

Aligning Contraception with Family and Life Goals of Married Adolescent Girls in Northern Nigeria:

The Case of Matasa Matan Arewa

January 2021



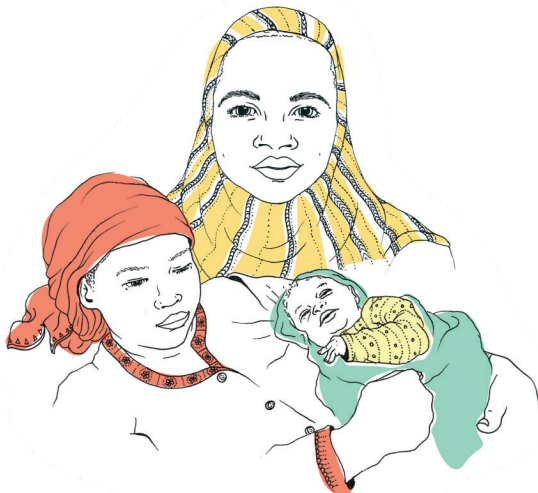
Introduction

Global health programs seeking to improve adolescent sexual and reproductive health (ASRH) have generated important learnings over the past three decades.¹ Yet questions remain about how to best design and implement sustainable, scalable programming that demonstrably responds to the priorities, needs, and experiences of adolescents and youth. Adolescents' experiences and needs are not homogeneous. Factors such as age, marital status, gender, and socio-cultural environment all need to be carefully considered in adolescent-focused policy and programming. As the ASRH field continues to advance its understanding of how to implement impactful programs, it is important to partner with adolescents directly to shape meaningful programming aimed at improving their health and wellbeing, ultimately contributing to the achievement of broader development objectives.

In 2016, Population Services International (PSI), with funding from the Bill and Melinda Gates Foundation and the Children's Investment Fund Foundation (CIFF), launched Adolescents 360 (A360), a 4.5-year program that worked directly with young people to design and deliver interventions that increase demand for, and voluntary uptake of, modern contraception among girls aged 15-19 in Ethiopia, Nigeria, and Tanzania. This technical brief presents the case of Matasa Matan Arewa (MMA), a Hausa phrase which translates to 'Adolescent Girls from the North.' Designed through a multi-disciplinary human-centered design (HCD) process, MMA is implemented by the Society for Family Health Nigeria (SFH) in two states in northern Nigeria: Kaduna and Nasarawa.

MMA engages married adolescent girls through female mentors, and their husbands using male interpersonal communication agents (IPCAs). Married girls who are interested in participating in MMA are invited to attend a series of mentored group sessions followed by a visit to a health center for voluntary counseling and contraception.

A360's intervention in northern Nigeria offers lessons for similar ASRH programs seeking meaningful partnership with adolescents to design and implement scalable, sustainable, community-based programming that aligns contraceptive use with their family and life goals.



Background

Adolescence Globally

The WHO defines adolescence as the stage of life between the ages of 10-19. There are approximately 1.2 billion adolescents in the world today, making up 16% of the global population.² Adolescence is a period marked by rapid physical as well as emotional development. Critical to this period is the formation of a new identity that bridges the gap between childhood and adulthood. Adolescents shape and refine their identities through exploration, experimentation, increased responsibility, independence-seeking, and pursuit of new experiences.³ Some of these new experiences and experimentation expose adolescents to risk. Social and emotional decision-making, and health-related behaviors during this period have direct bearing not only on present, but future health and developmental outcomes.⁴

Adolescents face a range of social, systemic, economic, and political barriers that prevent them from accessing critical information, services, and support, including limited access to accurate and appropriate sexual and reproductive health (SRH) information and services.⁵ Married adolescents face particular challenges around contraceptive access and use, often a result of social and religious norms related to decision-making and fertility. These challenges can have considerable impact on health and wellbeing.⁶⁻⁹ One third of girls in low- and middle-income countries (LMICs) are married or in a union before the age of 18, with many of these married adolescents experiencing cycles of rapid and repeat childbearing.¹⁰ Given the historically limited programming designed specifically to help young married couples in LMICs delay first pregnancy, it is not surprising that married adolescents without children have the lowest modern contraceptive prevalence rate of any group in all world regions, ranging from 29% in Latin America and the Caribbean to only 2.9% in West and Central Africa.¹¹

Among girls 15-19 globally, pregnancy and childbirth complications are the leading cause of death. Additionally, children born to adolescent mothers are at higher risk for low birth weight, neonatal complications, poor vocational status, and other long-term adverse effects than children born to women aged 20-24.¹² Even when girls safely give birth, adolescent mothers and their children can experience long-term social and economic consequences. For instance, girls who become pregnant before the age of 18 are more likely to experience intimate partner violence, and unmarried pregnant adolescents may endure social isolation, stigma, and family rejection.^{13,14} Adolescent pregnancy and childbearing often result in discontinuation of schooling, jeopardizing girls' educational attainment and diminishing their future employment opportunities.¹⁴

There are opportunities to reach adolescents with messages and services tailored to their needs across the development trajectory. In addition to other influential actors and institutions, a responsive health sector can be a powerful source of information for adolescents, provided there are opportunities for adolescents to discuss concerns with

respectful and knowledgeable providers, through health facilities or in other settings. Global evidence also points to the importance of strategies that extend beyond a single sector.^{15,16} In fact, the public health community increasingly pursues more holistic, multi-sectoral approaches to ASRH programming that expand beyond health alone.

There is increasing recognition that skills acquisition, positive beliefs, motivation, and confidence can normalize healthy behavior and help young people apply their acquired knowledge and skills to protect themselves from adverse outcomes, including unintended pregnancy.¹⁷ A positive youth development (PYD) approach includes meaningful, structured activities with peers and adults, targeted efforts to encourage belief in the future, and creation of opportunities for girls to build new skills and exercise self-efficacy. These PYD components are all relevant to favorable health outcomes. Adolescents who have positive educational, economic, and interpersonal aspirations are more likely to use modern contraception and avoid the consequences of early and unintended pregnancy.^{18,19}

Nigeria

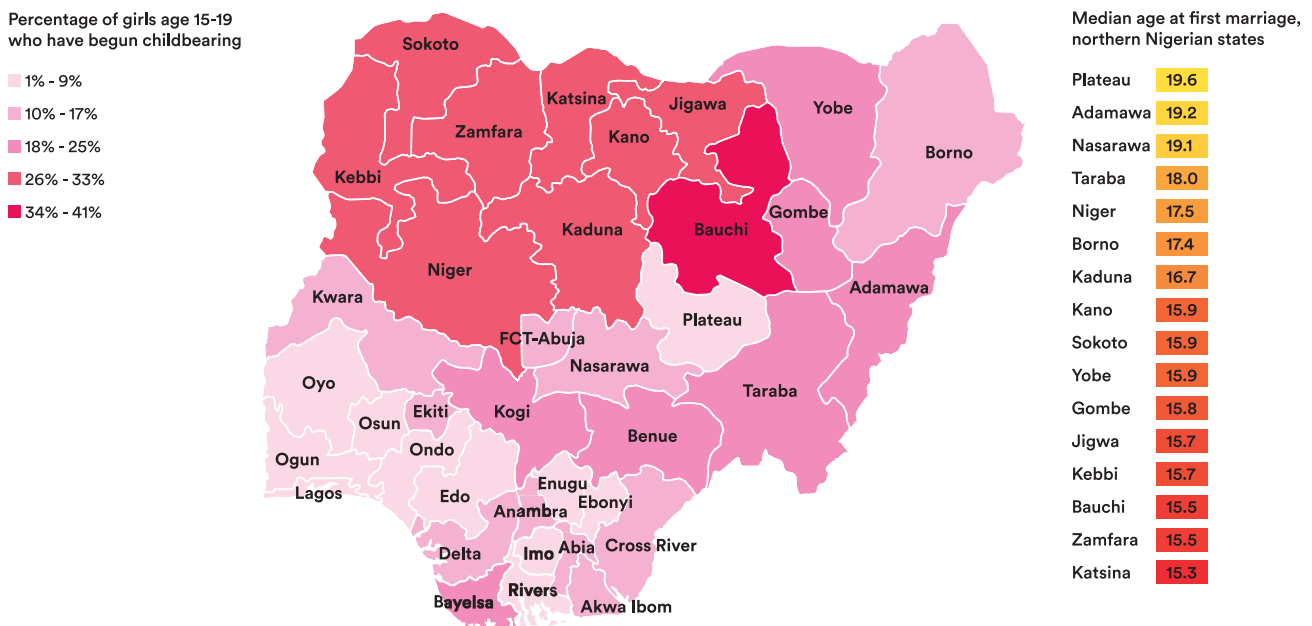
With a population of roughly 205 million, Nigeria is the most populous country in Africa. Nigeria's population is on a trajectory to double in under 30 years, shifting it from the seventh to the third most populous country in the world by 2050.²⁰ Nigeria is largely agricultural, but rapidly urbanizing. The country is ethnically and linguistically diverse, and roughly evenly split between Muslims and Christians. Thirty-one percent of currently married women reported being in a polygynous union. Polygyny is more common in rural areas than urban (37% vs. 21% respectively), and more common in northern Nigeria.²¹

