



A360 Evaluation Findings Synthesis: No 2.

Adolescents 360 Evaluation

What do service providers think about contraceptive service provision to 15–19 year old girls in Nigeria?



Introduction

What are service providers' perspectives of contraceptive service provision to adolescent girls in Nigeria?

In Nigeria, the Adolescents 360 (A360) program has developed two solutions aimed at improving the uptake of modern contraception by adolescent girls:

9ja Girls

Targeting unmarried adolescent girls (15–19 years) in both northern and southern Nigeria, the goal is to make contraception relevant to girls. 9ja Girls does this by connecting contraception to girls' lives and dreams through a core strategy of Skills for Life, Love, and Health [LLH].¹ This incorporates walk-in one-to-one counseling and Saturday sessions, which include classes in a health facility (focusing on LLH), opt-out one-to-one counseling with service providers and vocational skills training.²

Matasa Matan Arewa (MMA)

Building on the experience with 9ja Girls, Matasa Matan Arewa (MMA) targets married adolescent girls and their husbands using maternal and child health as an entry point. MMA utilizes male Interpersonal Communicators (IPCs) to discuss contraception with husbands, using health of the baby and mother as an entry point to encourage husbands to refer their adolescent wives to a female mentor or to a clinic for counseling. Female mentors also directly mobilize married adolescent girls. Married adolescent girls are then mentored through four Love, Life and Family (LLF) classes in a setting identified by them, after which they receive one-on-one counseling with a provider and a vocational skills class. MMA also incorporates sensitization work with religious leaders and communities, to emphasize the benefits of child spacing.³



The goal is to make contraception relevant to girls by connecting contraception to girls' lives and dreams.

9ja Girls

Programmatic data to June 2018 showed a heavy skew towards uptake of short-term methods over long-acting reversible contraceptives (LARC). This skew towards short-term methods is also reflected in national data from the Performance, Management and Accountability (PMA) 2020 survey.⁴

SFH and PSI felt that this skew could be grounded in service provider bias. This inspired them to ask the following research questions:

- **What are service providers' perspectives of contraceptive service provision to girls aged 15–19? What are the underlying causes of these perspectives, and what role might these be playing in quality of service delivery?**
- **What is contributing to the skewed method mix observed in 9ja Girls' service delivery performance?**

Methodology

Through a transdisciplinary approach, Adolescents 360 (A360) merges public health, human-centered design, adolescent developmental science, socio-cultural anthropology, youth engagement and social marketing to yield country-specific adolescent and youth sexual and reproductive health solutions. A360 is implemented by Population Services International (PSI) and works in partnership with IDEO.org, the Center on the Developing Adolescent at University of California at Berkeley and the Society for Family Health Nigeria (SFH). It is co-funded by the Bill & Melinda Gates Foundation and the Children's Investment Fund Foundation.

Itad is working in collaboration with the London School of Hygiene and Tropical Medicine and Avenir Health to independently evaluate and distil lessons from the A360 program. As part of this evaluation, a process evaluation has been specifically designed to support A360 with 'uncovering' contextual enablers and barriers, and to guide adaptive management and course correction. The process evaluation, grounded in A360's theory of change, has four areas of inquiry: process, context, experience and solution.

In June and July 2018, the process evaluation conducted participatory action research,⁵ which is the basis for this case study. The research questions were developed by SFH and PSI in response to A360 programmatic monitoring data. The process evaluation team worked with SFH and PSI to refine the action research focus, generate the data collection tools and identify stakeholders. The process evaluation team independently conducted data collection and analysis. In total, 30 key stakeholders from Ogun and Nasawara were interviewed and four focus group discussions held with 20 adolescent girls in Ogun.

Findings from the participatory action research were shared with A360 through a sounding workshop in October 2018. This provided a safe space for team members to critically engage with process evaluation findings and reflect on what they meant for the 9ja Girls and MMA interventions and for the wider adolescent sexual and reproductive health community.

Key findings

Findings are presented according to the two primary areas of inquiry for the action research: the service provider and systemic, community and adolescent bias. We present wider learning at the end of the case study.

1. Service providers

Enthusiasm and commitment

Understanding the benefits of serving adolescent girls

Service providers working on A360 expressed excitement and enthusiasm to serve adolescent girls. Many service providers (and other respondents) cited preventing unsafe abortion and maternal mortality as a key benefit of providing adolescent girls with access to contraception, and this appears to enhance their acceptance of adolescent girls using contraception. Respondents highlighted several incidents of adolescent girls taking up contraception who had already had multiple abortions.

