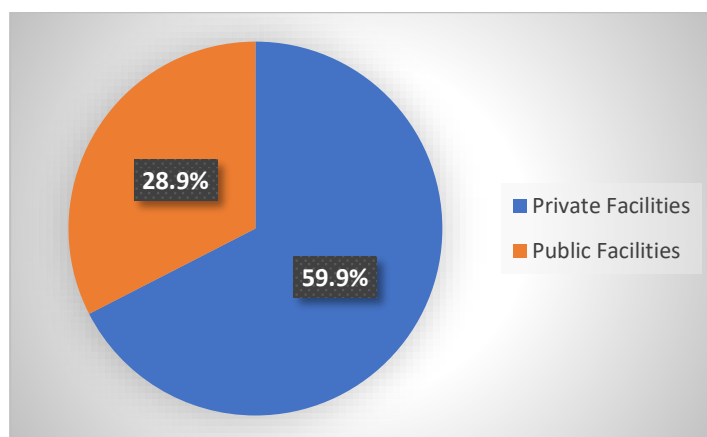


Figure 1 Sources of modern contraceptives in Nigeria

Although the Nigerian government has made improvement to ensure commodity security with the assistance of UNFPA, USAID and DFID through the Last Mile distribution programme, a lot needs to be done as gaps still exists in the facilities in terms of aligning, forecasting, procurement and distribution of commodities to meet the contraceptive needs of Nigerians (15).

The Federal Government of Nigeria (FGON) in the past 30 years have adopted and implemented various policies and strategic plans⁴ to create a favourable and conducive environment for the delivery of and access to quality contraceptive services for all Nigerians (1,15,26). The ultimate goal of these policies and strategies is to facilitate a continuous improvement in the health status and quality of lives of Nigerians (1,15).

Table 2 Policies and Strategies on Contraceptive Services in Nigeria (1,15)

National Population Policy for Development
National Reproductive Health Policy and Strategic Plans
National Reproductive Health Commodity Security Strategic Plans
National Guidelines on Contraceptive Logistics Management System
Midwife Service Scheme (MSS)
Free contraceptives and life-saving maternal/RH commodities
Accelerated implementation of activities around the long-acting reversible contraceptive (LARC) methods
Task shifting with appropriate supervision of the community health extension workers
Creation of budget lines and increased funding for key activities such as the procurement and distribution of required RH commodities
Increasing collaboration with the private health sector in health care delivery
The Nigeria Family Planning Blueprint (Scale-Up Plan)

1.6 Urban Reproductive Health

Nigeria is a country with many cities⁵ at various stages of urbanization (33). As countries experience urbanization due to socio-economic changes, people opt out of the agriculture

² Proprietary patent medicine vendors (PPMVs), informal drug sellers, pharmacies, and private clinics

³ See fig. I

⁴ Refer to Table II

⁵ Lagos, Abuja, Benin City, Ibadan, Kaduna, Kano, Onitsha, Port Harcourt

sector for the industry and service sectors thus new slums and informal settlements increase in the rapidly expanding cities. Many urban poor live on US\$1 per day and are faced continuously with challenges⁶ of living in the slums. In addition are diseases and health related challenges with its roots in violation of rights and poor political representation (34–37).

Nigeria has the 9th largest urban population in the world and most urban dwellers in Africa (1,38,39). 46.9% of the total population in Nigeria lives in urban cities while approximately half (50.2%) of urban dwellers lives in urban slums. Nigeria is one of the three countries (India and China) projected to account for 37% of the world urban population between 2014 and 2050 (40,41). With urbanization, issues like gender relations, women's participation in workforce and social structure are not static. This implies that there is a continuous need for shifts in evidence on reproductive health outcomes and needs in urban areas (36).

Urban maternal and new born mortality remain high in many LMICs, Nigeria inclusive. Inequalities exist in accessing quality maternal and child health (MCH) services in urban areas. Women with more wealth have better access to quality services than women with limited economic power, this can sometimes be poorer than what exist in the rural areas (42,43). Reproductive health outcomes in Nigeria varies with regional differences. 27.6% of currently married women in urban cities are using a modern method but regional data shows 21.6% in Northern Nigeria, 33.9% in Southern Nigeria and 36% in Abuja (44). This also applies to skilled birth attendance during delivery and institutional delivery in urban Nigeria. Access to finance and decision making ability by women are major determinants of utilization of reproductive health services and outcomes in urban Nigeria (44).

⁶ Challenges faced in slums includes poor living conditions, inadequate access to basic services, high transport cost, social isolation, insecurity, environmental hazards of various degrees, vulnerability to hunger and credit buying.

CHAPTER 2: METHODOLOGY

This chapter presents the problem statement with modern contraceptive uptake, justification, objectives (general and specific), search strategy, conceptual framework and study limitations.

2.1 Problem Statement

Evidence has shown a high level of knowledge on modern contraceptives among married men and women in Nigeria has not translated to increased uptake (1). A study conducted in Northern Nigeria including urban Kano revealed, high fertility is driven by factors such as having many children to prevent husbands from marrying another wife since the reason most of them gave for multiple wives was the desire for more children. The women believe with more children, the cost of providing for many children will prevent the husband from marrying another wife (45).

9.22 million pregnancies were reported in 2012 among married women age 15-49 in Nigeria. Although with variations across regions⁷, 59 pregnancies out of 1000 were unintended, 56% of the unintended pregnancies were terminated with the lowest recorded in the south west at 43% and the highest in the north west at 81% (46).

A study conducted in Nigeria estimated 33 induced abortions out of 1000 pregnancy among women in their reproductive age, this is irrespective of the restrictive laws on abortion in the country. Unsafe abortion was also reported to be high with 212,000 women treated for unsafe abortion complications in health facilities and 285,000 women who experienced issues that requires health intervention but did not seek for help (46). Unsafe abortion is one of the drivers of Nigeria's high maternal mortality rate (27). Women who intend to seek abortion services (safe and unsafe) face social stigma (46). The health system and women bear the financial consequences of an unsafe abortion (47).

On the average, urban dwellers are termed to be healthier with positive health outcomes than their rural counterparts, but with disaggregated variables, the vulnerable such as the poor urban are faced with significant health challenges (35,36,40,48). Though evidence shows contraceptive uptake is higher in urban settings than rural settings, recent reports has shown the urban poor have a lower uptake of contraceptives than the wealthy urban dwellers and in some cases the rural dwellers (48). For instance, maternal mortality ratio in two slums in Lagos, (Makoko Riverine and Badia East), was estimated to be 1,050 deaths per 100,000 live births which is twice the figure for urban Lagos at 545 per 100,000 livebirths while the risk of a woman dying as a result of pregnancy related issues was 1 out of 18 which is also twice for urban Lagos at 1 in 42 (49). A decline in total births in rural Nigeria and rapid increase in urban areas was reported with the widest gap in contraceptive use between the urban poor and the urban rich. Unintended pregnancies and high fertility rate are major drivers for rapid urbanization in Nigeria (48).

Low modern contraceptive uptake not only threaten the collective efforts of all partners involved in improving FP programmes in Nigeria, it also impair efforts to break the cycle of poverty and ensure sustainable development. The question is why fertile women, with information on modern methods, who do not want children, not using modern contraceptives and what evidence informed, cost effective interventions can increase utilization of modern methods among urban women especially the urban poor?

2.2 Justification

As part of the FGN commitment to reaching the FP2020 goal at the 2012 London FP summit, a target was set to increase the current CPR from 15% to 36% by 2018. This is projected to avert 400,000 infant deaths, 700,000 child deaths and 1.6 million unintended

⁷ Regions in Nigeria have distinct social determinants which influence outcomes for women. In addition, the proportions of women who live in urban areas and levels of female education are lower in northern zones than in southern ones. Compared with the other zones, the north west and north east zones have lower contraceptive prevalence and higher fertility.

pregnancies (15). Family planning benefits are not limited to positive health outcomes, it positively influence individuals and national social and economic outcomes (15,50).

75% of urban population growth in sub-Sahara Africa is confirmed to be caused by new births while 25% is due to rural-urban migration and other factors. Majority of pregnancies in urban centres are not planned and unwanted (43,51). This results into serious consequences for women and their families. One immediate consequence is induced abortion with majority unsafe with its own implications. For unmarried young women, they might stop schooling, face shame and stigma from the family or force to marry (52).

Although a substantial body of literature explores various issues surrounding contraceptives uptake in Nigeria and urban-rural disparities, only a limited explored urban reproductive health with disaggregated data on vulnerable sub-populations such as the urban poor, when compared to the publications available for urban reproductive health in Kenya slums (48,53).

There is need to explore the factors influencing the fertility intentions, choices, enablers, barriers and reproductive outcomes of urban dwellers in Nigeria. This provides a basis to meet the specific contraceptive needs of various sub populations in urban areas. It is also required for a thriving urban population and a better quality of life for the increasing urban dwellers in Nigeria (54).

2.3 Objective

2.3.1 General Objective

To explore the reproductive intentions and ability to uptake modern contraceptive methods among urban women of reproductive age (15-49) to inform the health system's response to their contraceptive needs.

2.3.2 Specific Objectives

- To explore the socioeconomic and cultural factors influencing the fertility decisions and uptake of modern contraceptives among women of reproductive age (15-49) in urban poor Nigeria.
- To explore the health system related factors contributing to the uptake of modern contraceptives among women of reproductive age in urban poor Nigeria.
- To identify evidenced informed interventions from sub-Sahara African countries to be applied to the Nigerian urban poor setting
- To propose feasible recommendations to improve the health system's response to the contraceptive needs of urban poor women in Nigeria.

2.4 Methodology

2.4.1 Study Design

To explore the fertility decisions and ability to uptake modern contraceptives among urban poor women in Nigeria, a review of peer-reviewed published literatures and grey articles was carried out.