In spite of the country's immense oil reserves, poverty is widespread. In 2009, an estimated 54% of Nigeria's population lived in extreme poverty. By 2019, half of the population still lived in extreme poverty, with only modest improvements in income. In northern Nigeria, widespread, severe poverty stems from increased reliance on agriculture, less developed markets, and a less educated populace (around a third of the Nigerian population receives no formal education). This number is even greater in the country's northeast and northwest zones where 55-57% of females and 40-47% of males receive no education.²¹

Nigeria's total fertility rate (TFR) has declined only slightly over the past 30 years (from 6.0 in 1990 to 5.3 in 2018). Nearly a fifth of women 15-19 are either currently pregnant or have given birth already. Nigeria has one of the highest maternal mortality rates (MMR) in the world at 512 per 100,000 live births, and the largest global total of maternal deaths.²² It is estimated that one in 34 women in Nigeria will die due to maternal causes, mainly obstetric hemorrhage, eclampsia, sepsis, and complications from unsafe abortions.²³ While abortion in Nigeria is only legal to save a woman's life, incidence remains high. A 2018 Performance Monitoring and Accountability 2020 (PMA2020) survey estimated that 4-6% of Nigerian women of reproductive age (WRA) had an abortion in the prior 12 months, an estimated 1.8 to 2.7 million abortions annually.²⁴

The modern contraceptive prevalence rate (mCPR) is only 12% among married Nigerian women 15-49, with stark disparities by geography. Just over 18% of married women in urban areas report using a modern contraceptive method, versus 8% in rural areas.²¹ Likewise, states in northern Nigeria have a lower mCPR compared with the southern states, less than 10% versus 15% or more, respectively.²⁵ Over half of married women aged 15-49 in Nigeria express

Figure 1. Teenage childbearing and age at first marriage by state, Nigeria



Source: Nigeria Demographic and Health Survey, 2018²¹

no intent to use contraception, but higher parity is associated with higher contraceptive use.²¹ Wealth quintile and educational level are additional factors influencing use of contraception in Nigeria.

Adolescence in Nigeria

Half of the population in Nigeria is under the age of 24.²⁶ The average Nigerian woman has sex for the first time at age 17 and marries at age 19, approximately nine years earlier than the median age of first marriage among Nigerian men.²⁷ A sizable age difference between spouses and the presence of senior co-wives in polygynous households can create complex power dynamics within households for newly married adolescent girls. Girls and young women often do not have the agency to make decisions independently. Even when given autonomy over decision-making, girls' choices are shaped by a host of cultural and social norms, including a preference for large families.

Nearly one in five adolescent girls in Nigeria has given birth or is pregnant with her first child, with clear disparities by residence and geographic location. For example, a rural Nigerian adolescent is three times more likely than her urban counterpart to have a child by the age of 19. Adolescents in the northwest are almost five times more likely to have begun childbearing than their peers in the southwest (29% vs. 6%).²¹ In Kaduna, an MMA implementation state, 31.3% of young women 15-19 have commenced

childbearing (**Table 1**). Young women in rural northern communities may experience pressure to bear children quickly to demonstrate fertility, often within a year of marriage. A lack of meaningful social and economic alternatives strengthens young women's desire to have children, as becoming a mother confers status within their households. Some adolescents in polygynous households may also fear that their husband might marry again if they do not bear a child soon after marriage.

These factors contribute to low levels of unmet need for contraception among young married adolescents in northern Nigeria, at only 12.2%.²¹ Though mCPR among all women of reproductive age has tripled over the past three decades, mCPR among girls aged 15-19 increased from only 1.9% in 1990 to 2.4% in 2018.²¹ By the time girls first use contraception in Nigeria, they are in their mid-20s and have already had two to three children (**Table 1**).^{29,30}

Early and frequent childbearing have dramatic effects on Nigeria's health outcomes. Two in five deaths among girls aged 15-19 stem from maternal causes.²¹ Unsafe abortion is a particular hazard for Nigerian adolescents. Of 15-19 year-old girls who reported having an abortion, nearly 90% reported their abortion as unsafe, meaning it was clandestine or self-managed, with a non-recommended procedure, outside the confines of the formal health system. Kaduna and Nasarawa are among the states with the highest reports of unsafe abortion.²⁷ Young women were also most likely to require post-abortion care (PAC) to manage abortion-related complications.²⁷

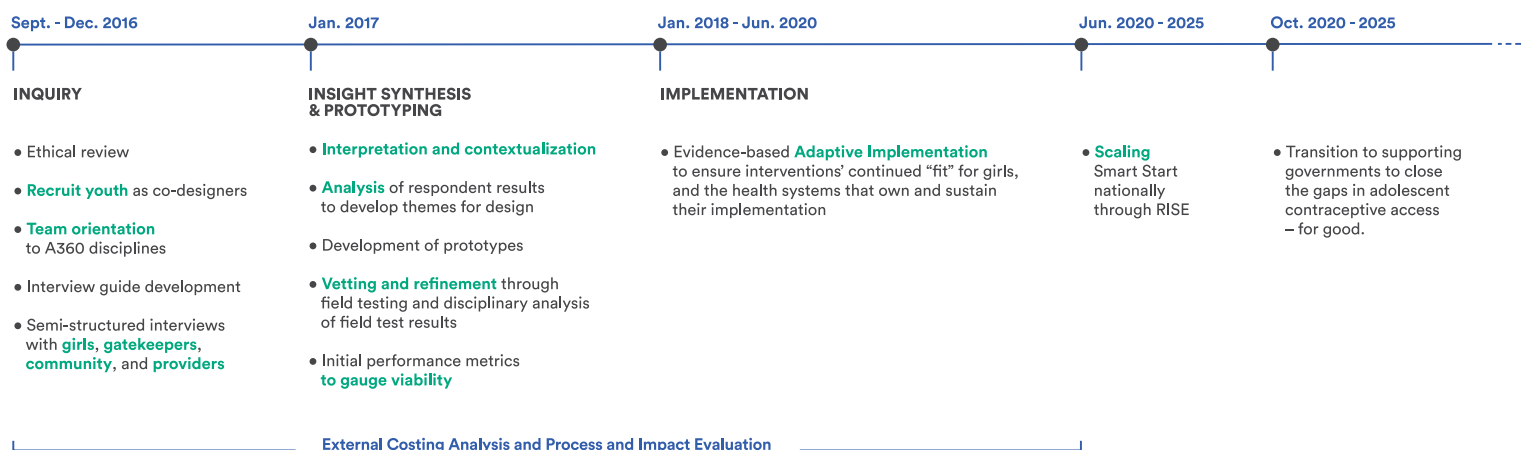
Table 1. Sexual and reproductive health landscape in northern Nigeria

Analysis of the two northern Nigerian states where MMA is implemented shows early sexual initiation, early marriage, and a high rate of adolescents (15-19) who have begun childbearing, particularly in Kaduna (the second highest of all of Nigeria's regions). First contraceptive use generally occurs only after a woman has two to three children. mCPR among young married women in Nigeria (15-24) is low (especially in Kaduna) with only about 15% of demand satisfied by the most effective, modern methods. In the two intervention states, 12-13% of pregnancies end in abortion.

SRH in Nigeria, national and by select northern states	National	Kaduna (North West Zone)	Nasarawa (North Central Zone)
Total fertility rate (TFR), women 15-49 ²¹	5.3	5.9	5.3
Median age first sexual intercourse, women 20-49 ²¹	17.2	15.8	18.2
Median age at first marriage: women (20-49), men (30-59) ²¹	19.1, 27.7	16.7, 25.0	19.1, 27.0
Median age at first birth, women 25-49 ²¹	20.4	18.9	20.3
Median age at first contraceptive use (urban, rural) ^{26, 29, 30}	24.9, 25.6	25.8, 24.8	25.5, 26.8
% of young women age 15-19 who have begun childbearing ²¹ (have had a live birth, or currently pregnant)	18.7%	31.3%	10.1%
Median birth interval* ²¹	30.9	29	30.1
mCPR, married women, 15-24 ²¹	10.5%	5.6%	8.2%
% unmet need for contraception, married women, 15-24 ²¹	16.1%	8.7%	30.1%
% of pregnancies ending in abortion** ³³	14%	13%	12%
Mean number of living children at first contraceptive use (urban, rural) ²⁶	1.4, 2.6	2.7, 2.7	2.0, 2.9

21. Nigeria DHS 2018; 26, 29, 30. PMA2020 Nigeria 2018; 33. Guttmacher Institute. Abortion in Nigeria, 2015; * For mothers 15-19, number of months since preceding birth drops to 26.9 months. The World Health Organization (WHO) recommends a minimum inter-birth interval of 33 months between two consecutive live births in order to reduce the risk of adverse maternal and child health outcomes; ** Figures represent summary totals for North West and North Central zones and include safe and unsafe abortions. Guttmacher reports that most abortions are unsafe, given that they are done clandestinely, and/or by an unskilled provider.