The role of training

A360 have incorporated training on 9ja girls into a seven day government training course for service providers. Providers who took part in this training said they had learned many things, particularly how to work with and counsel adolescent girls and how contraception can help girls reach their goals. Those who had undergone the seven-day training appeared more enthusiastic than those who had been recruited more recently (to fill gaps because of service provider attrition) and were receiving on-the-job training only.

'The way I work with my client, the way I talk with them. I must give them proper attention. I don't have to be judgmental about anything they say.'

Service provider, Nasarawa

Demonstrating individual commitment

Staff working on A360, ranging from SFH project staff to service providers and mentors, all appear to believe greatly in this project and are motivated to reach adolescent girls. Commitment to this project was demonstrated in individual stories of going above and beyond the scope of their job and using personal funds to support the adolescent girls attending sessions, for example providing them with money for transport and water. Some service providers highlighted that they worked extended hours in the evening so girls could access services after school.

'Sometimes we go out of our way to help these girls. They will tell you they don't have money for the bike home. We will give them some.'

Solution implementer, Nasarawa



Cognitive dissonance

Despite the aforementioned findings, there are gaps between service providers' desire to serve adolescent girls and what they do in practice. The research pointed towards several factors that contribute to this, including implicit biases of service providers, capacity issues (both clinical and counselling) and motivation. These are in addition to systemic and community and adolescent biases, discussed later in the case study.

Implicit bias⁶

Service providers presented views that contradicted their stated desire to serve adolescent girls. It appears that both service providers and facility managers⁷ are influenced by myths and misconceptions associated with injectables and LARC. These at times appear conflated with the side effects of the different methods. This may influence how they counsel adolescent girls about specific methods.

'The only method I am scared of is the injectable because of some of the side effects. It delays return to fertility – both Noristerat and Depo Provera. But I do counsel them that body structure is different and what happens to some people may not happen to others. It is also not harmful to introduce contraceptives to adolescents their age as research has shown it not to be harmful.'

Service provider, Ogun

Service providers and facility managers may couple their engagement with adolescents with messaging around abstinence and 'self-control' as part of both LLH sessions and counseling for unmarried adolescent girls. Adolescent girls interviewed in Ogun confirmed this. Despite the apparent support for adolescent girls using contraception, there appears to be messaging that abstinence is best.

'Take care of themselves, abstain from sexual intercourse so that no man can take advantage of you.'

Service provider, Nasarawa



Youths need all these things [contraception] for them to achieve their goals in life and prevent mortality. It prevents death during abortion.

Service provider, Ogun

Capacity

Many respondents, including service providers themselves, highlighted issues with service providers' skills and capacity to provide all methods of contraception, particularly the intrauterine contraceptive device (IUCD). It was suggested that is linked to training and cadre of service provider.

Training: Because of service provider attrition, service providers working on A360 have not consistently undergone the seven-day training for this program, which includes a component on contraceptive technology. Several service providers reported receiving additional training on implant insertion (delivered by Marie Stopes International in both Nasarawa and Ogun). However, there is still a skills gap on IUCD insertion, and staff at one clinic stated that IUCDs were not offered at all to adolescent girls.



I need to learn how to insert the IUD. I can place all the other methods but not IUD. I need training on IUD.

Service provider, Ogun

Cadre of service provider: Some respondents suggested that the type of method provided to adolescent girls might depend on the cadre of service provider serving her. As A360 has scaled up to new local government areas (LGAs), there appear to be more community health extension workers (CHEWs) supporting implementation of the program. Given the task-shifting policy in Nigeria,⁸ CHEWs can in principle provide LARC, and receive training to do so. However, some respondents (ranging from service providers to SFH staff and Ministry of Health respondents) suggested that, in reality, CHEWs were not able to provide LARC and might be less competent than a nurse or midwife at service provision. This perception seemed more apparent in Ogun.

'They have been doing implants but if they cannot do it, they call me, and I come because I don't want these girls to come into the main facility.'

Service provider, Ogun

Capacity to address myths and misconceptions: Adolescent girls interviewed in Ogun still maintain inaccurate beliefs about contraception around injectables and LARC, despite having gone through LLH and/or one-to-one counseling. In discussions with adolescent girls, some (notably older adolescent girls) said that LARC was 'too long' for them. Despite counseling,⁹ girls are not aware that they can remove an implant or IUCD and their fertility will return.