2.4.2 Search Strategy⁸

I searched for literatures in various databases: PubMed biomedical literature, JSTOR, PLOS ONE, ScienceDirect, Cochrane, POPLINE, Research Gate, Biomed, Studies in family planning, VU online library and Wiley Online library and relevant grey literature from Federal Ministry of Health Nigeria (FMoH), Nigerian Urban Reproductive Health Initiative

⁸ Key words- utilization, modern contraceptives, women within reproductive age, urban poor, Nigeria

(NURHI), Urban Reproductive Health, Measurement, Learning and Evaluation (MLE), Knowledge for Health, UN-HABITAT, UNFPA, WHO and World Bank by screening titles, abstract, findings and discussions. The objective was to establish any scientific work in relation to the review. Search strategy is found in Annex 2.

Articles were identified during the initial search using key words, synonyms and a combination of words and screened based on the inclusion criteria. Articles that did not meet the inclusion criteria were removed from the list. The remaining articles were screened through the abstracts and findings, articles that did not meet the study criteria were also removed from the study data base at the second stage. At the end of the process, 103 articles were reviewed for the study. A similar process was conducted for the articles used in the study background and problem statement.

The reference list of the articles were snow balled and those found to meet the review criteria were utilized. National Demographic Health Survey (NDHS, 2013) and National AIDS and Reproductive Health Survey (NARHS, 2012) are used as major sources of national estimates.

Inclusion criteria are (1) retrievable, either as a full study or as an article in peer reviewed scientific journals; (2) contraceptives or family planning studies (3) women within reproductive age (15-49 years) (4) Urban/poor settings (5) Nigeria, Sub Sahara Africa, Low and Middle-Income Countries (LMICs) and Developing Countries. All articles are written in English. I used recent literature published from 2007-2017 except for few relevant document/articles

The review excluded studies among children, young adolescents (10-14 years), high income countries/developed countries, traditional methods and rural areas since this is not the focus the study.

2.4.3 Study Limitation

The thesis is a review of literature thus findings are limited to information from reviewed articles. One inclusion criteria is to review literatures written in English, thus the study does not contain information that might be relevant but not written in English. Because published and peer-reviewed literature on contraceptives and sub populations in urban poor settings in Nigeria are limited, I extended my search to include urban and sub urban settings in developing countries, sub-Saharan Africa (SSA) and low and middle income countries (LMICs). Urban Nigeria is similar to other contexts in terms of inequality between the rich and the poor while specific differences such as health system response to the urban poor exist. Studies from specific Nigerian urban settings were utilized, this might not be a true reflection of all urban settings across Nigeria and results might be over or under estimated.

I used a conceptual frame work on accessibility to care by Levesque et al which has a wide coverage of issues. Due to limited word count, a more detailed analysis of policies, national investment, health systems and other determinants which though were identified were not analysed because they are beyond the scope of this study.

2.4.4 Conceptual Framework.

I utilized Levesque et al framework⁹ on access to healthcare initially developed by Penchansky and Thomas in 1981 (55). Levesque built the framework with a comprehensive view from the individual, health system and contextual factors and incorporated the scopes of demand and supply sides. This allow variables to be defined within various contexts of access (56), describes the determinants of access to healthcare from the supply side

⁹ See Annex 1

(service providers, service delivery points and health systems) and demand side (individuals, households and communities) (56,57).

There are five dimensions of accessibility and ability to access healthcare by the target group (55–58). The dimensions work interdependently, a dimension on accessibility to health care is paired with a corresponding dimension on ability of the target population to access healthcare. This is referred to as 'paired dimensions' (56). The framework is validated and has been utilized to study access to care among vulnerable populations in peer-reviewed published article (56). It is a frame work of choice because it explores determinants influencing access from the point of identifying there is a health care need to the point of meeting such need (57).

2.4.5 Adapted Framework

I adapted the Levesque et al, 2013 framework (Fig II) on access to healthcare to conceptualize the interplay between the determinants influencing fertility decisions and uptake of modern methods in the context of an urban poor environment. Using the framework, the current situation of contraceptive uptake and fertility issues were discussed in the background and problem statement of the study. The determinants (supply and demand sides) were explored under each outcome as paired dimensions.

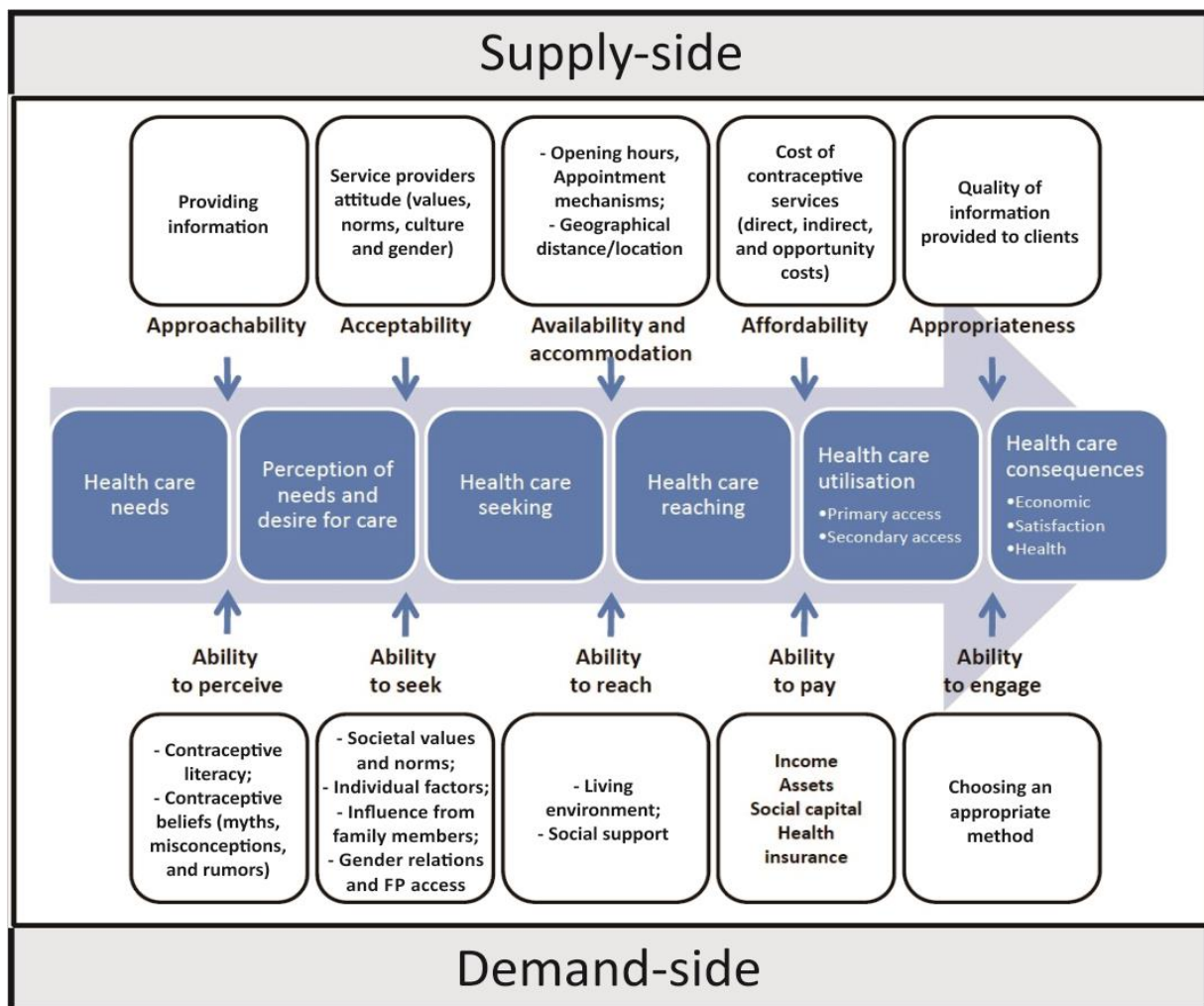


Figure 2 Adapted from Levesque et al 2013

CHAPTER 3: DETERMINANTS OF REPRODUCTIVE INTENTIONS AND UTILIZATION OF MODERN CONTRACEPTIVES.

This chapter explores some determinants influencing fertility decisions and utilization of modern methods from a supply and demand perspective based on the dimensions of the adapted Levesque framework. Fertility decisions and reproductive intentions are used interchangeably.

3.1 Perception of Contraceptive needs and desire for family planning services

3.1.1 Approachability.

Refers to being able to identify available FP services, service delivery points (SDPs) where they can be accessed and the benefits of utilizing available services by those with contraceptive needs (56,57).

- **Providing information on family planning services:**

For couples to decide freely and responsibly either to space or limit family size, information on contraceptive methods and how to access services is critical to make an informed decision (59).

A study conducted in Nkwanta district in Ghana indicate that women access information on FP basically through health workers followed by friends/family and radio while the least source of information is the newspaper. This is because health care services including FP services are brought to their door steps through a well distributed system called community based planning services (CBPS). FP messages are not received on regular basis through the radio because of poor reception in this particular district (60).

Unlike Ghana, various sources reported that radio is the main source of FP information for both women and men across Nigeria although variation exist based on level of education, wealth and place of residence (1,32,61,62). Adebayo et al and Okigbo et al in separate studies indicated that women in urban settings who heard about modern methods through the mass media¹⁰ use modern methods more than women who never had such exposure (32,61). Another study evaluating a project in urban settings reported that women who listened to NURHI programs aired on radio in local languages¹¹, those who recognized the puzzle logo and slogan called "Get It Together" on the television, at the health facilities, on posters, billboards, and umbrella are likely to use modern contraceptive methods than those who never had any of these exposure (62).

Aside information on FP, studies indicated that women who were provided information on where to source for their method of choice (where to buy, where to access for free, where outreaches are being held) reported increase utilization than those who do not have such information (32,62). For instance, methods that require to be inserted into the body and require more instructions (IUDs, Implants and injectables) are sourced for in the hospitals (private and public), while those with few instructions like condoms and pills are sourced from pharmacies and drug stores (15,31).

