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"*Doctors are in the best position to know . . .*": The perceived medicalization of contraceptive method choice in Ibadan and Kaduna, Nigeria

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ABSTRACT

Objectives: The medicalization and clinic-based distribution of contraceptive methods have been criticized as barriers to increasing levels of contraceptive use in Nigeria and other settings; however, our understanding of how clients themselves perceive the contraceptive method decision-making process is very limited.
Methods: Focus group discussions among men and women in Ibadan and Kaduna, Nigeria, were used to examine attitudes and norms surrounding contraceptive method decision-making in September and October of 2010.
Results: Choosing a family planning method was presented as a medical decision: best done by a doctor who conducts clinical tests on the client to determine the best, side effect free, contraceptive method for each client. An absolute trust in health professionals, hospitals, and governments to provide safe contraception was evident.
Conclusion: The level of medicalization placed on contraceptive method choice by urban Nigerians is problematic, especially since a test that can determine what contraceptive methods will cause side effects in an individual does not exist, and side effects often do occur with contraceptive method use.
Practice implications: Provider and client education approaches would help to improve client involvement in contraceptive decision-making and method choice.

1. Introduction

Nigeria is a country characterized by high fertility, high maternal mortality, and low contraceptive use. Only 10% of currently married Nigerian women are using modern methods—3% use injectables, 2% male condoms, 2% oral contraceptive pill, 1% IUD, 1% other, and less than 1% use implants and female sterilization [1]. In April of 2011 the federal government of Nigeria made contraceptives free in public health facilities [1]. Women can source contraceptives from a variety of public and private facilities in Nigeria; however, they most commonly use the private sector (60%), in contrast to the public sector (29%), or other options (11%) [1].

Considerable research has been conducted in developing countries, including Nigeria, to examine levels of contraceptive use and identify common barriers to family planning among married women, young women, and sexually active unmarried women [2–4]. Across West Africa, accessibility has been identified as a supply-side factor in the stagnantly low rates of contraceptive use in the region [2]. In Nigeria, demand side factors such as desire for more children, lack of knowledge, and opposition by the user or a family member are also barriers to contraceptive use [1,5]. Fear of side effects and infertility are among the most common reasons for nonuse [6,7] and are a concern for a variety of subpopulations in Nigeria, including university students [8], antenatal patients [5], and urban women [9].

Researchers have also identified common determinants of contraceptive method choice. Informed, appropriate, safe method choice is important for both uptake and continuation of family planning. Family planning programs that offer a balanced method

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mix allow for a wide variety of client preferences and method attributes [10]. Contraceptive method choice is one of the six elements of Bruce's framework for quality of care in family planning and has been found to be an important determinant of contraceptive uptake and sustained use [11]. For example, in urban Pakistan, uptake of contraceptive methods was more likely in health centers that had more methods available [12], while in Indonesia clients who received their method of choice displayed the lowest rates of discontinuation at follow up [13]. The ability to switch methods is also important for long-term contraceptive use in order to meet the changing needs of clients depending on tolerance of side effects, stage of the life cycle, desired length of spacing, and other factors.

Bulatao developed a framework for understanding method choice based largely on evidence from Asia and the United States that emphasizes the individual and includes four dimensions, namely: contraceptive goals, contraceptive competence, contraceptive evaluation, and contraceptive access [14]. In these and other studies, client characteristics, such as: age, parity, education, exposure to family planning messages, and partner approval are known to influence method choice [15–18]. Government policies and programs, history of method introduction and availability in the country, as well as method attributes such as cost, effectiveness, and ease of use are additional factors that have an effect on the method mix available to a population [10].

Evidence also exists of health facility barriers in method choice, including staff levels, expired stock, provider bias, and lack of training in Nigeria and other developing countries [3,17–19]. The general medicalization of family planning and the clinic-based nature of distribution has been criticized as a barrier to increasing levels of contraceptive use [20–22]. These medical barriers include eligibility criteria, over applied contraindications, and numerous process hurdles that clients face when trying to obtain contraception [22]. For example, blood tests and pelvic exams may be administered before prescription of oral contraceptives, although these practices do not contribute substantially to safe and effective use of many contraceptive methods in the WHO Selected Practice Recommendations for Contraceptive Use [23]. In Nigeria, the National Family Planning/Reproductive Health Service Protocols [24] recommends the availability of certain screening tests, including urinalysis and blood tests, primarily to detect pregnancy and sexually transmitted infections, although these tests may not be commonly administered due to unavailability or cost.

Although many of these barriers have been identified in Nigeria, our understanding of how clients themselves perceive their choice of method is nonexistent. Who do they think has control over contraceptive method choice? How do clients perceive the process of deciding on a method?

This study uses qualitative data from the cities of Ibadan and Kaduna, Nigeria, to examine attitudes and norms surrounding contraceptive method choice decision-making. Understanding the client's perspective on decision-making about choice of method has the potential to improve family planning programs and policies to increase initial uptake and sustained use of contraception.

2. Methodology

This study is part of a larger qualitative study that was designed to understand key factors influencing the demand for family planning in two urban areas of Nigeria. For this sub-study, focus group discussions were used to obtain information on contraceptive method decision-making, utilizing projective techniques, which provided an indirect approach to gain information about underlying norms that can be overlooked or otherwise influenced by direct questioning or facilitator bias.

2.1. Recruitment

Family planning service providers recruited individuals who were using family planning into the study at family planning facilities through the use of a screening questionnaire to determine eligibility.

To recruit individuals who had never used family planning a similar screening questionnaire was used at the community level with the assistance of community leaders who mobilized potential study participants. The community leaders were highly respected gate-keepers in their communities. The community leaders were first informed about the study purpose and objectives in order to

Table 1
Focus group discussions by attribute, Ibadan and Kaduna, Nigeria, 2010.

City	Sex	Age	Marital Status	Neighborhood Socioeconomic Status	Family Planning Use
Ibadan	Female	18–24 years	Not Married	Low	
			Married	Low	Never
					Current
				Middle	Never
					Current
		25–49 years	Married	Low	Never
					Current
				Middle	Never
					Current
	Male	18–24 years	Not Married	Low	
			Married	Low	
				Middle	
		25–49 years	Married	Low	
				Middle	
Kaduna	Female	18–24 years	Married	Low	Never
					Current
				Middle	Never
		25–49 years	Married	Low	Never
					Current
				Middle	Never
					Current
	Male	18–24 years	Not Married	Low	
			Married	Low	
				Middle	
		25–49 years	Married	Low	
				Middle	