Figure 2. A360 Process and Timeline



Like many young people globally, adolescents in Nigeria face challenges accessing comprehensive SRH services. Barriers include inadequate knowledge about SRH, distance to services, financial constraints, consent requirements, lack of decision-making autonomy, limited mobility, and social stigma. Health system constraints, including inconvenient facility hours, long wait times, and privacy concerns, also prevent many adolescents from accessing services. Provider bias against provision of SRH services to adolescents and youth represents an added barrier.^{28,31,32} Adolescents remain a critical population in need of information and access to SRH services, particularly married adolescent girls who encounter added social pressure for immediate and repeat childbearing. Meeting adolescents' SRH needs, including for modern contraceptive services, is vital for Nigeria to achieve better national health and development outcomes.³³

Design

Beginning in 2016, A360 undertook a design process to better understand the unique needs and desires of Nigerian adolescents (married and unmarried), and to identify innovative ways in which the project could better respond to these needs. This design process took into consideration the high maternal (and child) morbidity and mortality rates in northern Nigeria – trends that are linked to early, frequent, and closely-spaced pregnancy,³⁴ reliance on unsafe abortion,²⁷ and low demand for SRH information and services among currently married women.²¹ Led locally by SFH, A360 brought together a consortium of experts in public health, adolescent developmental science, anthropology, and HCD, to complement its own expertise. The project partnered with young people to understand and address contributing factors to poor reproductive health outcomes and to support healthy timing and spacing of pregnancy (HTSP). A360 was structured to follow four phases: 1) inquiry; 2) insight synthesis; 3) prototyping; and 4) adaptive implementation (Figure 2). The first three phases constituted A360's design process. This structure allowed the project's varied disciplines to interrogate and test ideas,

maintaining curiosity and commitment to respond in real-time to the insights that emerged about girls' experiences and desires. Thoughtful, ongoing monitoring and evaluation was embedded throughout, via prototyping report cards, a process evaluation, client exit interviews, and mixed methods research. Country- and region-specific insights allowed segmentation and differentiation in programming for married versus unmarried adolescents, and a tailored approach based on unique enabling environment and contextual factors.

Methods

A360's design process adhered to two key principles: meaningful youth engagement and transparency in communicating results of the design process. The project recruited young people to work as co-researchers and program designers alongside disciplinary experts, ensuring that youth perspectives were an integral part of research, synthesis, and program design. The project sought to understand girls' goals for the future and to identify the structural and enabling environment facilitators and barriers that support or prevent girls from achieving these goals. These factors helped A360 to understand how to position contraception as relevant to girls' aspirations. A360's interventions were informed by and co-created with young people, supporting them to actively lead and provide insight at every stage of the design process, from situation analysis all the way to implementation, evaluation, and scale up. Eight young people were recruited as "youth researchers"ⁱ and were trained in systematic data collection methods, including in-depth interviews and direct observation, to work with the team throughout the inquiry phase. As part of design team onboarding, adult consortium members and young designers participated in exercises to build skills in youth-adult partnership, encourage power sharing, and effectively foster respect for the contributions of young people.

The A360 team gathered insights from girls using methods intentionally designed to generate empathy with respondents. In addition to in-depth interviews, the team

i. SFH hired youth researchers between the ages of 18-24 years of age, who were residents of the intervention area, conversant in English and the local language, who demonstrated strong verbal and written communication skills, and were holders of a senior secondary level certificate at minimum. Following the inquiry phase, SFH adjusted the title of "youth researcher" to "young designer" to reflect the ongoing role of these youth as the A360 design process evolved.

employed a variety of supplemental design research methods. This included identification of trusted sources, storytelling, and direct field observation. These approaches revealed deeper insight into respondents' lived experiences—inclusive and beyond SRH—probing to explore the motivations and feelings behind girls' behaviors and decisions. Working together, the multi-disciplinary youth-adult design research teams conducted 365 semi-structured interview sessions across Kaduna State in northern Nigeria and Lagos State in southern Nigeria in 2016. This included interviews with adolescent girls, their key influencers (mothers, fathers, adolescent boys, and male partners), community stakeholders (imams and local government leaders), and service providers. As part of its commitment to ethical engagement with young people, the team obtained Institutional Review Board (IRB) approval for all design research activities.



A360 conducted data analysis through collaborative theming workshops in which youth-adult teams worked to build consensus on the meaning and significance of findings. A360 facilitators encouraged balanced contributions to synthesize insights in a way that reflected both the disciplinary expertise of the project's consortium as well as the perspectives of young designers. Launched in northern Nigeria in January 2018, the SFH team modeled MMA after A360's southern Nigeria programming, 9ja Girls, and capitalized on A360's design insights gathered across southern and northern Nigeria.

or getting married are generally made for them, most frequently by their parents. Girls often enter into marriage in adolescence and then have children fairly quickly, often within their first year of marriage.

Findings: Insight Synthesis

A360's research in Lagos and Kaduna states generated insights about the lives of Nigerian adolescents. The insights from northern Nigeria ultimately coalesced around the following overarching themes.

Anxiety and uncertainty about how to secure a stable future

In northern Nigeria, many adolescent girls dreamed of finishing secondary school, getting married, having a family, and then continuing their education. However, girls also indicated that decisions about pursuing education

"My parents decided to get me married, but I wanted to further my education."

Married girl, Igabi

Given the current realities of limited education, diminished employment prospects, and financial insecurity faced by most Nigerian youth (and especially girls), their influencers saw marriage as a protective measure. While parents in northern Nigeria often share the same educational aspirations for their daughters as girls themselves, they also view marriage as necessary to preserve girls' morality and to prevent pregnancy outside of marriage. Girls also indicated a pressure to marry early, to avoid the stigma and shame of being an "older" single girl.

"If a girl marries, even without education, at least you have given her out."

Mother, Igabi

"Any girl that is not married at the age of 20 is considered a leftover."

Unmarried girl, Igabi



Girls perception of contraception as irrelevant and a threat to fertility

Girls interviewed had a clear vision of what they wanted to achieve for their lives – they perceived motherhood as a dependable and reliable life joy. For married girls in

northern Nigeria, lack of autonomy, pressure to prove fertility, and in many cases, a genuine desire to achieve their family's childbearing goals all negated the relevance of contraception.

Additionally, both girls and their influencers often held deeply entrenched myths and misconceptions about contraceptive use, including the belief that contraceptive use can lead to promiscuity or infertility. The fear that contraceptive-related side effects could jeopardize future fertility, posing a threat to girls' dreams of motherhood (and with it, the ability to achieve social standing, happiness, and security) made use of contraception unacceptable.

"Contraception causes barrenness."

Boy, Chikun

Isolation and mistrust among married adolescent girls

Girls in northern Nigeria indicated a lack of reproductive autonomy and agency in decision making. Those who did desire to access and use contraception said their ability to do so was largely dependent on support from key influencers in their lives, primarily their husbands, but also their mothers-in-law. These key influencers may or may not support contraceptive use for a myriad of reasons – from religion, to lack of knowledge, to fears about side effects. Given the impression that they would not be supported to use contraception, a number of girls interviewed said that they either did not adopt contraception, or accessed it covertly, exposing them to the potential risk of backlash or isolation if they experienced side effects.

"In our culture here, the men and husbands make family planning decisions for their wives."

Male partner, Chikun

"If the husband did not agree to contraception, it can cause a crisis in the marriage."

Provider, Igabi

Northern Nigerian respondents identified several sources of SRH information as appropriate and desirable for adolescents. These include teachers (via sex education in schools), religious leaders in churches and mosques, and health providers. While health providers could be a source of beneficial, accurate SRH information and services, Nigerian adolescents did not trust that their visit to a provider would remain private and confidential. This could pose a deterrent to girls' care seeking behaviors. Those interviewed expressed how anonymity and privacy were essential when accessing reproductive healthcare, though not guaranteed. Some providers also showed unwillingness to supply adolescents with contraception without the presence of a parent or spouse.

"They don't like to go to hospitals to get contraceptives because the workers might know them."

Community Influencer, Igabi

"The healthcare providers usually ask the girls to bring their husbands before giving family planning to them."

Mother, Chikun

Married adolescents girls indicated that support from their husband was critical for them to access, take up, and continue using contraception. However, male partners often lacked sufficient SRH knowledge and showed a preference for traditional contraceptive methods, such as withdrawal, for religious reasons. As a result, religious leaders' endorsement of contraception was seen by married women, as well as key decision-makers in their lives (husbands, mothers-in-law), as a necessary precursor to their contraceptive use. Only a small percentage of girls interviewed said that they could adopt contraception if their partner did not approve.

Technical Strategy

The body of insights that A360 generated was used, alongside expertise from the project's consortium of disciplinary experts and the global evidence base, to craft a technical strategy. This strategy informed the design of early-stage prototypes for the 9ja Girls program for unmarried girls in southern Nigeria. These prototypes were field tested and revised following collaborative analysis and decision-making within youth-adult design teams. More information can be found in *Connecting Contraception to Girls' Lives and Aspirations in Southern Nigeria: The Case of 9ja Girls*.



Security concerns in northern Nigeria during the design phase limited A360’s ability to design a context-specific intervention for northern Nigerian girls. As a result, SFH conducted a rapid assessment based on insights and prototypes from southern and northern Nigeria as well as A360’s other geographic contexts to inform the northern Nigeria intervention prototype – a replication of 9ja Girls which was adapted to meet the unique needs of married adolescents in northern Nigeria. In early 2018, SFH tested a series of rough prototypes to interact with married girls aged 15-19 at different touch points in their lives, namely around major life milestones. This period of prototyping increased A360’s body of insights, highlighting the specific, practical concerns of adolescent girls in northern Nigeria. Girls wanted to learn about their bodies, sex, and pregnancy, as well as about nutrition and vocational programming. They were interested in joining groups where they could receive support from other adolescent girls and mentorship from older women. Girls also desired sessions with counselors where they could ask questions anonymously and have a private moment with a youth-friendly provider. Finally, girls sought support from their husbands to access contraception, and saw religious leaders as key gatekeepers to their husbands’ support.