3.1.2 Ability to perceive.

This relates to factors that influences the clients to identify that they need FP services (56,57).

¹⁰ Exposure to FP information through the media(TV, radio, newspaper, flyers, billboards)

¹¹ Yoruba, Hausa and Bini

- **Awareness on Contraceptives**

Evidence from country surveys shows that lack of knowledge about family planning in developing countries have reduced substantially in the past two decades (63), though few women reported they are not using any modern method because they are not aware of specific method or do not understand what fertility means. This was reported more among women in African countries (Benin, Cameroon, Chad, Ethiopia, Madagascar, Mali and Mauritania) who cited poor awareness on specific method and what fertility entails as reasons for not using modern methods (63).

In the Nigeria context, various sources reported that the last decade has witnessed a gradual and consistent increase in knowledge about FP, though with variations in the different regions, socioeconomic status and level of education (1,26,64). Recent surveys indicated that men and women are well informed about modern contraceptives¹² (Fig 3) and the benefits of FP (1,26).

Different studies confirmed more awareness on modern methods than traditional methods. The male condom, pills and injections are the most popular modern methods while diaphragm, foam or jelly are barely known. The most popular traditional methods are withdrawal and rhythm methods. These studies also indicated that unmarried, sexually active women are more knowledgeable than their married counterparts. Contraceptive awareness is driven by factors such as level of formal education, age, place of residence, region and socioeconomic status (1,26,64,65).

Aransiola et al added that women who participated in FGDs in 2 urban slums indicated that FP helps to space childbirth, improve family’s financial conditions, protect the health of the woman and help women in career development (28).

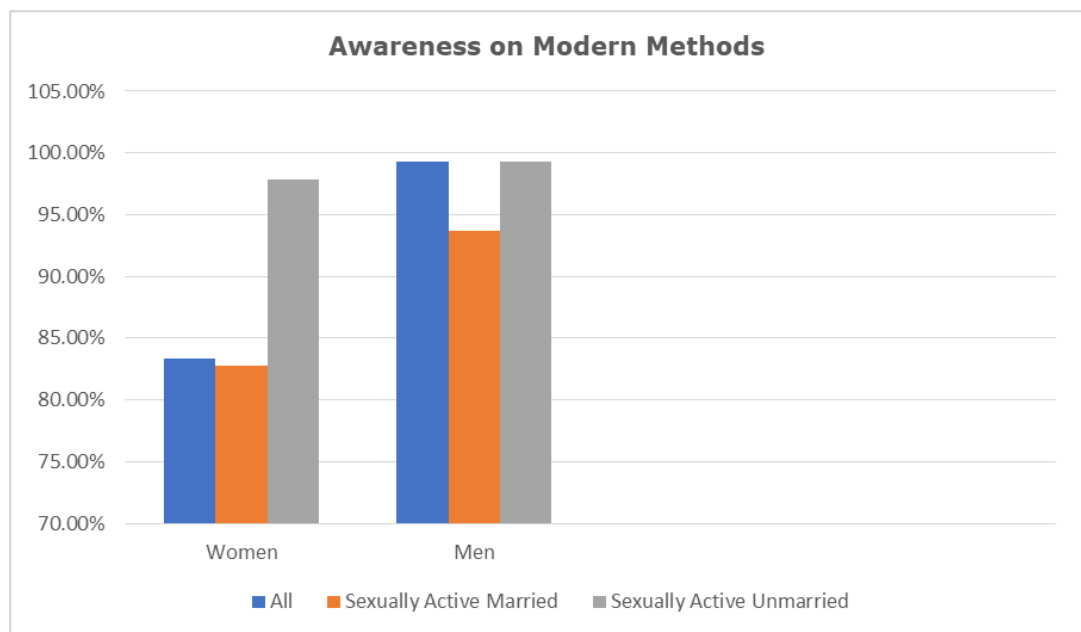


Figure 3 Awareness on Modern Contraceptive Methods in Nigeria (1)

¹² Fig III

- **Contraceptive Belief (Myths, Misconceptions and Rumours)**

Studies have demonstrated rumours, misbelief, myths and misconceptions are driven by misinformation (66), previous unpleasant experience with method use either by the individual, other women or just mere perceptions (67,68) or inadequate appraisal of side effects or health risk before taking up a modern method (69). Though these methods are safe, fear of side effects is most reported among women who used injections, IUDs and OCPs in the past (67,68).

Though majority of women involved in various reviewed studies are fertile, sexually active and need contraception, they are not using any modern method as at the time of studies (63,66–69). For instance, women in developing countries including West and East African countries fear using modern methods because of perceived side effects such as menstrual disorders, health risks and contraceptive induced infertility (60,63,69–71). Sedgh reported that women who are breastfeeding and not concurrently using any modern method perceived they are at low risk of becoming pregnant because they are yet to resume monthly menstruation post-delivery or they believed using a hormonal method makes the breast milk harmful and affects the health of the woman (69).

Misconceptions, misbeliefs, rumours come in different forms. For instance, Eke reported that many sexually active young college students at Nnewi, a sub urban setting in south east Nigeria are not using long acting reversible contraceptives (LARC) because they fear it will induce abortion for those pregnant or cause infertility in the future (66). Some women from 2 urban settings in Nigeria believed modern methods does not only cause infertility, prolong use of methods such as oral contraceptive pills (OCPs) can make the stomach swell because it is stored in the body (Ibadan-south west Nigeria) and can result in drug addiction or destroy the woman's immunity (Kaduna-Northern Nigeria)(72). Ankomah in a survey and Aransiola through focus group discussions (FGDs) in different urban settings reported that some women are not currently using modern contraceptives because they believed it makes a woman promiscuous or loose¹³, (28,73), cause cancer, it's expensive to access (73).

Misconceptions are not limited to the women alone, a large percentage of men from the Yoruba tribe, south west Nigeria who are not in support of modern contraceptives cited health concerns and contraceptive induced infertility as reasons for not allowing their wives or female partners to use modern method (74). Another urban study reported community members might discourage potential users from using contraceptives because of the general belief that it destroys a woman's womb and harmful to the health of the woman (61).

3.2 Seeking Family Planning Services:

3.2.1 Acceptability.

Describes the sociocultural determinants that influence the attitudes and behaviours of family planning service providers. These includes norms, values, gender dynamics and cultural practices (56,57).

- **Service Providers Attitude (values, norms, culture).**

Service providers (SPs) implements the programmes, policies, best practices and act as the link between global population knowledge and the end users

¹³ Casual and unrestrained in sexual behaviour

(75), thus can enable or limit the uptake of modern FP services (76,77). A study conducted in 6 Nigerian urban settings revealed that though this sometimes emanates from a protective behaviour, SPs limit access based on their own values, norms and culture and decides who should or not use a method considering the client's age, parity and marital status. This is referred to as provider-induced barriers (77).

A study in Mali reported that young women who desire to use modern methods and source from the health facilities are afraid to patronize the facilities for fear of negative reception from the providers because the providers believed contraceptive services are meant for married women alone (78).

Herbert reported in a study that most providers in Nigeria limit access to FP services for youth and unmarried. The young people had negative experiences and were judged as been promiscuous. Providers gave religious advice instead of contraceptive services. This prevents young and unmarried to access sexual reproductive health services when needed subsequently (76).

Another study in 6 urban cities¹⁴ reported similar findings with the studies cited above. Potential users are screened based on age, number of children and marital status which are not recommended by either World Health Organization (WHO) Eligibility Criteria or the FGN. For instance, unmarried clients can access less effective male condoms and emergency contraceptive pills (ECPs) but most providers will not want to give more effective or LARC such as IUDs, implants or injectable thus forcing them to use less effective methods which might not be the client's choice(77).

Provider's attitude is driven by various reasons as reported in different studies. Schwandt reported it is sometimes related to the gender of those accessing the method and the method of choice. As revealed in the study, male condom doubles as the most widely used and with the least provider bias. This is said to be associated with the fact that the society is less restricting with unmarried young men without children when it comes to sexual behaviour and use of contraception than the women in the same group (77).

Another study revealed some providers are bias because the provider is not well informed about certain health conditions and a method, such as concerns about IUDs and increase risk of infections. FP guidelines might be outdated, not available or the providers might not adhere to the instructions in the guidelines. They might also lack trainings to equip them with updated skills, knowledge and attitude which would have limit or prevent bias (79).

Provider bias increase the risk for unintended pregnancy and unsafe abortion because clients are not able to access their method of choice and might be discouraged from accessing FP services (77,79).

3.2.2 Ability to Seek.

Describes the factors that influences an individual's ability to access FP services (56,57). Elements contributing to this determinant are societal values and norms, individual factors, influence from family members and gender dynamics. Societal values and gender dynamics will be discussed in chapter 3 while individual factors and influence from family members can be found in Annex 4.

- **Societal Values and Norms**

¹⁴ (Kaduna, Ilorin, Zaria, Ibadan, Benin and Abuja)

Prevailing cultural norms and gender inequality issues influence people's decision to either use or not use healthcare services (80,81). Low contraceptive prevalence in West and Central Africa is reported not to be driven only by access and/or utilization factors but also a complex interaction of culture, social norms, gender inequality and the status of women and girls (81). This is confirmed by a study in developing countries which reported that women not currently using any modern methods cited cultural norms and beliefs which reflects their society as reasons for not using modern methods. These barriers are expressed as negative attitude, which does not support the use of modern methods and could be from the women themselves, male partners, mother-in-law or others from their communities (69).

Nigeria is a multi-cultural, ethnic and religious country and this is a major determinant in health behaviours and outcomes (1). A study in northern Nigeria highlighted how sociocultural/religious factors interplay to influence reproductive intentions and utilization of modern methods. Irrespective of formal education, northern Muslim women are bounded by traditional/cultural role models and gender norms (45). Socio-cultural factors such as polygyny, early marriage, high rate of divorce, multiple marriage and Islamic inheritance system are major drivers of high fertility as reported in 2 northern states including urban Kano. Another reason given by the women is that, high fertility in the region guarantees the survival of their local community, religious faith and promotes self-actualization (45). The Islamic doctrine and cultural practices across Nigeria accept polygamy. Wives are in fierce competition to outdo each other to inherit more wealth because wealth is shared based on the number of children and sons a woman has. Polygamy remains a major driver of high fertility and low contraceptive use in Nigeria (45,64).