'The condom is what [we] know that they mostly collect because some they are scared that if she takes the one in the arm, you know she will be thinking that in that five years that she won't get pregnant again.' Adolescent girl

The older girls interviewed appeared to still have many questions and concerns about methods, despite counseling. These included concerns about the 'cord' of the IUCD and the implant. This may be because older adolescents have lower exposure to 9ja Girls than young adolescents. Younger adolescent girls appear more likely to attend multiple 9ja Girl Saturday sessions compared with older adolescents, who may only attend a walk-in counseling session with a service provider.

'It is planted under the skin; I know another person who did it and the place they insert it, it sits out that you will know something is there.'

Adolescent girl

'The injection aspect, because a friend of mine did it, initially they said she wouldn't see her period for a month after she took it she did not see her period but the following month she had it for like a month, is it possible?' Adolescent girl

Motivational factors: Remuneration for working on A360 was consistently flagged as too low, a factor that is exacerbated by payments being made late and deductions being made for public holidays.¹⁰ Respondents noted that this was already a factor in attrition and affected SFH's ability to maintain a fully trained cohort of service providers. This may also affect how service providers perform their critical role on A360, with some suggestions that they are demotivated because of the poor pay.



[The salary] makes one not enjoy the job. Probably, it makes me feel if I see another better offer, I will leave. If they do not deduct anything from the little salary they pay and the little they give to us comes on time, we will be able to appreciate it and know that is what they are paying us.

Service provider, Ogun



2. Systemic, community and adolescent biases

This section highlights findings from the wider public health system and communities in which service providers work.

Systemic biases

Systemic bias includes factors that may affect service providers' ability to do their job and the impact this may have on how they provide counseling.

Stock-outs of consumables and commodities:

Service providers in both states reported occasional stock-outs of both commodities (short-term and LARC) and consumables.



We run out of stocks sometimes and it takes a while to replenish the stocks. The girls will therefore have to wait and need to come back several times before we get stocks. We ran out of injectables.

Service provider, Ogun

Infrastructure: Service providers frequently cited challenges with the clinic settings. These included limited space, no electricity supply and no access to toilets and running water in some cases. One service provider said they had no way to remove an implant in the clinic she was working in. Some providers were concerned about their ability to sterilize equipment for the provision of LARC. This appeared most acute in Ogun.

'We do not have a sterilizer. We use 1:6 mixture of Jik [bleach]. We need to sterilize the forceps we use to remove implants. Another challenge is that the clinic does not have a restroom. We often have to go to the family planning provider matron's room. This place is not available on Saturday so girls just look for a place around the clinic to ease themselves. We also do not have running taps so we wash our hands into a basin and then throw the water away.' Service provider, Ogun

Other providers in the clinic: It was notable that, among facility managers, there is still strong judgment of unmarried adolescents who are sexually active. While facility managers appear willing to provide contraceptive methods to girls, there remains judgment in terms of how they speak about unmarried adolescent girls who are sexually active. This was most apparent in Ogun.

While these facility managers do not always work directly on 9ja Girls, they do work closely with the service providers delivering 9ja Girls sessions and reportedly assist when a girl takes a method that the service provider cannot deliver or requires support on. It is not clear if these facility managers have undergone adolescent-friendly training or how their views may affect other service providers in the facility.

'The providers can provide all services, however, when a client needs IUCD the facility provider does it, not the young provider because we want them to be more proficient. Some of them are doing it though but we are after client satisfaction that is why we allow the older providers to do it because they have done it for many years.' SFH respondent

Support and supervision: The support provided by the quality focal person (QFP) is a key aspect of improving the service providers' counseling skills through observing one-to-one counseling sessions and LLH classes. The QFP is also considered to have an important role in terms of monitoring the availability of consumables and commodities. It is noted that there have been gaps and inconsistencies in the QFP role throughout scale-up. Given the role QFPs play in monitoring the quality of both LLH classes and counseling, this is an important issue to address.



The policy environment

In Nigeria, service providers are required to obtain parental consent for medical procedures performed on under-18s. In some regions, long acting contraceptive methods are understood to fall within this policy. This is perceived as an acute barrier to the uptake of LARC by younger adolescents. Even when adolescent girls do return with a consent form, it is not always clear that a guardian or parent has signed it. Service providers and other respondents in both states highlighted that obtaining parental consent for LARC was a challenge, and they asserted that they were 'losing girls' because of it. In another scenario, in Ogun, the lack of consent forms to provide to the girls was highlighted as a cause of girls not accessing LARC.