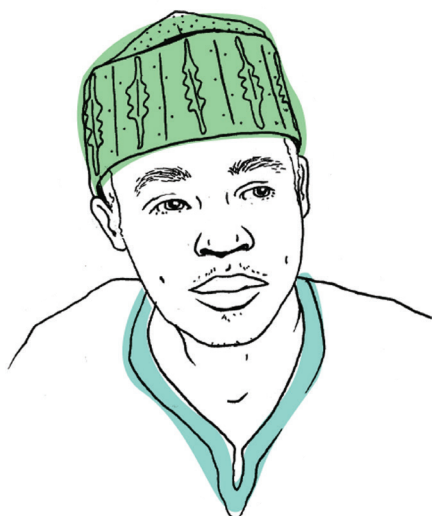
Insights pointed to a clear need to reach married girls with a unique strategy – one that differed from that used to reach unmarried girls in southern Nigeria (see **Table 2**). This model included a distinctive outreach strategy, different entry points for establishing the relevance of contraception, and a modified approach to building an enabling environment for girls’ voluntary contraceptive use. During prototyping, SFH tested intervention components that engaged a mix of married and unmarried adolescent girls, and their key influencers and gatekeepers, such as husbands, mothers, and religious leaders. MMA utilizes family health and skills building classes as entry points to engage in contraceptive counseling, framing contraception as a tool to space births in support of healthy children, mothers, and families. In MMA, married adolescents and their husbands are mobilized via targeted one-on-one outreach by



female mentors and male IPCAs respectively. Girls mobilized by female mentors can choose to attend four mentorship sessions with a cohort of their peers or go directly to the facility for services. Male IPCAs play an important role in raising community awareness of contraception and challenging prevailing myths and misconceptions. Male IPCAs approach husbands in public gathering spaces, delivering critical information about the benefits of HTSP.

MMA prototypes adapted or expanded several of the tools and approaches employed by 9ja Girls based on the needs and desires of the married adolescents. For example, SFH modified, expanded, and renamed 9ja Girls’ Love, Life, and Health (“LLH”) classes to Life, Family, and Health (“LFH”). Throughout the four guided mentorship sessions that comprise the LFH curriculum, girls who desire to receive counseling and a contraceptive method can access these at any time, unless they opt out,ⁱⁱ via a nested SFH or public sector provider within the facility where the mentorship sessions take place. Both government and SFH-embedded providers receive training on youth-friendliness and contraceptive technology to build technical skill and address bias. MMA applies PSI’s Counseling for Choice (C4C) methodology to improve the quality of counseling, and there is ongoing supportive supervision to reinforce provider skills and performance.ⁱⁱⁱ These embedded providers support continuous youth-friendly services and facilitate an exchange of knowledge about MMA to public sector providers.

MMA aims to deliver a unique experience for a married adolescent girl in northern Nigeria. The program cultivates curiosity, taps into life goals and aspirations, helps clients to feel respected and safe when accessing services, and supports girls and their partners to continue to use contraception for as long as desired in line with life goals. This unique experience is reflected in MMA’s ‘user journey’ (**Figure 3**).



ii. ‘Opt out’ is an evidence-informed approach where every girl has an opportunity to meet with a provider, unless she opts out. As some LFH classes take place in the community rather than at a facility to reduce transit costs, girls are not necessarily in a position to transition straight from LFH classes to opt-out contraceptive counseling in each MMA session. However, every girl has an opportunity to meet with a provider, unless she opts out, prior to completion of the LFH sessions. For example, girls are offered contraceptive counseling following the class on child spacing, held at the facility.

iii. Counseling for Choice (C4C) is a PSI initiative that contributes to a positive narrative around contraceptive choice. C4C pulls from existing counseling best practices and is intended to maximize client satisfaction and reduce method discontinuation among girls and women in need of contraception.

Table 2. How insight synthesis and A360’s implementation experience shaped the MMA technical strategy

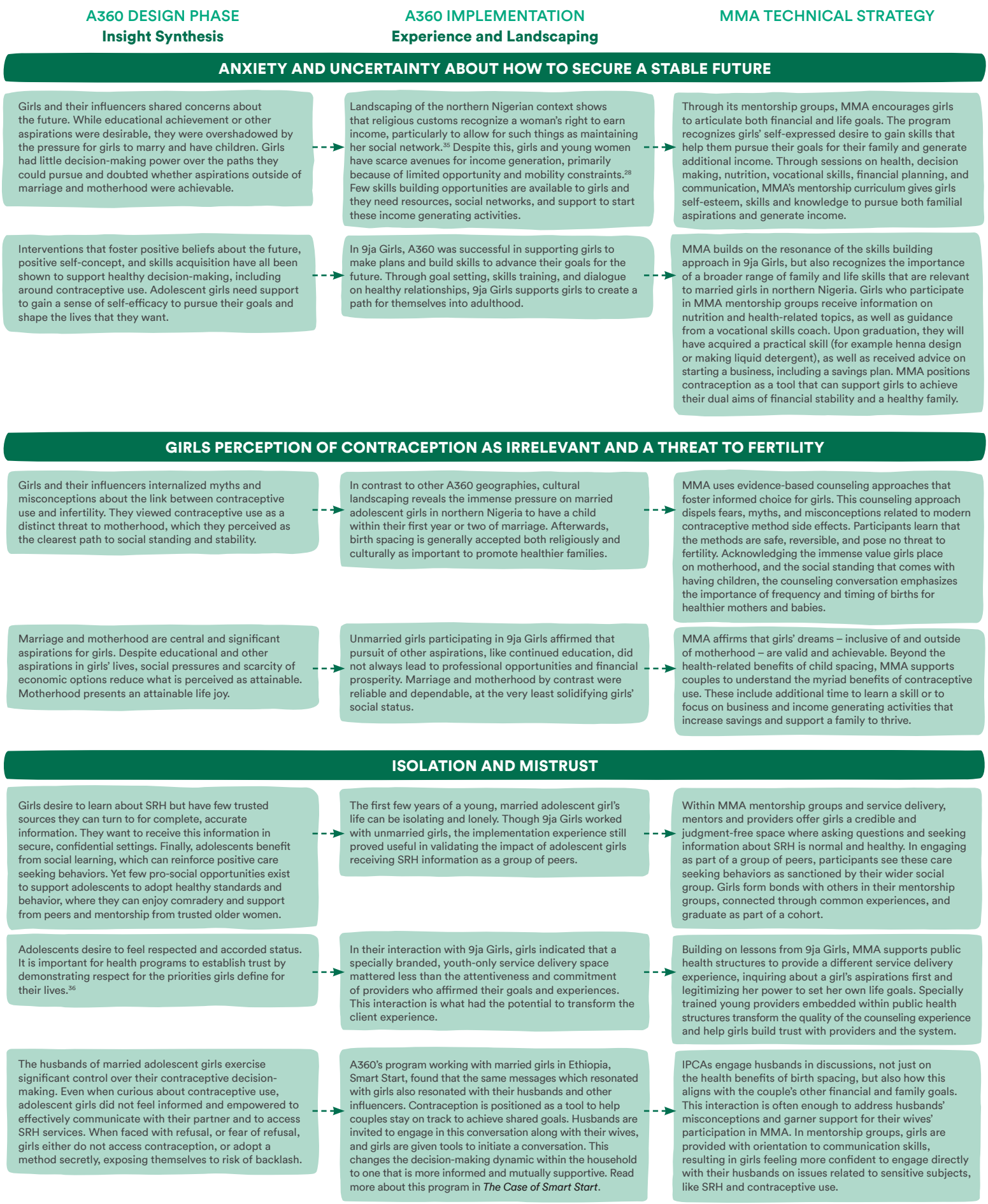


Figure 3. MMA user journey

MMA is designed to create a unique experience for a girl, one where she: feels inspired; has a safe and fun environment to ask questions about health, life, and family skills; is encouraged to identify goals for herself and her family; receives support to begin planning to achieve her goals; and hears messages that position contraception as a relevant tool to help her achieve her goals.



**STEP 1
Mobilization**

"I'm intrigued"

A married adolescent girl learns about MMA from a female mentor, or from her husband. She is curious and agrees to attend a mentored LFH course or counseling session because this service feels relevant to her and she feels supported by her partner to attend.



**STEP 2
Aspirational engagement**

"I'm inspired and motivated"

She attends up to four LFH sessions or goes directly to the health center for walk-in services. In the LFH sessions, she learns about topics that are applicable to her, including nutrition, child spacing, interpersonal communication, and financial management. She gains life and vocational skills and feels confident she can use these skills in her daily life, possibly to generate income. She sees how contraception can help her achieve her plans.



**STEP 3
Contraceptive counselling & service delivery**

"I feel respected and safe"

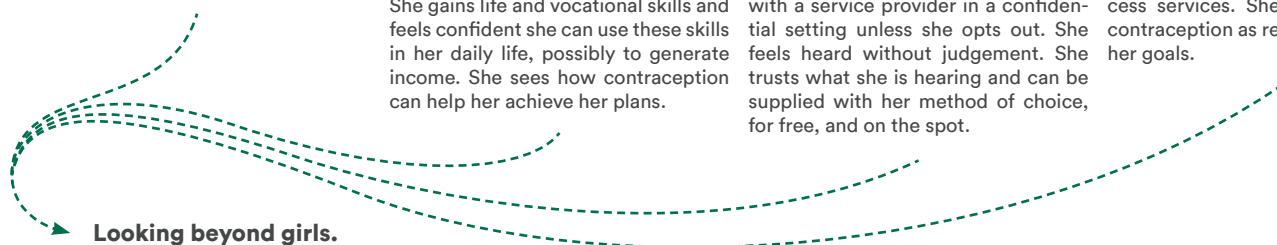
By design, she feels invited to share her vision for the future with the service provider (including during private walk-in appointments) and views contraception as relevant and valuable to realize her life plans. LFH sessions provide opportunities for her to meet with a service provider in a confidential setting unless she opts out. She feels heard without judgement. She trusts what she is hearing and can be supplied with her method of choice, for free, and on the spot.