- **Gender dynamics**

A survey conducted in Tanzania reported that gender norms and unequal power relations between couples may limit a woman from using modern contraceptives. As revealed, pronatal attitude of men, women's limited ability in making decision, poor access to resources, information and services and different views on fertility and contraception are gender related issues that can act as barriers to utilization of modern contraceptives (82).

Nigeria is a patriarchal society and male are dominant in all matters including issues on women's health across all ethnic groups although variation exist (30). Two separate studies in urban settings in south west Nigeria confirms that when a man is in full control of his household, his ego is boosted and the society also term his wife as a well-trained woman (74,83).

A study among men in Gwagalada, a sub urban setting in the middle belt of Nigeria revealed that though majority of the respondents supports family planning, they are dominant in making decision on issues such as the size of the family, what method of contraceptives to use and timing of pregnancy (84).

Men in various studies were reported to play a crucial role in the utilization of modern method. Aransiola reported that though majority of the men in a study setting which is an urban slum are not likely to initiate discussions on family planning and fertility issues, they are still responsible for taking the final decision (28). Okigbo et al confirmed in a separate study that women who discussed fertility issues with their husbands or male partners use modern methods than those who do not (61). In other studies, women unanimously agreed a woman should not take up FP services without the husband's consent as he has the final say. They feel if she decides on her own and in case of any eventualities, she can be maltreated or divorced by the man or the man might decide to marry another wife to punish her (28,45).

Although studies reported that men support FP in urban Nigeria, this is influenced by various factors (84,85). For instance, the societal recognition of a large family size linked to prestige, honour and wealth make some men not to believe in controlling fertility, some believe God decides the number of children a family would have, while some want more sons and children to outlive them. The implication of this is that such couple will continue to procreate irrespective of the risks associated for the mother, children and quality of life (28,45,84,85).

3.3 Reaching Service Delivery Points:

3.3.1 Availability and Accommodation.

Refers to the presence of physical space and providers, distribution of SDPs and ability to provide needed services in an adequate and timely manner (56,57). Accommodation, opening hours and appointment will be discussed below while geographical distance can be found in Annex 4.

- **Accommodation, Opening hours and Appointment Mechanisms**

The ability of women to access family planning services and whether methods are available influence contraceptive use (81).

In urban Kenya settings, women who participated in a study reported they patronize private facilities including faith based organizations (FBOs) more than the public facilities because the private facilities provide quality services, do not delay clients and providers interact well with clients (86).

Studies reviewed in the Nigerian context reported that the supply and distribution of contraceptive methods in Nigeria is primarily by the public and private sector. Although the use of the public sector as source of modern methods increased from 23% to 29% in the last 5 years, the private sector remains the main source by providing 70% of modern methods (1,26,81).

Other studies reported that women in urban Nigeria prefer to patronize the local drug stores and the pharmacists than health facilities because it is easier for them to access FP services in the drug stores. For instance, women on ECPs patronize local drug stores and pharmacies because their method of choice does not require a skilled provider. Clients are not required to arrange a pre-appointment booking and registration. A client can just walk in, at any time, access service and leave. Drug stores are opened 6-7 days/week for 10-11hours/day. In addition to these, the drug stores are about 1km from their place of residence. Despite commitment made by the government and partners as explained in the background, commodity stock out remains a major issue in public health facilities (64,81). Various sources reported that poor method mix (injections and IUDs are not always available), commodity stock out, and inconvenient opening hours are reasons given by urban poor women for not using the government owned facilities (32,61,87,88).

3.3.2 Ability to reach

- **Living Environment**

Geographical location, living space and social boundaries are major influencers of an individual's behaviour (28).

Ettarh reports that disparities exist in utilization of modern contraceptives and unmet need across counties (regions) in Kenya. For instance, the central region is the most urbanized because of Nairobi. Modern contraceptive prevalence is

said to be high and unmet need lower in this region than others because FP programmes and interventions are concentrated here and women have increase access to health facilities (89).

In Nigeria, women who lives in environment that values a large family size will also have a large family size. Women are influenced by their neighbours and friends through observation and what goes on generally in the environment. For instance, communities exposed to FP messages through the media were reported to utilize modern methods more (61). As noted in other paragraphs, demographics, sociocultural and religious , level of education and economic determinants strongly influence uptake of FP, and the environment in which women lives reflects these determinants as seen in northern and southern Nigeria (28,30,31,90).

The utilization of preventive health care services such as family planning is influenced by the socioeconomic development in the living environment of the client. This explains why women from similar community seek services from the same set of providers or use same methods. The urban poor women tend to source for contraceptive services from the informal private sector than the public sector because they reside in informal settlements not fully recognized as an important part of the city. These settlements have poor access to social services such as healthcare including FP services. Because the government is not responsive to their needs they resort to use informal providers who are not regulated, provides poor quality services and also more expensive (48,71).

An environment can also be made of significant others. A negative environment created by male partners, family members especially the mother in law and community members who are not in support of modern methods for reasons identified previously can influence a woman's decision not to use modern methods. For women who are in an environment made up of supportive significant others, they are more likely to use modern methods (28,45,74,85).

3.4 Utilization of modern contraceptives

3.4.1 Affordability.

Describes the ability of clients to afford paying for and spending time to access family planning service (56,57)

- **Direct, Indirect and Opportunity Cost**

The difference between the socioeconomic power between the rich and the poor in developing countries influence access to and ability to afford contraceptive methods (91).

In developing countries, women who want to access healthcare services might not be able to because of informal payments and opportunity cost for the client and those who might want to accompany her to the facility. The implication for the poor is that in seeking and paying for healthcare, they are subjected to catastrophic spending and financial distress which might worsen their state of poverty (80).

Contraceptive commodities in public health facilities in Nigeria is free (64). Despite this, women in the lower economic class are restricted from using modern methods (30,92,93). For instance, injectables in Nigeria are provided basically by health facilities and taken by women bi-monthly or once every three months (1,26), despite providing the injections for free, women who are poor might not be able to afford the cost of transportation to the facilities (30,92,93)

or as reported by another study, consultation and management for method related side effects are not free (83).

Majority of users currently on modern methods in Nigeria are using male condoms and pills (1,26), these methods are accessed from the informal private service providers which they need to pay for. This might be difficult for the poor to afford because they barely have enough resources to feed with, they rather buy food for the family to eat with the available money rather than paying for contraceptives (60,89).

3.4.2 Ability to pay.

Ability to pay refers to the various means by which clients can pay and the determinants of her ability to pay for FP services (56,57).

- **Financial capacity of women**

The financial power of a woman is a major determinant for using modern contraceptives (1,30,64,94). NDHS 2013 indicated that women in the highest economic class have a higher met need of 37% compared to women from the lowest economic class with a 2% of met need (1)

Adebowale reported that women who are empowered financially are protected from limitations associated with the cost of accessing quality FP services. Women who might insist on using a desired method of choice but could not access it from a public facility due to contraceptive stock out might resort to private facilities or pharmacists at a higher cost. While those who are poor will have to wait till the public health facilities replenish their stock. This might lead to unintended pregnancies (30,93).

Most urban poor women are financially dependent on their male partners because of their low economic power (28). For instance women in northern Nigeria irrespective of place of residence or socioeconomic status practiced seclusion. The poor among them are further thrown into poverty and hardship because they might not be engaged in any meaningful productive activities. They are forced to depend basically on their husbands for survival (45). Even though they want to use FP services, poor women are limited because majority do not have the financial capacity to obtain service (28).

3.5 Consequences of utilizing modern contraceptives

3.5.1 Appropriateness.

Appropriateness refers to interpersonal relations, quality of information given to potential users, the technical competence of providers, continuity of care/follow up which all inform if the provider is able to provide the most appropriate method to clients (56,57,95). But for the purpose of this study, the focus is on quality of information provided.

- **Quality of information provided.**

Informed choice is crucial for effective FP service delivery. It require that providers give information on potential side effects, what to do in case of any side effects and other methods. This improves the coping ability of the client and reduce the rate of method discontinuation (1).

Globally, less than 50% of women were informed about possible side effects of method of choice, how to deal with them in case they experience any and other family planning methods they could use (81). This influence their ability to make

an informed choice and it is an evidenced of gaps in the quality of care provided and the ability of the women to fulfil their reproductive rights (81).

In Nigeria, 59.6% were informed of possible side effects, 54.3% were informed on how to deal with the side effects while 55.4% were informed of other methods they could use (1,26,81).

Women using OCPs when asked exaggerated the implications of missing a pill. The participants opined it is dangerous to miss 1 pill because it can cause unwanted pregnancy. This might be because they were not well informed by the service provider during counselling or either the provider or the client could not differentiate between the combined oral pills and progesterone-only contraceptive pills and the consequences of missing a pill. Majority of the women interviewed by Schwandt in this study were also not aware that the side effects reduce or become non-existent with time. Some have never seen an IUD before when they were shown (72).

The 2013 NDHS and another study reported users patronizing drug stores and pharmacies are less likely to receive information about side effects and how to manage them than those patronizing the public health facilities (1,78). Though service providers see it as a duty to provide services and inform clients on FP, when asked about information, education and communications (IEC) materials to aid providing FP information in the communities and to clients, majority do not have. Some have FP logo which signifies FP services are provided in the SDPs (76). Another study gave a reason for poor information on certain methods to be that SPs are likely promoting the use of some methods at the expense of the others (72). A similar report was given by women patronizing chemists for oral contraceptive pills. Evidence showed they were not provided with adequate information on how to use the pills, consistency in using the pills, likely side effects and what to do in case of any side effects and if they miss a pill, what new or returning users should do (96).