'Once a choice is made, I applaud them for their choice. Then I explain the consent form in simple language if she needs to do this and then let her get someone to sign for her instead. Some come back with their parent, some come back with the signed form, some take the form and do not come back.' Service provider, Nasarawa

There was some approval regarding the use of consent forms in Ogun, with one service provider considering it a safeguard in serving younger adolescents.

State Ministry of Health buy-in and communications

There appears to be a good level of State Ministry of Health (SMOH) buy-in to A360 in both states. A caveat to this is that, while both SMOHs would like to see A360 scaled up, there is an acknowledgment that there is no budget currently for SMOH to sustain it beyond donor funding.¹¹ At SMOH level in Ogun, there is a view that adolescent girls can access methods without consent, but this position has not been articulated to service providers, who continue to seek parental/guardian consent.

'It is very appropriate. We have a lot of adopters. Most of these faces are first timers because of this program rather than going for abortion and dying on the process. So, I think the implementation is a good one. Is really working positively for the adolescent.' SMOH, Ogun



The project is welcome. It is enhancing the uptake and skills of health workers. We will reduce so many problems from our communities. I pray and hope you stay above the time you set. SFH has been very good.

SMOH, Nasarawa

Community biases

Entrenched social norms in the communities where service providers work also came out strongly in the analysis of the data collected. These norms, and resulting biases, were reported consistently by all categories of respondents.

Widespread myths and misconceptions

Respondents consistently pointed to myths and misconceptions in communities about contraception, particularly LARC, as a barrier to uptake of some methods. All respondents highlighted that public perceptions about contraception, notably injectables and LARC, were extremely negative. This was particularly related to infertility and delays in returning to fertility, and, to a lesser extent, an association with gaining weight and causing cancer. This also came across in the focus group discussions with some adolescent girls. At times, this is conflated with a lack of understanding of the side effects of contraception, such as no longer or infrequently menstruating or experiencing heavy bleeding.

'I think it's the fear. Our environment has created so much fear about the use of long acting contraception.' Service provider, Ogun

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What she told me is that she is choosing the short acting [methods] because she is afraid, and I am not to force her. I explained all the benefit to her. The short and long acting works the same way. She said she will prefer the short acting as she can always come back. She is 19 years old. She is learning a trade and might likely get married soon.

Service provider, Nasarawa

Religious beliefs

Across the respondent categories, many referenced religious beliefs as a challenge to the uptake of contraception. Many respondents in both states spoke of religion as a barrier to the uptake of contraception.¹² The use of contraception by unmarried adolescent girls is associated with being sexually active before marriage, and for married couples there is a belief that children are a blessing from God. Previous rounds of the process evaluation found a perception that adolescent education about contraception represented permission to become 'wayward'.

'You know most religions don't support family planning, least of all support for adolescents' access to family planning.' SMOH, Ogun, Nasarawa

Limited access to information

Many respondents spoke of the need for increased education of the wider community about 9ja Girls and the benefits of contraception. This is in relation to myths and misconceptions but also in light of perceptions that 9ja Girls may be 'spoiling' adolescent girls, and the need to mitigate this through education /awareness-raising. There continue to be reports of instances where girls are put at risk by using a method. There is an explicit desire to reach more men through activities that improve their knowledge and perceptions of family planning. Respondents suggested that increasing social approval of family planning could overcome some of the challenges with uptake.

'The major challenge is the community. Once leaders are aware and give permission, people will learn that it is beneficial. No religion is against child spacing it is just people's understanding.'

Solution implementer, Nasarawa

Adolescent girls' bias

Adolescent girls themselves are influenced by their environment, and some have preconceptions about contraception before they attend 9ja Girls.

Fear that their friends will know they are using contraception

As previously found in the process evaluation, it appears that counseling may be rushed as a result of concerns related to time privacy – or, in other words, the longer the time with the provider, the stronger the perception by others that a girl is taking contraception. Girls are reported to want to hurry up with the counselor on skills session days so other girls will not suspect them of using a method. In addition, some reportedly do not opt for an implant because, if they leave the room with a plaster, their friends will know. Two service providers said that they encouraged these girls to return with long sleeves, to cover the plaster.