**STEP 4
Follow up**

"I feel supported"

She feels listened to and supported. She is confident that she can return to the health center whenever she has questions, experiences side effects, or needs a resupply of contraceptives. She receives follow-up calls from the provider and feels empowered to access services. She continues to see contraception as relevant to achieving her goals.



Looking beyond girls.

Given married girls' limited autonomy and reliance on gatekeepers for approval to access SRH services, MMA engages the community and girls' key influencers to build support for their participation in MMA and to contribute to an improved enabling environment for girls' SRH and decision-making.

Collaboration with local and state government

Government partnership assists MMA to leverage existing health system resources and to provide additional support when there are gaps in service provision for adolescent girls. SFH partners with local government to select the facilities where MMA is implemented, recruit and train providers and mobilizers, and to conduct supportive supervision.

At the state and national level, ongoing engagement with the State Ministry of Health, Primary Health Care (PHC) Board and with the Federal Ministry of Health (MOH) facilitates government support for A360, particularly as it scales.^{iv}

Involving the community and key influencers / decision-makers

MMA engages with key leaders and decision-makers, including religious leaders, as an entry point into communities. Support of the state-level MOH was similarly important to build community acceptance of the program. After entering a community, the continuing work of sensitization is carried forward through the ongoing presence of mentors, IPCAs, and youth-friendly providers. MMA's vocational and life skills components foster buy-in from the community by tapping into shared priorities around future financial prosperity.

Mobilization through female mentors extends the reach of service sites

Female mentors and male IPCAs rely on existing community structures and peer networks to mobilize married adolescent girls. Mentors recruit girls to join MMA's LFH classes or access services directly from the facility, and male IPCAs use their networks to inform husbands about MMA and generate support for their wives to attend the program. MMA relies on this personal, one-on-one or group outreach to reach girls and couples beyond its static service delivery sites.

Strengthening public health facilities

Strengthening public sector service provision is critical for program scale and sustainability. SFH partners with the MOH to train a cadre of full-time providers to deliver youth-friendly services. These providers work alongside existing government providers as embedded staff within health centers. SFH offers coaching and technical guidance to public sector providers on adolescent-friendly service provision, technical competency, quality assurance, and supply chain management.

Capacity-building efforts to improve the quality of service delivery and counseling include ongoing on-the-job training (OJT) from SFH-hired Quality Focal Persons (QFPs),^v review meetings, and supportive supervision. SFH staff play an active role in attempting to manage stock outs at certain sites where this is a persistent issue by moving stock from site to site when stock outs occur, and by working directly with government to forecast need more accurately.

iv. The decentralized nature of government in Nigeria led the team to look to both state and local government administrative leadership for support, mapping key stakeholders and speaking with community leaders.

v. SFH hired QFPs that have previous experience with PSI's Women's Health Project (WHP) Quality of Care Standards. A QFP is assigned to each state, visiting clinics on a monthly basis. Based on the outcome of the QFP reports, SFH makes decisions around the frequency and focus of the visits.

Intervention Description

Mobilization

"I'm intrigued"

Over half of MMA participants hear about MMA from a female mentor, either individually or in groups. This is a girl's first touch point with the program. Female mentors are recruited from within the community they serve, prioritizing those who have some formal education, speak the local dialect, and have trusted reputations. These qualifications make mentors relatable within the community and ensure they can skillfully navigate community dynamics and sensitivities. Mentors receive training and coaching to refine their skill in delivering MMA's unique messaging during mobilization and when leading the LFH sessions. Mentors receive payment based on performance, with an expectation that 12 girls are recruited for each LFH session, with 48 graduating per month (four cohorts). Mentors follow up with girls via phone (or in person) to remind them of upcoming events, and to support them to address any barriers that might prevent them from participating in mentorship groups. This attention to complete referrals is supported by a pay-for-performance mechanism, with payment tiers based on the number of girls who successfully graduate.^{vi} Mentors conduct home visits to introduce MMA to girls and key influencers who may have cultural and social authority over an adolescent girls' attendance, including mothers-in-law and co-wives. Mentors are deliberate about the timing of recruitment, reaching girls in the late morning when they tend to be free from school, chores, and other work.

Beyond the female mentors, husbands are a key referral source for the program, with around 40% of MMA participants hearing about the program through their husbands. Male IPCAs are expected to contact 400 men per month and give 100 referrals. Male IPCAs meet with male partners of adolescent girls to orient them to the program and clarify how birth spacing can support their family and financial goals. Discussions with male IPCAs are an opportunity to increase men's knowledge about contraception. Birth spacing is framed as a practice that can support healthy, thriving families, a shared goal within communities. The discussion emphasizes visiting a trained health provider before choosing a method, return to fertility, and that the couple, "can stop and resume having children whenever [they] want." The skills building content of the MMA mentorship group sessions is often an important inducement for attendance in the program as this component is appealing to girls as well as their key influencers.

Aspirational engagement

"I'm inspired and motivated"

Girls attend up to four, two and a half hour LFH mentorship group sessions led by trained mentors. Some of these sessions take place at the house or compound of the

community leader, and a minimum of two are held at a health facility (see **Figure 4**). Storytelling, rhythm, rhyme, and repetition help girls to internalize learning and make the LFH session more interactive. Mentorship groups allow married girls the opportunity to socialize, reflect on course content, and discuss their goals in a safe and open environment. The curriculum encourages group engagement and building of support networks, culminating in the experience of graduating as part of a cohort. Mentors inform girls of the opportunity to go walk in for confidential, one-on-one SRH counselling. For some girls, this is sufficient for them to make the decision to go directly to a provider for contraceptive services without attending LFH sessions.

MMA's vocational and life skills components are important contributing factors to the program's success at reaching girls and their influencers. Girls mobilized through MMA frequently indicate that the ability to gain a marketable skill introduced by someone within the community is a primary motivator for attending mentorship groups, sparking curiosity and giving the program improved relevance to girls' goals and desires.

"The mentor came to our compound to invite us, she told us that we will be learning about how to take care of our family, about nutrition, FP but what got me interested was that she said at the end, we will learn a skill."

Girl, Nasarawa

MMA Process Evaluation Data Collection, Itad

Figure 4. MMA LFH Curriculum Content

SESSION 1

Improved family nutrition, personal hygiene, and sexually transmitted infections and reproductive tract infections

SESSION 2

Child spacing, decision-making, and (spousal) negotiation around child bearing

SESSION 3

Interpersonal communication, including effective communication, relationships, and conflict resolution

SESSION 4

Financial management, making and managing money, saving, presentation of a vocational skill, and graduation

^{vi}. Mobilizers receive payment for attendance referrals redeemed only. No payment is linked to contraceptive uptake, in line with principles of informed contraceptive choice and to prevent incentivization that could lead to coercion.

Contraceptive counselling and service delivery

"I feel respected and safe"

MMA mentorship sessions provide a safe space for girls to discuss SRH, gain confidence, and be linked to a youth-friendly provider who is trained to supply quality, reliable SRH information and services. Whether girls reach a provider through the LFH class or directly through a walk-in visit, once with the provider, all contraceptive services are provided on the spot and free of charge (with the exception of permanent methods, available at referral sites).

Within A360's process evaluation and qualitative research findings, girls reported high satisfaction with the quality of contraceptive counseling. The project introduced several strategies to enhance service quality, including a revised counseling protocol, method choice book, and method choice box. SFH also conducts joint supportive supervision visits in partnership with the government. In 2018, SFH incorporated the C4C approach, supporting MMA providers to deliver key SRH and contraceptive information using evidence-based approaches that promote informed choice. Job aids support providers to deliver comprehensive counseling in stages, fostering comprehension of key information, and identification of methods most likely to suit girls' needs and preferences based on their self-identified priorities. C4C leads with the most effective methods, affirms return to fertility, and prioritizes contraceptive information based on interest.