3.5.2 Ability to engage

Ability to engage describes the involvement and participation of clients in making an informed decision on FP utilization, continuation and adherence to method of choice (56,57).

- **Choosing an Appropriate Method**

Women are faced with the dilemma of what method to choose from and the attributes of their choice when making decision about what contraceptive method to use. This sometimes lead women to choose methods that do not meet their contraceptive needs (97). Factors influencing which method is most suitable for couples and individuals include age, parity, size of the family, their level of awareness on methods and whether their culture and religion accept the use of such method (11). Choosing the most suitable method is crucial to contraceptive utilization (98).

Giving accurate, specific and detailed information on each modern method before insertion or dispensing is crucial for acceptance, adherence, meeting client's contraceptive needs and satisfaction (99). For instance, discussing with clients who wants an implant that bleeding might be a side effect and it comes in various patterns (100), what to do when bleeding starts and other methods she can use will enable women utilize their reproductive rights, choose from a range of methods and meet their family needs and goals (81). A Cochrane review reported that though literature is scarce on the effectiveness of counselling techniques on adherence and continuation of methods, a study

reported that clients who were counselled repeatedly before receiving a modern method (DMPA injection) continued with the method despite experiencing method induced bleeding and women are more satisfied with their method of choice (100). The Cochrane review concluded that intensive counselling before insertion or dispensing methods may improve adherence and acceptability (100). Couples can realise their reproductive goals and rights when they are provided with sufficient information which enables them correctly and consistently use a reliable and choice contraceptive methods (1).

CHAPTER 4: EFFECTIVE EVIDENCE INFORMED INTERVENTIONS

This chapter review evidence informed interventions that has contributed to increased utilization of modern methods among urban poor.

- **SRH Policies and Political commitment**

To meet the RH needs of the urban poor, a fundamental intervention is creating effective policies specifically targeting the urban poor and sub populations among the urban poor and not urban average, which also requires strong political commitments and funding (48,54,101).

Political will is critical for the success of FP programs and facilitates the development of an enabling policy framework, and program implementation. It facilitates mobilization of financial and technical resources from development partners, and consequently enables increased local budgetary allocation for family planning programs. These ultimately increase access to and use of FP information and services (102).

For example, a national policy on community health workers (CHWs) system was initiated in Rwanda, resources were mobilized by the governments and more than 45,000 CHWs were integrated into the formal public health system. This contributed to increased access to FP services, promoted referrals, reporting and linkages within the health system (103). A 60% reduction in MMR and 70% reduction in under-5 mortality were recorded since year 2000 (54). The government in Rwanda built new hospitals and health centres across all regions to meet the contraceptive needs of Rwandians patronizing the 40% FBOs not providing FP. The MOH built secondary health post close to the faith based clinics to reduce distance and made it easier for clients to access the clinics (104,105). These were effective because the Presidency was committed to improved health outcomes including RH outcomes of Rwandians (104).

The aftermath of the 2012 FP summit was increased commitment by the FGN. A national FP Blue Print to scale up CPR to 36% by 2018 was launched. This was projected to “avert 31,000 maternal deaths and 1.5 million child deaths and save more than 700,000 mothers from injuries or permanent illness due to childbirth” (15). Although financial commitment remains poor (64), costed implementation plans (CIPs) are available at both national and state levels. FP policy reforms include the task shifting policy which allows the CHEWs- the lowest cadre of health provider in the public sector to provide injectables and implants (106,107); policy on free contraceptives in public health facilities and reviewing nurses and midwives curriculum to be proficiency based supported by rigorous supervision (107). Recently, the Nigerian government during the July, 2017 FP2020 summit in London made new commitments to make policy to close equity gap and increase FP access to the poorest Nigerian women through partnering with relevant stakeholders (108).

- **Public-Private Partnerships**

One of the principles through which FP2020 initiative hope to achieve its target is through “strong partnerships among and between a broad base of stakeholders which include both public and private sectors to help ensure high-quality service delivery and outreach to more disadvantaged groups” (109).

According to Ezeh, the concentration of public and private providers in the urban poor setting is an opportunity to meet the high unmet need for modern contraceptives among the urban poor. This could serve as an opportunity to strengthen or initiate interventions such as social franchising of services, voucher schemes and alternative financial options e.g., community based insurance schemes (48).

The Ethiopian government has been able to effectively coordinate and manage its PPPs in increasing access to modern methods. The NGOs procure, manage and distribute FP commodities through mobile outreaches via social marketing programs and social franchising. Some are into training, monitoring and evaluation, quality improvement, research, policy reform and reaching out to the vulnerable groups like adolescents and women in urban poor settings (110).

In Malawi, the PPPs initiative known as the Banja La Mtsogolo, a Marie Stopes International initiative (BMI/MSI) recorded an effective and affordable mobile outreach system (103,111,112). Through this partnership, the Malawian government was able to provide 65% of the country's contraceptive needs especially to urban poor women and young people. Quality FP services are delivered through a network of health facilities, mobile outreaches and social franchise. In 2016, the BMI/MSI provided modern contraceptive to over 1 million women, and averted 308, 547 unintended pregnancies (111).

In Nigeria, the government is into various PPPs. For instance, a pilot intervention to promote immediate post-partum family planning (IPFP) in private facilities reported that, 41% out of the women who participated in the pilot study accepted IUD immediately after delivery (113). Another form of PPP is the "BlueStar/Marie Stopes International" (BS/MSI) initiative on social franchising launched in 2012 and Healthy Family Network/Society for Family Health (HFN/SFH). The BS/MSI supported about 300 private facilities in southern Nigeria, out of which 70% are midwives and provided LARC especially implant to more than 65,000 women as at 2015. The HFN/SFH reportedly partnered with private providers to provide IUDs (107). DKT Nigeria is increasing access to modern contraceptives through social marketing through SPs, distributors and retailers (114). MSI partnered with the public facilities to coordinate FP outreaches and were able to reach 63,000 women in 2015, and through the Family Health Plus initiative is supporting 20 states in training, supportive supervision and contraceptive logistic management system (CLMS)(107).

- **Community Based FP Service Provision**

Community based intervention can significantly improve utilization of modern methods. The high population density that exist in urban poor settings is an opportunity to increase modern contraceptive uptake. A large number of users can be accessed quickly which is also cost effective (48).

An effective way of engaging the urban poor is by leveraging on the community health worker programme which is an initiative taken by countries globally to increase access to healthcare services in order to achieve universal health coverage among hard to reach and the underserved populations (115,116). A systematic review reported that CHWs from Malawi, Ethiopia, and Uganda provided FP methods such as OCPs, condoms, ECPs and injectables efficiently while they also refer effectively clients who want LARC and permanent methods to the health facilities (117). Another systematic review indicated that women are underserved due to their SES, level of education, age, non-supportive male partner, marital status use modern injectables through CHWs than the facility based provider as in Ethiopia, Uganda and Madagascar (118). Ethiopia witnessed the most significant effect of integrating FP into the HEWs program. 2 HEWs per health post were trained through task shifting to provide FP services including injectables and implants in 17,000 new health posts (103,110). Rwanda utilized CHWs to provide injectables in communities and increased access to vasectomy, post-partum IUD and other methods in hospitals through referrals (103). Several barriers to uptake of voluntary FP services in Rwanda were removed through decentralization of programmes and services at the community level. The CHWs were crucial in helping women make an informed fertility decision and the use of appropriate modern method. The CHWs programme was reorganized and strengthened; capacity building through

comprehensive trainings supportive supervision, on the job trainings, monthly salary payment and recognition by the community motivated the CHWs and contributed to its success(119). Increased access and utilization in Malawi was achieved by training and supporting health surveillance assistants to provide FP information, injectables and referral in the communities (103,112) while clinical officers were trained to provide female sterilization in both public and private health facilities (103).

The scope of roles and responsibilities for CHEWs in Nigeria allows for provision of injectables in addition to standard day method, lactational amenorrhoea, OCPs, condoms (106), although some partners are training CHEWS on insertion of implants and IUD (107,120). CHEWs by principles resides in the community where the PHC facility they work is. By this, there is a level of trust the women have in the CHEWs because they are seen as one of them. This is an opportunity for greater impact in terms of accepting modern methods, making informed fertility decisions, use of method than the facilities and increasing demand for services in the facilities. They provide essential services including FP both in the community, through outreaches, home visits and in the facility (106,121). Evidence from a pilot project on increasing community access to modern methods using CHEWs in 2 states in northern Nigeria reported increased uptake of modern methods- male condoms, OCPs, Noristerat and DMPA, while the community based distribution had a couple's year of protection (CYP) of 582, facility based CYP was 143. Services were provided based on standard protocols and none of the subjects reported a needle injury (122).

- **Community Engagement¹⁵**

When designed and executed properly, Cyril et al in a systematic review indicated that community engagement (CE) improves health behaviour and health among disadvantaged group which includes the poor (123). CE utilize the sociocultural context of the beneficiary community to ensure the underserved e.g. urban poor are involved in the proposed interventions to improve the quality of interventions and close existing health inequalities (124).

Cyril et al reviewed studies that utilized the principles of collaboration, partnerships and empowerment which involves beneficiaries in decision making, using top-bottom and bottom-top approach and conducting a needs assessment ended with positive outcomes. Studies where CHWs were utilized for engaging the communities reported positive programme outcomes. Health promotion messages were more effective, health behaviour improved, cultural norms and access barriers were overcome and participants were more engaged. The CHWs and representatives had a cordial relationships which was improved continuously through training. In addition, partnering with the community promotes cultural acceptance of interventions and beliefs. Utilizing existing social networks such as religious organizations, traditional ruling councils and various artisan associations promotes understanding the culture of the beneficiary community and the interventions, which viz-a-viz promotes cultural acceptance and sustainability after project close out (123).