'We don't have many that adopt on Saturday because some of them came with friends and they do not want their friends to know because they also will notice they spent a long time in the counseling room and then they ask probing questions. "We spent 10 minutes in counseling, so why is your own so long like that?" So, some of them would now promise to come during the day. So our adoption on Saturday is just condom.' Service provider, Ogun

Access to information

Knowledge of contraception prior to exposure is limited. Some younger girls had never heard of contraception before 9ja Girls and are not sexually active, whereas some older girls reported knowing only about condoms. The majority of girls said they felt girls their age used condoms, as these were 'easy' to get and also 'prevent diseases'. It was also suggested that, because adolescent girls were familiar with condoms, they might be more inclined to select these over other methods. This suggests that counseling is not improving adolescent girls' familiarity and comfort with more efficacious forms of contraception.

'I was amazed, I only know that it's the condom they use to protect, but I didn't know there are injections so when they now explained to me, I got to understand.' Adolescent girl





Conclusion and wider learning

Despite a self-reported desire to serve adolescent girls with any method of contraception of her choice, aided by the additional training they receive through A360, service providers working on the 9ja Girls and MMA interventions are confronted with implicit and systemic biases that prevent them from doing so in reality. This is confounded by pervasive myths and misconceptions associated with LARC in the community and other factors outside the service providers' control.

When these findings were presented at a sounding workshop with A360 staff, the following areas were identified as learning for the wider adolescent sexual and reproductive health sector:

- Service providers face a 'battle to serve' adolescents. Existing adolescent-friendly training is not sufficient to overcome the implicit and systemic biases service providers face to provide adolescent girls with modern contraception, particularly LARC. This is further exacerbated by myths and misconceptions, often conflated with side effects, associated with injectables and LARC at community level. In addition to addressing the 'friendliness' of service providers towards adolescents, there may be a need to explore their own beliefs around injectables and LARC.
- By focusing on driving down the cost per user, trade-offs have to be made, but there is a balance between driving down costs and getting the intervention 'right'. The focus should be on getting the intervention right before the quest to drive down costs begins. The most notable trade-offs in Nigeria relate to low salaries for service providers, and the lack of an explicit male engagement strategy, particularly for MMA.
- Anticipate social norms surrounding contraception for girls, including pervasive stigma, and plan for them intentionally as part of the human-centered design process. Recognizing that it is difficult for one organization to address every aspect of social norms, consider partnering in the design phase to take forward activities associated with social norm change.
- By using language around 'child spacing' instead of family planning, religious leaders can be harnessed as allies for married girls using contraception.

footnotes

1 A360 Nigeria: System Overview & Pilot Strategy Document

2 Read more about 9ja Girls: <https://www.a360learninghub.org/cause/southern-nigeria/>

3 Read more about MMA: <https://www.a360learninghub.org/cause/northern-nigeria/>

4 <https://www.pma2020.org/program-countries/nigeria>

5 Participatory action research is 'a set of principles and practices for originating, designing, conducting, analysing and acting

6 'Implicit biases explain a potential dissociation between what a person explicitly believes and wants to do (e.g. treat everyone equally) and the hidden influence of negative implicit associations on her thoughts and action': FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMC Medical Ethics. 2017;18:19. doi:10.1186/s12910-017-0179-8

7 The National Task Shifting and Sharing Policy in Nigeria aims to tackle a national shortage of health care workers through changing the curriculum for pre-service education and in-service training to produce more knowledgeable and skilled health care workers, to make the best use of staff employed in health facilities. <http://www.familyplanning2020.org/resources/task-shifting-and-task-sharing-policy-essential-health-care-services-nigeria>

8 Facility managers reported supporting service providers with the delivery of methods such as implants and IUCD on occasion.

9 Girls reported attending 9ja Girls three to five times. They said that one-to-one counseling lasted for anywhere between four and thirty minutes. It appears that, when girls attend multiple sessions, they still go to one-to-one counseling each time but it is very short on subsequent visits. In one focus group discussion, girls reported that one-to-one counseling was after the skills class and they still waited for it.

10 In addition to service providers, the majority of respondents, including some Ministry of Health respondents, highlighted that salaries on this project were too low across all staff working on A360.

11 It was noted that buy-in at state level could be further enhanced through including LGA staff in support and supervision visits on Saturdays.

12 Respondents in the north suggested that Ramadan limited uptake, as it is difficult to engage married adolescents in particular during this time.

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