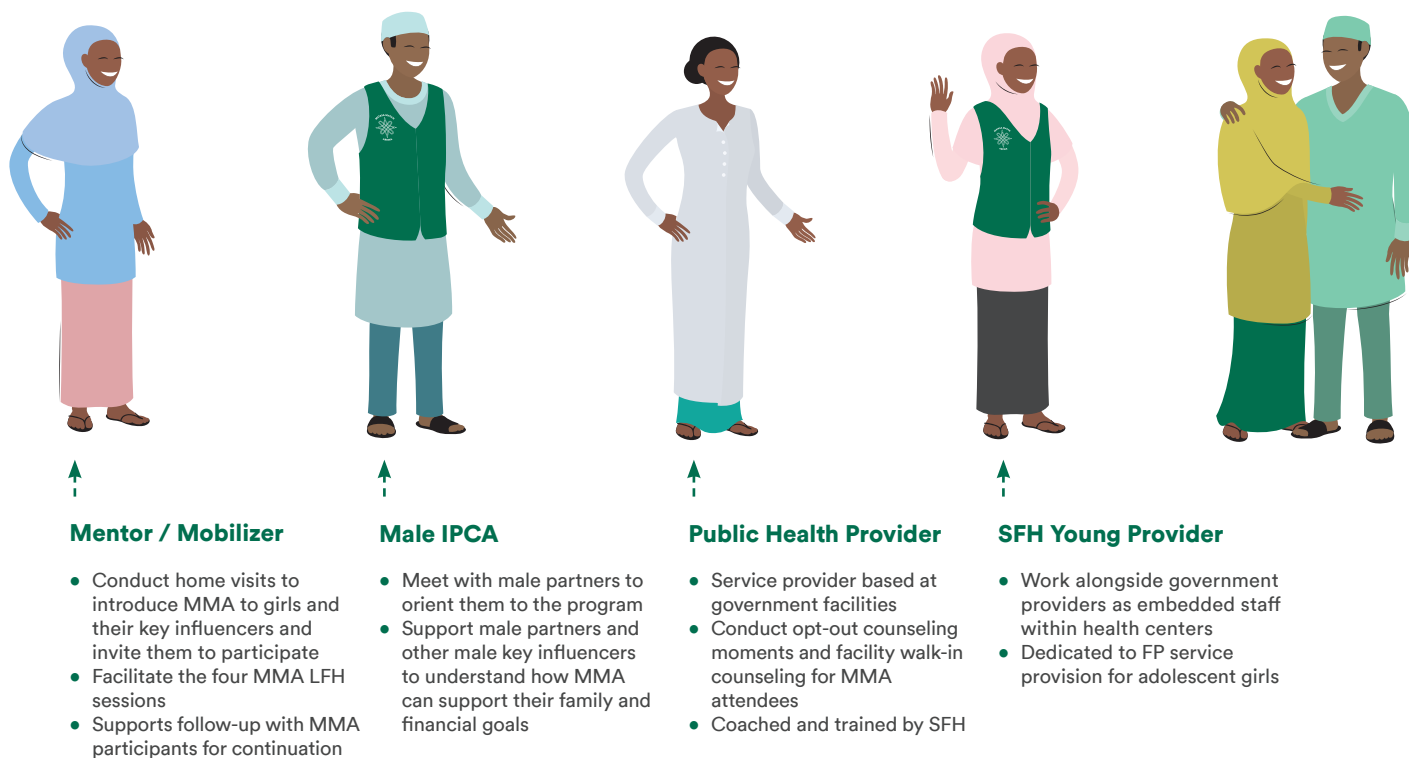
Follow-up

"I feel supported"

At the end of each counseling session, contraceptive adopters are reminded to return for follow up, with a schedule tailored to the method chosen. Providers follow a strict protocol for client follow up, giving out appointment cards that include their phone numbers and calling two to three days after method uptake, midway into method use, and then 2-3 days prior to when resupply would be needed. Girls are invited to return whenever they may need to, for example if experiencing side effects. Providers assess each girl's confidence with her chosen method, experience of side effects, and invite questions in order to assess her level of need for subsequent support. For girls who are not actively experiencing issues with side effects and who voice confidence in their method, providers shift their follow up approach to client-initiated. Providers record completed follow-up in their facility log which is regularly reviewed by the QFP. Through these calls, providers continue their relationship with girls and work to build girls' ongoing confidence to continue with their method of choice. Mentors occasionally assist with follow up, though this is in addition to their core responsibilities and not a formal part of their role. In Nasarawa, for example, girls sometimes felt inclined to contact their mentor if they had an issue as opposed to going directly to the provider.



Figure 5. Makeup of the MMA team



Implementation Experience

Beginning in the inquiry phase, SFH collaborated with federal and state officials to cultivate a sense of joint ownership of MMA. As A360 moved from design to implementation of MMA in early 2018, the project set the foundation for its adaptive implementation phase. In this phase, A360 rapidly responded to learning from data on performance, client experience, clinical and programmatic quality, and cost-effectiveness in order to improve MMA for girls and for the health system that would be the eventual owner of the intervention. From 2018-2020, A360 pursued iterative improvements in pursuit of cost-effectiveness, improved service delivery, and increased impact. Throughout implementation, state governments were invited to participate or lead in MMA recruitment, site selection, training, supportive supervision, data collection, and analysis.

Revising MMA's implementation strategy

SFH collaborates with local government officials to introduce MMA to the community, meeting with influential community leaders identified by government administrators to explain MMA's approach and seeks approval to begin recruiting and training mentors and male IPCAs and mobilizing adolescent girls. In 2019, SFH altered its implementation strategy, which originally consisted of static facilities that held outreach events at nearby clinics. These static facilities and nearby clinics became hubs and spokes, respectively, in MMA's new 'hub and spoke' model. In most sites where SFH is operating, one hub facility is attached to four spokes. Hub facilities are selected from

densely populated areas using data that suggest a relatively higher unmet need for family planning and are where some LFH mentorship groups meet. These sites also have nested SFH-paid providers and are where female mentors and male IPCAs are based. Hub facilities are more likely to see both LFH and walk-in clients. Spoke facilities are on the periphery in less densely populated rural areas, where girls tend to marry earlier. SFH staff offer guidance and coaching to the spoke facility providers and strengthen their ability to provide youth-friendly services. These facilities are also supported by SFH to host reach-out events. Girls attending spoke events are mobilized by government mobilizers who support MMA on an ad hoc basis, and aspirational program offerings are more limited than at the hub facilities with an abridged version of LFH that does not include vocational training.

Hub and spoke facilities are both government-managed primary care facilities run by the local administration. In both hubs and spokes, SFH supports data collection, as well as consumable procurement and support with forecasting to ensure consistent, free contraceptive services for girls. The goal of transitioning to this model was to create an adolescent-friendly service delivery infrastructure, allow MMA to extend the program's reach, and connect with girls farther away from hub sites while building capacity among government-run facilities.

During the 2020 COVID-19 pandemic, SFH adapted the hub and spoke model to respond to changes in the operating environment. This adaptation has been called 'modified reach-out.' Instead of holding events a few times

per month at spoke facilities, government mobilizers and providers that have previously been contracted to support ad hoc reach-out events began offering continuous one-on-one mobilization, counseling, and service provision at spoke facilities. This adaptation has proved to be successful, and SFH plans on continuing to implement in this way even after pandemic-related restrictions are lifted.

Balancing short-term uptake and long-term impact

Early in A360’s implementation phase, considerations of cost and a focus on adoption rates drove decisions regarding which components of MMA to adapt or drop entirely. This focus on cost-efficiency meant that intervention components that had an immediate impact on contraceptive adoption were prioritized over components that might have had longer-term impact. A360’s mid-term evaluation reinforced the potentially perverse incentives of focusing on cost-efficiency. In response, SFH, in partnership with young designers and public providers, strengthened MMA’s intervention design to support not only adoption, but contraceptive continuation. SFH brought providers and girls together to create new provider-initiated follow-up mechanisms. Girls can opt-in to a follow up program with providers, consenting to be reached via phone or text message according to preference. Providers follow up at three intervals to check in with girls, assess their need for ongoing support, and tailor further calls as needed based on the results of this initial follow-up. Additional detail on A360’s

response to learnings from this initial focus on cost-efficiency can be found in A360’s Learning and Growth since the 2018 Mid-Term Evaluation.