Understanding that gender dynamics such as male privileges and patriarchy are embedded in cultural patterns and social structures which influence over sexuality and SRH including FP is the basis for prioritising and implementing FP interventions that are gender transformative. Evidence has shown that gender transformative interventions have been effective in changing men's behaviours and attitudes. This ensures men are supportive, couple's communication and joint decision making is promoted, men are more responsive to their partner's contraceptive needs and programmes outcomes are more positive (125,126).

¹⁵ See anecdotal evidence 5 and 6

In Nigeria, the NURHI phase 1 utilized FP demand generation activities to reach out to men in selected urban settings across Nigeria. Comprehensive demand activities such as mass media (radio and television), interpersonal communication (meetings, outreach activities, engaging religious leaders, community dialogues) and branding of program materials with slogans such as "Know, Talk, Go" which stands for knowing about family planning, talking about FP with your partner and going to a facility to obtain more information about FP and uptake a method were utilized. Men could communicate with their wives and among their peers on FP planning, some religious and traditional leaders publically support FP, while some men could follow their wives to the facility for FP services (127).

Reports from Rwanda indicated that community members were engaged by incorporating FP as a topic of discussion by officials either during monthly workouts, compulsory monthly community service called "Umuganda" every last Saturday of the month or through the media channels such as TV and radio (103,104). Government officials and other leaders promoted smaller family size as a welcomed national norm through these mediums and other types of community outreaches (103). The support of religious and traditional rulers was crucial for the direct strategies to work, the MOH partnered with the rulers to enlighten their followers about modern contraceptives, thus reducing sociocultural barriers, increasing acceptance and demand for modern methods (103,104).

In Nigeria, NURHI 1 (2009-2015), an initiative to increase access to quality FP services in urban settings especially the urban poor engaged with the community through various means such as involving stakeholders in the host community as members of quality improvement team, mobilizers for facility based outreaches are selected from the community, the 72 hours makeover is contracted to artisans in the community and community dialogue with representatives of subgroups including men in the community. Stakeholders were made as FP champions. FP messages was disseminated through call-in-radio program, billboards, flyers, lapel, branded shirts, umbrella and caps. These promoted community ownership and community members involved became unofficial foot soldiers for modern contraceptives. With CE and other approaches the project reported 11% CPR in the 6 project urban settings (128).

- **Improving quality of FP counselling.**

Another effective strategy crucial for increased utilization of modern methods is the quality of FP counselling. Women require quality FP counselling to use the most appropriate method (129). Lopez et al in a Cochrane intervention review indicated that there is need for adequate information on how methods work, the benefits and disadvantages associated with each method, what factors influence the method of choice in order to make an informed decision (130). Secura in a study indicated that potential users need to understand the benefits and implications associated with each method especially the method of choice. Choosing a method depends on potential's users understanding on how effective the method is in preventing pregnancy and factors that might influence method effectiveness (131).

A systematic review on the determinants of quality of care in some African countries-Kenya, Ethiopia, Tanzania and Ghana including urban settings reported that the quality of information in terms of positive talk by the SPs, information given to clients during counselling on how to use methods, side effects, other RH questions and when to return for follow ups are identified by clients as quality information that leads to clients' satisfaction and resulted to increase use of modern methods and adherence (132).

In Nigeria, a randomized controlled trial conducted to determine the influence of multiple exposures to structured contraceptive counselling sessions during antenatal clinics (ANC) in comparison to the routine one-time postnatal counselling on the

utilization of modern methods. Women in the ANC group were exposed to three counselling sessions on FP tailored to meet their contraceptive needs while women in the postnatal group were involved in the single exposure to counselling 6 weeks postpartum specific for their contraceptive needs. Counselling sessions covers both modern and traditional methods, genitalia, ovulation, fertility postpartum, how methods works, side effects of each methods, pros and cons of each method. Sociodemographic characteristics of women and contraceptive history in both groups were similar. Six months post-delivery, the ANC group reported a significant use of modern methods than the post-natal groups. The implication is that increased provider-client interactions and multiple exposures to structured counselling on FP during ANC significantly influenced fertility decisions and ability to utilize modern method than the single 6 weeks postpartum FP counselling (133).

In conclusion successful FP intervention requires more than one strategic intervention but multiple channels to ensure universal access to FP services by all women to a range of effective, acceptable and affordable modern methods which is most appropriate for their needs which is provided through synergy of multiple service delivery channels. This requires political will and various stakeholders' commitment to provide human, financial and technical resources. The diverse needs of the urban poor population, the reproductive intentions of individuals and couples and the strength of the FP interventions are crucial in delivering effective interventions ultimately to increase FP acceptance, increase demand for modern FP, utilize appropriate the most method and adhere to method chosen. Though some best practices and interventions are small scaled, they can be scaled up to the regional and national levels (134)

CHAPTER 5: DISCUSSION

This chapter discuss the main findings of the thesis.

Findings revealed that despite high awareness on modern contraceptives among urban women (urban poor), acceptance and utilization is low. Factors influencing fertility decision and utilization of modern methods varies from the supply and demand sides. Determinants include wide spread of myths and misconceptions, patriarchy, socio-cultural and religious factors peculiar to regions, poverty, lack of access to quality FP information, regional and traditional gender dynamics that limits the women's ability to make decisions about fertility and use of modern method of choice, opposition from gatekeepers such as husband or male partners, mother-in-law, peer groups or social networks, societal recognition for a large family size, real or perceived health concerns on safety and side effects and cost of accessing services. Others include source of SPs-the informal private sector remains the major provider of modern methods because they are easily accessible, the opening hours are convenient for the clients, pre-registration before service is not required and method of choice are always available while the public sector is a lesser choice because of commodity stock out, far distance to place of residence and opening hours are not conducive for clients. One major issue with the private sector provider is that they are poorly equipped to provide FP services for the clients, provider bias, poor insurance coverage and cost of FP services.

The review clearly point out opportunities for improvement in making fertility decisions, acceptance, increase in demand and utilization of modern method use among urban poor as seen in other countries and project specific areas of interventions in Nigeria. Political commitment and strategic policies targeting sub populations among the urban poor is critical for effective FP programs. This means a conducive environment in terms of fulfilling financial obligations, prioritising FP at all levels and making policies that specifically target their contraceptive needs. Policies should enjoy robust political and financial backing as seen in Rwanda and Malawi to ensure quality FP services are available to meet the high unmet need among urban poor in Nigeria. Policies strengthening and regulating public-private partnerships especially with the informal sector-local drug shops and pharmacies for optimal performance in providing modern methods to majority of intending users in the urban poor settings. Local drug shops and the pharmacies are the major supplier of modern method in Nigeria, building a thriving relationship with the association of private patent medicine vendors (PPMVs) also known as "Chemist" in Nigeria and association of community professional pharmacists of Nigeria (ACPPON) is crucial to ensure the large percentage of urban poor patronizing these providers have access to quality FP services including modern methods. This can be achieved through social marketing and social franchising by partnering with private organizations like MSI, SFH and DKT Nigeria. This will ensure profits are made, they have access to extra incentives to motivate the providers, the organizations provides a system to monitor clients flow and referral system through a triplicate referral booklet.

Urban poor setting is a potential opportunity for successfully implementing both innovating and existing interventions because of the large and heterogeneous groups of residents in the slums. To utilize this opportunity, it is not just crucial to take FP services to the door steps of urban poor women but to also leverage on the heterogeneous support networks that exist in the different urban poor settings. As indicated in the findings, this support groups are made up of other people¹⁶ apart from the male partner who might influence the use of modern method. These groups of people are bounded by rules and regulations governing their trade associations and accord a lot of respect for their elected leaders who also serve as gatekeepers. The government and other organizations can leverage on the success stories of NURHI 1 and DKT in organizing FP talk and outreaches on their monthly meeting days. Acceptors are linked to a government owned facility in their area for follow-up. The advantage is that with exposure to adequate FP information and structured

¹⁶ These others might be the in-law, friends, neighbours or respectable men and women in the community

counselling during outreaches, members of the groups serve as foot soldiers in their social circle and local community leading to increase acceptance, support, demand, utilization and adherence.

Community service delivery can be maximized by utilizing the community health extension workers (CHEWs). These cadre of HWs are the lowest cadre of SPs in the public health sector and have contributed significantly in changing socio-cultural norms, overcoming barriers and resistance in the communities. Evidence from the reviewed sources revealed they have contributed significantly to increasing acceptance, demand for and utilization of modern methods by providing information, dispelling myths, misconceptions and rumours through outreach services, door-to-door interaction with community members and mass campaigns. The recent task policy and its implementation in Nigeria has provided a legal ground for the FGON and her partners to train more CHEWs to provide injections and in some cases insertion of implants in addition to FP counselling, LAM, standard day methods and OCPs. While LARC and permanent methods are referred to the hospitals. The quality of services provided by the CHEWs can be monitored and improved through supportive supervision, on the job training and creating a budget line and prompt release of funds to implement regular community FP services. Efforts should be made by the relevant employer to employ CHEWs to provide services within their communities (60%) and PHCs (40%) attached to such communities. These makes it easier for the CHEWs, their various strategies and interventions to be accepted. They are more familiar with the norms and traditions in the communities and making it easier to influence the fertility decisions and utilization of modern methods among the urban poor women. In addition, CHEWs can actively participate in outreach activities, community mobilization and community development activities and leverage on these media to provide information on FP.

The urban poor setting is a community with traditional and religious leaders who the residence are subject to at the community level. Support from relevant stakeholders was revealed to be a major contributor in Rwanda. From the Presidency to the local leaders, everyone became a FP champion promoting FP and modern contraceptives and smaller family size as a national norm until it became acceptable. This cannot be said in the Nigerian setting, although the Federal Government made a financial commitment during the London 2012 FP summit, there is yet to be a proof of fulfilling the pledge. Further commitments were made in the July 2017, London Summit on FP in particular to reach women from the lowest SEC which includes the urban poor. Efforts should be made by advocacy core groups made up of relevant religious, professionals, traditional, women and men representatives; and donors to make sure Nigerian government live to her policy and financial commitments. Efforts should be made by all partners and stakeholders to make FP a national and social norm. Champions who supports and promotes FP should be made out of relevant stakeholders from the Presidency to the traditional community.

FP messages were transmitted through the media and interpersonal communication in the 3 countries-Rwanda, Malawi and Ethiopia. These in addition to other strategies has increased awareness, acceptance, demand for and utilization of modern methods. In the urban poor Nigerian setting, effective demand generation activities are ongoing within the communities but this is supported by partners and not the government. FP messages are transmitted through the radio, TV, billboards, flyers, posters, branded materials. Although there is need to increase funding for more media slot to ensure continuity. Other means of exposure to FP messages such as community outreach, discussion with health worker and friends and family should not be ignored as they all complement one another in ensuring people are exposed to the right message.

One factor that stood out in the findings is that SPs are not providing sufficient information required to make informed decision on method to use. Women are not properly counselled on different methods, side effects of method and what to do in case there is a side effect.

This is said to be a major reason why women though need contraceptive are not taking up methods. To increase utilization of modern methods, Kenya and Rwanda trained providers across cadres providing FP services which include counselling (for informed choice and CLMS (to prevent commodity stock out) to improve service delivery. Providers were trained on Balance Counselling Strategy Plus (BCS +), provision of LARC for nurses and, LARC and vasectomy for doctors. The implication for service delivery is that, more women within the urban slums accepted and utilized modern methods especially LARC.

Various trainings are ongoing in Nigeria through the support of partners and NGOs, but there is no evidence on the quality of the training. It is important the government regularize and set a minimum standard for trainings of providers across all cadres. SPs should be followed up 6 weeks post training to supervise and identify gaps on the spot. Periodic supportive supervision and on the job trainings in addition to making counselling materials for structured counselling available will guide the SPs in providing balance counselling required to make an informed decision about fertility intentions and uptake of appropriate methods. Private providers in both formal and informal sectors are also undergoing training at various level to improve the quality of FP services provided. The government can leverage on the expertise of relevant organizations like MSI and NURHI to build the capacity and monitor the quality of care being provided by the private sectors.

This review adds value to current literature as it included both qualitative and quantitative studies and explores the supply and demand side determinants as "paired dimensions" driving fertility intentions and utilization of modern methods. The literature shows clearly factors responsible for low utilization despite the high level of awareness on modern methods. Peer reviewed articles on FP service delivery peculiarities in urban poor settings in Nigeria are lacking. More evidence is needed to close the gap between the urban poor and the rich and sub populations. This is crucial to meet the contraceptive needs of a rapidly growing urban population and ensure the urban poor enjoy the non-medical benefits of FP.

The framework was useful in identifying the relationships between different elements and dimensions (demand side and health systems) and how it influence fertility decisions and ability of urban poor women in Nigeria to utilize an appropriate modern method.

There were limitations in using this framework. One of such is that, due to its multiple dimensions and elements, few elements were selected to suite word count. Another limitation is for instance, appropriateness is an element of quality of care that is globally recognized. But in the frame work, appropriateness is a dimension while quality of care was not expressly stated but I had to include quality of information provided to clients as this is a major determinant for making an informed choice and client's satisfaction.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

Various factors are responsible for the gap between the level of awareness, the intention to regulate fertility and actual uptake of modern methods among urban poor women. The review highlighted factors from the demand side to include wide spread myths and misconceptions about modern methods; fear of side effects which could be real or perceived; perceived opposition from male partner and poor communication between couples; poverty, sociocultural factors like societal recognition of large family size, patriarchy, preference for male child, religion especially Islamic religion in northern Nigeria and societal influence.

Review on the health system gaps revealed radio is the main source of disseminating information on FP in Nigeria; clients are not provided with quality information required to make an informed choice; the informal private sector (local drug stores and pharmacies) are the major providers of modern methods and they are not adequately equipped to provide quality services which also affect acceptance, utilization, adherence and continuity; provider bias, inadequate capacity of the public sector to meet contraceptive needs, poor political commitment, contraceptive stock outs, poor method mix and poor universal health coverage.

Evidenced informed interventions include making SRH policies backed up by political and key stakeholder's commitment; strengthened public private partnerships, community based FP service provision using CHEWs effectively, community engagement, improving the quality of FP counselling and providing evidence on urban poor FP peculiarities through qualitative research.

These interventions along with recommendations highlighted below are crucial for Nigeria to meet the contraceptive needs of urban (poor) women in Nigeria.

6.2 Recommendations

Based on the findings of this study, the following recommendations are provided to the FGON and her partners increase uptake of modern contraceptives among urban poor women in Nigeria;

6.2.1 SRH Policies and Relevant Stakeholder's Commitment

- Make policies targeting urban poor and sub populations in urban poor settings to meet the contraceptive needs
- Be committed in fulfilling her financial obligations made at the London 2012 summit towards FP2020 goal.
- Create a budget line for FP services and release allocated funds promptly to run FP service delivery in both facilities and within the community.
- Political elites, religious and traditional rulers and other stakeholders at all levels should publically champion FP, modern contraceptives and the implication of smaller family size on individual and national development, economic growth and quality of life.

6.2.2 Effective Demand Generation Activities

- The government and other partners should sponsor more demand generation activities through community mobilizers, local radio and television programmes on FP and specific programs slogans and branding of materials such as umbrella, fliers, shirts and lapel to increase awareness and increase utilization among urban dwellers particularly the urban poor.
- Integrate FP messages and outreach activities into events such as community association meetings, religious services, and child naming, wedding and

graduation ceremonies to increase awareness, acceptance, utilization and adherence to modern methods.

6.2.3 Community Service Provision

- Re-emphasize the task of CHEWs in increasing access to FP service within the community and ensure resources are mobilized for community service provision. This will ensure FP services are taken to the door steps of clients, increase access to quality and modern FP services and prevent near misses.

6.2.4 Improving the quality of FP counselling

- Train SPs on counselling using Balanced Counselling Strategy Plus (BCS+), Medical Eligibility Criteria (MEC), pictorial flip chart, models and standard protocols for each category of provider to counsel clients in making an informed choice.
- Adopt a NURHI strategy called 72hours makeover. This strategy involves renovating, refurbishing and equipping FP clinics with instruments, equipment and IEC materials in high volume PHCs and general hospitals. This will make FP services more inviting for clients and increase demand and utilization.
- Continuous monitoring and on-the-job training to identify gaps in quality and provide on the spot technical assistance for SPs

6.2.5 Further Research

- Qualitative research should be supported to provide relevant evidence for policy and action on FP in urban poor context and among the sub-populations to enable policy makers and FP program experts develop effective strategies.
- The influence of peer groups and social networks on modern contraceptive uptake in urban settings
- Disaggregated data on FP among the urban poor should be included in the NDHS as this is the primary source of information on health issues

6.2.6 Engage the private sector meaningfully

- Strengthen the PPPs with pharmacies, local drug sellers through social franchising and marketing programmes utilizing the whole market approach.

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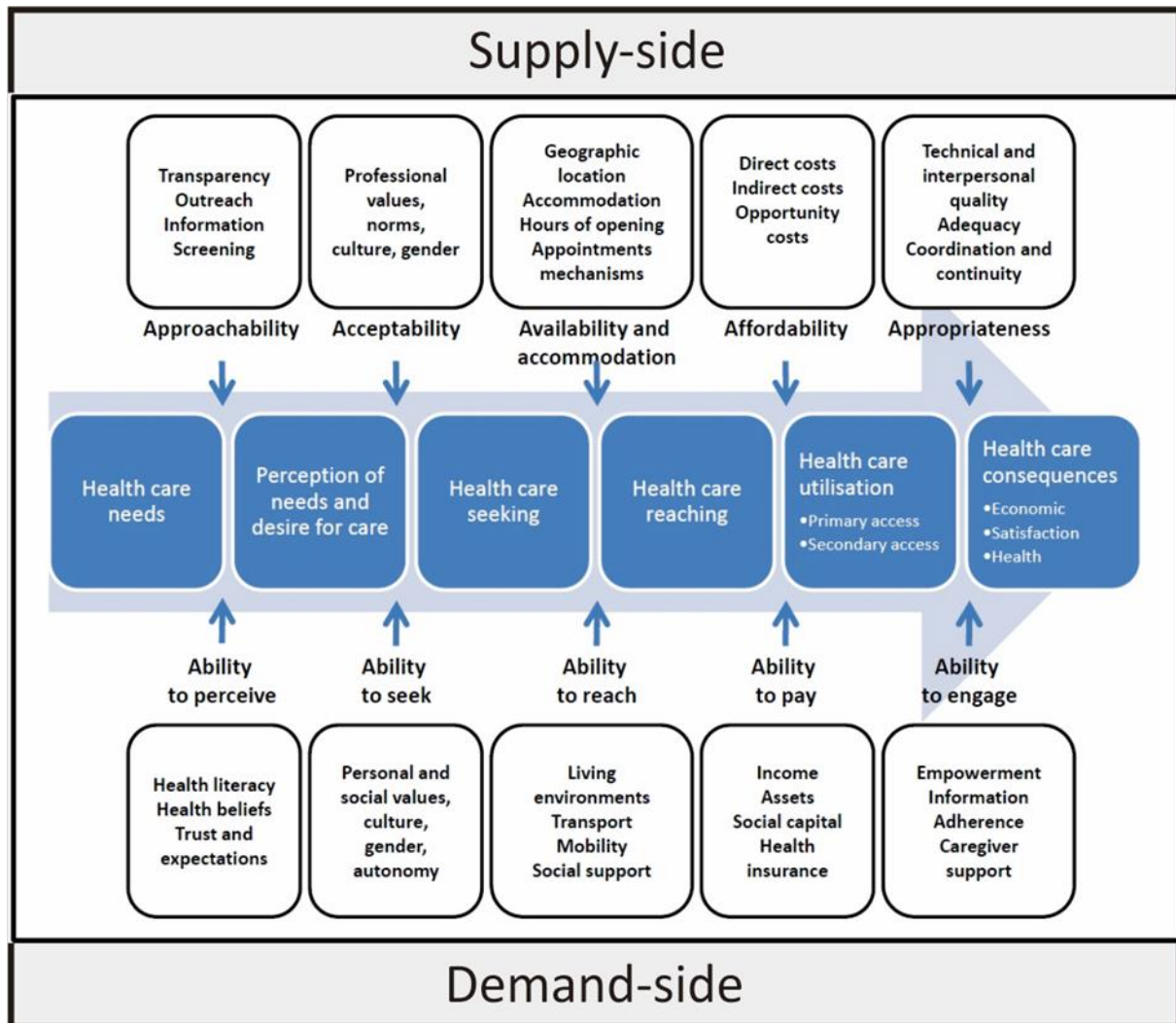
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Annex

Annex 1: A Conceptual Framework on Access to Care by Levesque et al 2013.