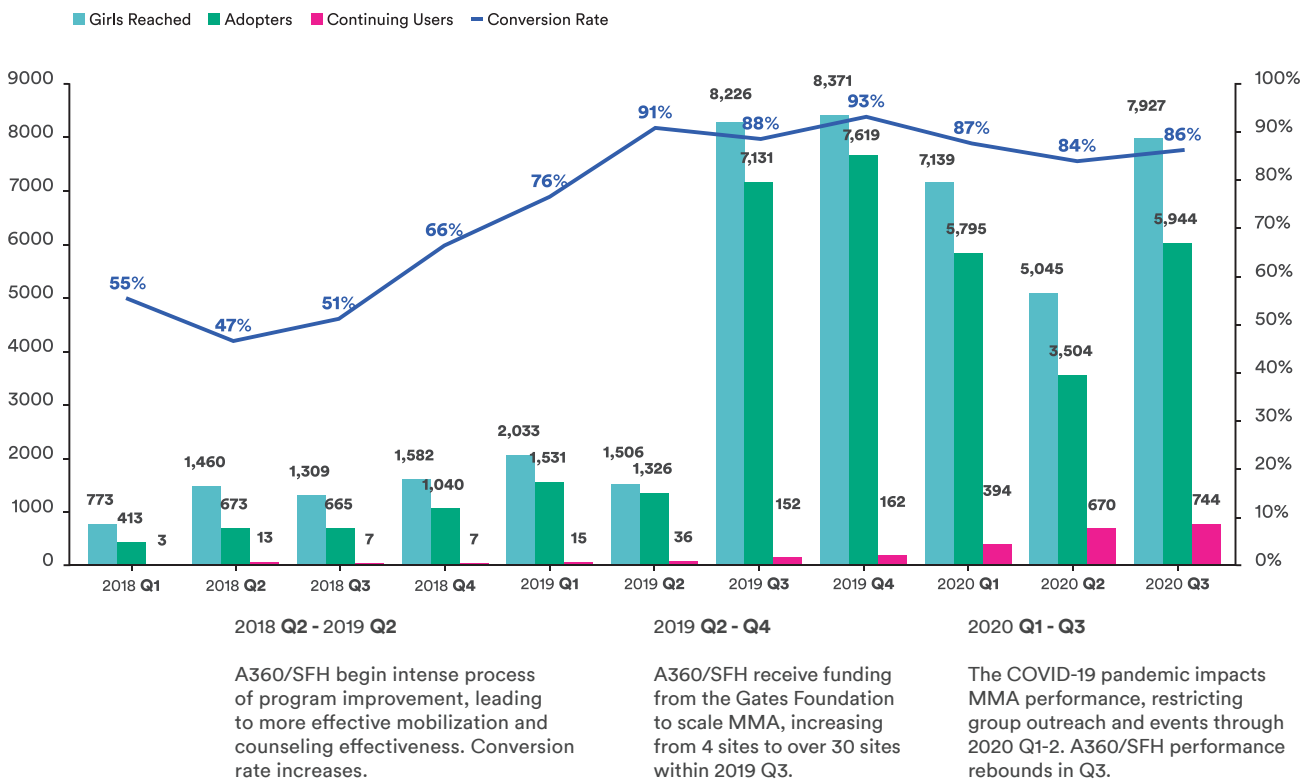
Understanding the gender context

As a project focused on adolescent girls, A360 is acutely aware of the challenges these girls face in accessing health services or making decisions within their families and households. The project recognized its failure to include gender as a specific disciplinary lens during the design process for its interventions. In 2019, findings from A360’s process evaluation pointed to a critical need to further understand the role of gender norms in influencing girls’ agency and contraceptive decision-making within MMA. A360 partnered with a local Nigerian organization, the Center for Girls Education, to implement a mixed methods research study which aimed: i) to understand the landscape and gendered context which influences the lives of married adolescent girls in Kaduna state in Nigeria, and ii) to assess the impact of this gendered context on the user journey for MMA clients. This research has generated a rich body of evidence on how girls’ interactions with MMA are mediated by gender norms that inform their attitudes and shape their experiences.

Findings showed that the final decision about a girl’s participation in MMA was ultimately made by her husband, and that husbands’ interactions with IPCAs often did not do enough to address their reluctance or misconceptions.

Figure 6. Number of girls reached by MMA, adopters, and conversion rate^{vii}

MMA key performance indicators, January 2018 – September 2020



vii. The conversation rate reflects: Total adopters ÷ Eligible girls (with eligible girls defined as all girls reached minus those pregnant or currently using a method). In Figure 6, this would be reflected as the green bar ÷ (blue bar - pink bar).

Girls' and their husbands' interest in the program coalesced around the vocational skills component, with husbands highly supportive of the additional skills their wives learned during their interaction with MMA. Girls who participated in MMA often shared what they learned in the groups with their husbands (as well as other women) and said they were pleased with their husband's response. A360 will be using these findings to continue to adapt MMA, particularly in considering how to engage male partners to support girl's agency and SRH decision-making.

"My husband was uninterested in birth spacing but after he met with the IPC, he changed his mind. It would have been difficult for me to convince him, but he listens to other men."

Married girl, MMA participant

"I thought my husband knows everything and whatever he says is what I must do. After MMA I began talking with him about what I thought, and I was surprised to see that he was happy with this. Now if he is doing something that I am not happy with I am able to tell him in a way that he will accept."

Married girl, MMA participant

Adapting to COVID-19

MMA adapted its programming to ensure program continuity – mobilization and program participation were tailored to the realities of life during the COVID-19 pandemic. Mobilization, LFH class attendance, and maintaining the health and safety for A360 clients posed distinct challenges given restrictions on movement and group activity during periods of lockdown. Mentor and provider WhatsApp groups were established in each state for communications and training purposes. This is being expanded to include girls that consent to participate in their own group. In southern Nigeria, where phone ownership is higher, providers are holding LLH classes over WhatsApp, hosting text discussions, and a Q&A session (which includes an option

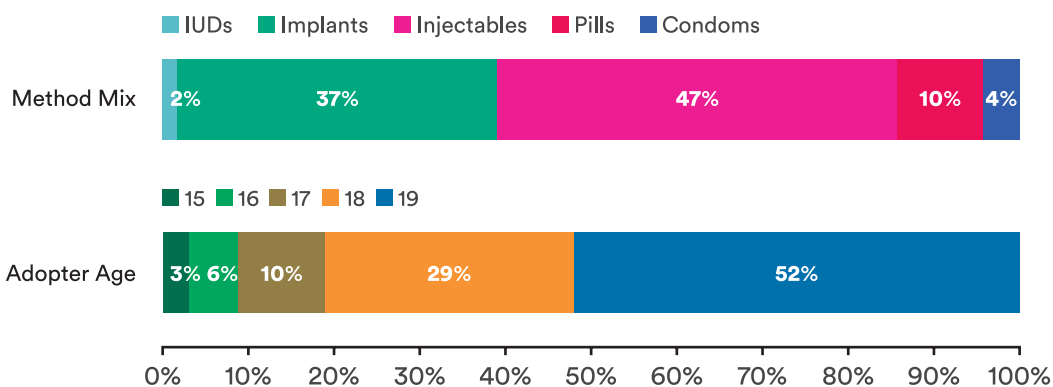
for sending private questions to the provider). Given lower phone ownership in the north, mentors are instead going house to house to reach girls and refer them to facilities for services. Additional site-level precautions are in place including training on COVID-19 prevention and protection via WhatsApp and distribution of personal protective equipment (PPE) to mentors, male IPCAs and providers.

Performance

MMA has succeeded by making contraception relevant to what girls and their influencers want and need, as well as by improving access to youth-friendly contraceptive information and services. This has raised SRH awareness and acceptability in the community, and demand for contraceptive services including long-acting reversible contraception (LARC): implants and IUDs. Since the start of implementation, approximately 45,300 adolescent girls have attended the program, whether through a mentorship group or through a walk-in to a supported facility. SFH piloted MMA in four sites in January 2018; by August 2019, the program had received funding from an anonymous donor to scale the program. MMA is now operational in nine hub facilities, and 34 spokes. Overall, 35,641 adolescent girls voluntarily adopted modern contraception in project-supported sites from January 2018 to September 2020 (Figure 6).

Since implementation launched in January 2018, over 40% of girls who voluntarily adopted a contraceptive method through MMA chose a LARC. Implants and injectables were the method of choice for most adopters. With nearly two in five adopters taking up a LARC (Figure 6), MMA's performance sharply contrasts with national survey data, with only around 4% LARC use for married Nigerian women 15-49 overall (3% implants, 1% IUDs).²¹ Preference for LARCs, particularly implants, may be even higher than these numbers suggest as MMA sites were impacted by LARC stock outs in Nasarawa and Kaduna States.^{viii} High LARC uptake also represents a shift from early MMA implementation, when around three-quarters of adopters took up a short-acting method. The majority of MMA adopters are older adolescents and tend to have already started childbearing. Increased LARC uptake among MMA

Figure 7. MMA project to date method mix and age disaggregation, January 2018 – September 2020



viii. There was also a drop in the number of girls reached and adopting a method in subsequent quarters of 2020 resulting from lockdowns and reduced service delivery due to the COVID-19 pandemic. Kaduna State also experienced security issues, which reduced the number of girls attending events and accessing services.

adopters is likely the result of several factors, including public sector capacity-building, on the job training, supportive supervision, and improved counseling protocols at the facility level to build provider comfort in LARC service provision and to address provider bias. This also suggests that A360 is addressing barriers to access and stigma around LARCs, while creating influencer buy-in and supporting girls to better understand the relevance and importance of contraception. Young providers interviewed for MMA's process evaluation were confident in their role, felt they were receiving sufficient training and support, and spoke about how the program had changed their attitudes toward providing services to adolescents.

Analysis conducted by A360's process evaluator, Itad, concluded that girls who attend LFH sessions are generally younger, with older adolescents (18-19) more likely to go straight to walk-in counseling, bypassing MMA's LFH component. Girls participating in LFH sessions were also significantly less likely to choose to adopt contraception compared to walk-ins. This data suggests that walk-in clients have a more expressed desire for contraception. In contrast, girls who attend mentorship groups seem to prioritize the program's life and vocational skills components, which may eventually serve as a critical bridge to understanding contraception as relevant to achieving their life goals. There may also be confidentiality concerns, with girls not wishing to agree to adopt in a group setting, in the presence of their peers, but returning to the facility at a later date as a walk-in.

Parity is also an influencing factor in whether and what method girls chose to adopt. Those with no living children were consistently the least likely to voluntarily adopt a method, likely tied to the social pressure married adolescents in northern Nigeria face to have at least one child before beginning contraceptive use to space births. Within MMA, girls with two children were most likely to adopt contraception, followed by those with one child. Girls with children were also more likely to adopt a LARC. In client exit interviews (CEIs) conducted in early 2020 with MMA participants, the majority of girls interviewed stated that they wanted to delay pregnancy, with nearly half of girls saying they wanted to wait three to five years before becoming pregnant. Younger adolescent girls desired a pregnancy sooner than older girls, and those in monogamous marriages desired pregnancy sooner than those in polygynous marriages.