Annex 2: Search Strategy

OBJECTIVES	KEY WORDS
<ul style="list-style-type: none"> To explore the socio-cultural factors influencing the fertility decisions and uptake of modern contraceptives among women of reproductive age (15-49) in urban Nigeria. 	Determinants, Drivers, Enablers, Barriers, influencers, perception, attitude, awareness, knowledge, sources of information, FP messages, belief, myths, rumours, misconception, misinformation, fertility choices, reproductive choices, informed decision making, counselling, Choice to become pregnant or not, Unmet need for modern contraceptives, Delaying pregnancy, Spacing Births, Unintended/Intended/Mistimed and Unwanted pregnancy. Values, Norms, Cultural practices, individual factors, Gender dynamics, Decision making power, Male partner support/male involvement, Peer pressure, modern methods, modern contraceptives, oral pills, emergency contraceptives, injectables, implants, IUDs, male condoms, WRA, older adolescents, young people, married women, unmarried youths/women, breastfeeding mothers, fertile, sexually active, socioeconomic status, urban settings, urban slum, informal settings, urban poor, SSA, LMICs
<ul style="list-style-type: none"> To explore the health system related factors contributing to the uptake of modern contraceptives among these women within the Nigerian context 	Public facilities, private facilities, service providers, health professionals, service delivery point, supply sides, PPMVs, local drug stores, Pharmacists, Provider's attitude/bias/opposition, Commodity stock out, facility opening hours, distance, travel time, direct, indirect and opportunity cost, NHIS, insurance coverage, counselling, IEC materials, protocols, training, counselling skills vulnerable, urban settings, urban slum, urban poor, SSA, LMICs
<ul style="list-style-type: none"> To identify evidenced informed interventions from elsewhere to be applied to the Nigerian urban setting 	Best practices, success stories, end line project reports, Demand Generation Activities, Quality improvement, System strengthening, Service delivery FP outreach, mobile clinic, one stop shop, trainings, facility make over, consumables, commodities, CLMS. Rwanda, Ethiopia, Malawi, NURHI, WHO, UNFPA.
<ul style="list-style-type: none"> To propose evidence based recommendations to improve the health system's response to the contraceptive needs of these women. 	Best practices, Cochrane reviews, Systematic reviews, Success stories

Annex 3: Definitions of access dimensions based on Levesque et al (57)

Supply-side dimensions of accessibility of services	Definitions	Demand-side abilities of patients to access services	Definitions
Approachability	Approachability of services relates to the fact that people facing healthcare needs can identify that some form of services exists, can be reached, and have an impact on their health	Ability to perceive	Ability to perceive translates into the ability of people to identify their needs for care.
Acceptability	Acceptability of services relates to social and cultural factors determining the possibility for people to accept the aspects of a service.	Ability to seek	Ability to seek healthcare relates to factors that would determine expressing the intention to obtain healthcare.
Availability and accommodation	Availability and accommodation refers to the fact that health services (either the physical space or those working in healthcare roles) can be reached both physically and in a timely manner.	Ability to reach	Ability to reach healthcare relates to factors that would enable one person to physically reach service providers.
Affordability	Affordability reflects the economic capacity for people to spend resources and time to use appropriate services	Ability to pay	Ability to pay for healthcare is described as the capacity to generate economic resources to pay for healthcare services without catastrophic expenditure of resources required for basic necessities
Appropriateness	Appropriateness denotes the fit between services and clients' needs, its timeliness, the amount of care spent in assessing health problems and determining the correct treatment	Ability to engage	Ability to engage in healthcare relates to the participation and involvement of the client in decision-making and treatment decisions, which is in turn strongly determined by capacity and

	and the technical and interpersonal quality of the services provided.		motivation to participate in care and commit to its completion.
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Annex 4: Study Findings

3.2 Ability to Seek

- **Individual Factors**

Various factors influence an individual's ability to use contraceptives or not. Some according to NDHS are the number of children the woman have, the level of education and the socioeconomic status of the woman (1). Adebayo et al reported in his study that in Nigeria, women including urban women use or do not use contraceptives and specific methods because they are affordable, easily accessible, they perceive a method is right for a particular group of women, knowledge about specific methods (135) and the benefits on their economic power(136).

Okigbo indicated that high self-efficacy¹⁷ is another major influence that enable women to use modern contraceptives as seen in 6 cities across Nigeria (Abuja, Ibadan, Ilorin, Benin, Zaria and Kaduna). Women with high efficacy, i.e., ability to decide to use modern methods as individuals are seven times more likely to use modern contraceptives than those with low self-efficacy. Self-efficacy is influenced by level of education, socioeconomic status and geographical region (61).

For others, women in their late reproductive age may use contraceptive less because this age doubles as the onset of menopause and many of them might not see the need for a modern contraceptive because they think they might get pregnant anymore (63,135). While Aransiola reported that some women reported they sometimes wants a larger family size even though their husbands does not. This is because of personal belief on fertility or when they want a particular sex for a child or competing with other wives in a polygamous setting (28).

- **Influence from Family Members.**

Aransiola 2014, reported women in his study revealed and emphasized the role played by extended family or close non-family members in the utilization of modern methods. This is common among men with less formal education. For instance, majority of the extended family members favour a large family size, and men with less formal education bows to the pressure exerted upon him by his mother to have more children even though the couple had decided earlier they want a small family size (28). Women who participated in the study also revealed they can influence their husband to support FP utilization by asking their husband's close male friends, older women in the community who supports FP which could be their mother in law or a significant older woman in the community to talk to their husbands to allow them use family planning services(28).

3.3.1

- **Geographical Distance/Location**

The geographical location or distance of a service delivery point can limit a potential user from obtaining family planning services(60,77,89).

For Kenya, it was reported that women who lives about 5KM form the health facilities use modern contraceptives more than those who lives farther away. This was confirmed by the service delivery points as those far from potential users reported low patronage and uptake of modern methods (71,89). In northern Kenya the distance of the facilities affects the cost of accessing FP services, type of providers they source services from and determine the type of methods potential users adopt (137,138).

A study in West African countries, Nigeria inclusive revealed that though FP services might be free, women might not access FP services if they need to travel a long distance (139). A study across the 6 geopolitical zones in Nigeria reported that, clients source their method of choice from the closest provider which apparently are patent medicine

¹⁷ Ability to make decision on using contraceptives or not

dealers and pharmacies. Providers located far recorded low patronage and the method of choice are limited to methods available in closest SDPs (31).

3.4.2. Insurance Coverage

National health insurance system (NHIS) in Nigeria covers only the formal sector employees (public sector employees, organized private sector and Armed Forces, Police and other Uniformed Services. Coverage is provided at the 3 tiers of health care delivery. Family planning services are part of the benefit package (140). The informal sector Social Health Insurance programme was adopted for Nigerians in the informal sector. This covers artisans, voluntary participants, rural dwellers and those not covered in the formal sector. This is executed under the Community Based Social Health Insurance Programmes and Voluntary contributors Social Health Insurance Programmes(140). Despite this, coverage has been ineffective with less than 3% of the total population enrolled under the three schemes(141). The scheme though aim to reduce out of pocket payment for healthcare services among the poor and inequity it has failed as 94% of Nigerians pay OOP for health services. This implies majority of the poor who cannot afford cost of seeking for healthcare are not under any form of insurance coverage (141–143).

Annex 5: Anecdotal evidence on influence of support networks

Anecdotal evidence from the field in Lagos Nigeria shows that different trades/artisans have their local associations. Community based FP programmes can leverage on this peer groups to provide information on FP, correct all forms of misinformation and the group members can serve as foot soldiers for FP within their community. This also encourage context specific interventions to be successful in communities. Although evidence on how the peer groups influence use of modern methods in urban poor setting in Nigeria and SSA is lacking, anecdotal experience as an outreach coordinator in Lagos slums revealed the importance of these peer groups. Mobile clinic was incorporated into monthly meetings of association of hairdressers and barbers. A slot was given to educate the women on FP and importance of planning a family. Women who are interested are duly counselled to make an informed choice and provided with methods-short acting and LARC while the few who wanted tubal ligation were referred appropriately. Prior to the day of the meeting, volunteers from the association who resides within the community where meeting was scheduled to hold created awareness starting 3 days before the meeting until the meeting was over.

Annex 6: Anecdotal Evidence on CHEWs in Nigeria

Anecdotal evidence from field experience revealed that the government need to re-emphasize the role of community health extension workers (CHEWs) especially in community service delivery including FP and be supported in terms of financial commitment. The CHEWs in Nigeria are part of the formal health system and they are into two categories; the Junior CHEWs and the Senior CHEWs. The JCHEWs by protocol are supposed to spend 60% of their time in the community and 40% of their time in the facility while the protocol for SCHEWs is vice versa. Currently, CHEWs in Nigeria are not going into the community as proposed. One reason is absence of funds to buy fuel or mobilize their going into the community. The LGA which is responsible for health care delivery at the primary care and community levels are not making funds available to mobilize service delivery in the community.