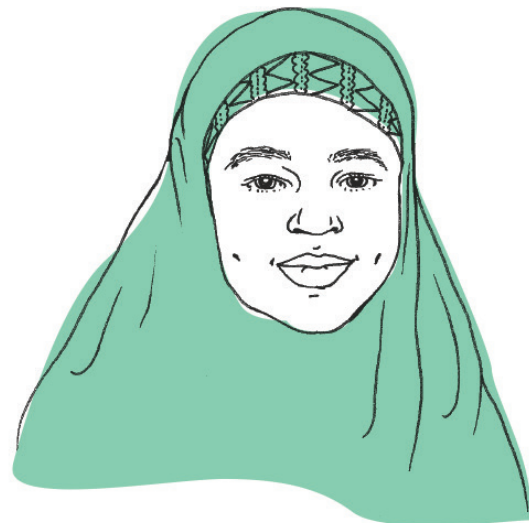
The foundational components of informed and voluntary decision-making were reflected in girls' responses to their service delivery experience. Nearly all girls who adopted a method following an MMA event said they were informed about alternative methods that they could use, 90% said they were informed about side effects, and 87% about what to do if they experienced side effects. Four in five girls said they understood that they could switch methods if they needed or wanted to do so. Nearly all of the girls interviewed said they planned to continue to use contraception for a full year and indicated that they knew where to go to access follow-up services.

Within A360's process evaluation data, girls consistently said that they trusted and respected the MMA mentors and were able to speak with their mentor with ease and confidence. They experienced their interaction with mentors as non-judgmental and felt comfortable discussing their questions and concerns. In both northern and southern Nigeria, girls said that the mentorship sessions built their confidence and self-esteem.

According to CEIs, after visiting with a mentor, nearly all participants had a specific goal for their life/future, felt they could achieve this goal, and reported feeling supported to achieve this goal. 80% of those who had a specific goal for their future went on to voluntarily adopt a method. Both the process evaluation and CEIs validated the importance of support, notably from girls' husbands, to adopt and continue contraception in this context. CEIs showed that 93% of girls discussed attending MMA with someone (predominantly her husband) prior to participating in an event or a counseling session with a provider. Of those girls, all said they had received support for their participation in the program. In Nasarawa, there were indications that counseling was effective enough to slowly move the needle and shift prevalent myths and misconceptions around side effects among girls and their husbands, removing some fear and confusion about contraception.

"Before now, I was told that anyone who takes contraceptives will not give birth again, but now I know is not true that contraceptive is for child spacing and not child stopping"

Girl, Nasarawa



Reflections, Lessons Learned and Recommendations

As A360's initial investment draws to a close, there is an opportunity to reflect on project learning that can inform and strengthen future ASRH programming.

Aspirational programming

MMA's vocational skills component excited and motivated many (mostly younger) girls to attend LFH sessions. The belief that MMA was a vocational training program led to great interest at the time of recruitment among girls and their influencers given MMA's perceived potential to elevate a woman's status and bargaining power in the household and to increase her ability to contribute to daily expenses. One male shopkeeper commented that, "A lot of wives are completely dependent on their husbands to solve every little financial need. This can lead to abuse... When a wife learns a trade, she gains a little freedom and can solve little problems without relying on her husband."³⁷ That said, girls and their influencers asked for more support from MMA in pursuing their financial goals. Concerns such as lack of capital, insufficient time to learn and practice, and a mismatch between the skill provided and the available market often prevented girls from applying the skills that they learned in MMA to generate income. The evidence remains: the intersection of SRH and economic empowerment for girls provides a critical opportunity, provided we can deliver on what girls want and need. There may be a number of options to retain the beneficial aspects of MMA's aspirational content, while not overstating what support MMA can offer. This is something that A360 is reflecting on and adapting in its next project phase.

Male involvement

Acknowledging the role of husbands as key influencers in girls' lives, male IPCAs were engaged to generate support from husbands for girls' participation in MMA. There are benefits to this approach. Support from key influencers is often critical and valued both in the decision to adopt contraception and in the ability to continue method use, especially in a context where consent may be required even to access a health facility. Many MMA attendees who did not adopt a method indicated that expectation of disapproval from their husbands was a key factor in their decision not to adopt. Some girls took up a method of contraception in secret, without the knowledge of their partner, putting themselves at potential risk. For MMA, husbands often pose a barrier to girls' access to contraception, but a supportive partner can also be a facilitator. This provides a clear rationale for meaningful male partner engagement.

A360 has encountered this particular tension – how to involve male partners constructively while recognizing the central importance of *girls'* agency and voluntary decision-making. As many family planning interventions target women, they are often more knowledgeable and informed about SRH than their partners. This highlights the

importance of increasing male partners' SRH knowledge, thereby decreasing their susceptibility to prevalent myths and misconceptions. Ideally, this improved knowledge cascades to increased support (or acceptance) for their wives' contraceptive use and SRH decision-making. Per MMA's gender assessment, nearly all of the husbands interviewed expressed satisfaction with the decision to enroll their wives in the program, and a number of them said that they now approved of birth spacing for improved maternal and child health. The husband of one couple that had relied on a traditional form of contraception in the past said, "*I'm seeing exactly what the nurse told us. The modern we are using now is more reliable. My wife hasn't experienced any of the severe side effects that I was worried about before.*"³⁷

MMA engages in this balancing act, "promoting empowerment through life skills and contraceptive services, and using messaging that is acceptable to communities and husbands in a setting where contraception is stigmatized and husbands hold most of the decision-making power."³⁷ Discussions with male IPCAs as a means of beginning this conversation with men are vital, but not enough. Pastors and imams wield significant influence in the community and with girls' male partners. Greater work at the community level, for example through engaging with religious leaders, could create a more favorable enabling environment around choice to adopt contraception.

Government partnership and pathway for sustainability

As the first phase of A360 concludes and the next phase begins, the project is focusing its efforts on the pathway for sustainability. This includes pursuit of institutionalization of all or components of its interventions within public structures. Similar to A360's other interventions, MMA is implemented within the public system. The government of Nigeria remains SFH's primary partner, with the primary interaction at the state level given Nigeria's decentralized system of government. SFH leverages government providers, trainers, space for service delivery in PHCs, and commodities for MMA implementation. The program's engagement with state governments in the north is notably strong, with UNFPA funding a government-led pilot of MMA in Kaduna state, for example. Yet, A360's experience thus far has reinforced that some core components that have underscored MMA's relevance can be at risk when prioritizing integration, especially when governments lack the capacity to recruit and retain cadres of youth-friendly providers or to implement the unique aspirational components of A360's interventions. Without key partnership across government ministries, and strategic capacity building for government stakeholders, A360 risks MMA being watered down to something that no longer responds to girls' needs and experiences. This struggle to fundamentally shift how the government serves adolescent girls is not unique to A360. Global ASRH programming wrestles with this same issue. The lack of a solid evidence base on how to implement and sustain effective ASRH programming through government systems is one of the key reasons why so few ASRH programs have proven scalable. As A360 moves

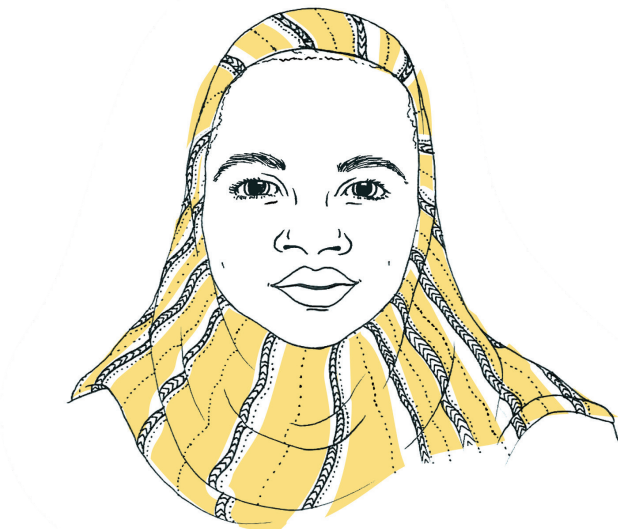
forward in pursuit of sustainability, the project hopes to learn with the global community how to find this balance – between fidelity to MMA’s unique user journey and adaptations needed to create fit for government integration of A360 approaches into policy and practice.

Next Steps

Over three years of design and implementation, MMA has remained focused on supporting local health system actors to better reach and respond to the SRH needs of married adolescent girls. By recognizing and supporting the needs and aspirations of girls themselves, including vocational and life skills to pursue a stable future, health systems gain a pathway to improved modern contraceptive coverage. MMA has worked to advance an innovative multi-sectoral approach to ASRH in partnership with federal, state,

and local governments, community leaders, and marital partners, and aims to continue building local implementation capacity to sustain this model into the future.

Although A360’s initial investment period ended in September 2020, additional funding has been secured to extend programming through 2025. With this investment, MMA will focus on three key areas: **adaptation** of A360’s interventions to improve effectiveness; **integration** within government health structures to sustain implementation; and **learning** and **contribution to the global evidence base** to advance global ASRH. A360 will continue to strive for sustained, quality, client-centered services. The project commits to further exploring cross-sectoral opportunities that can respond to girls’ holistic needs, and to support girls and governments to understand how contraception can be an effective tool to delay first birth, avert unplanned pregnancy, and achieve their individual and collective goals.



Contributing Authors

Appearing in alphabetic order. Italics indicate authorship.

Alexis Coppola
Meghan Cutherell
Oowo Anita Elabo
Rakiya Idris Labaran
Sara Malakoff
Fifi Ogbondeminu
Joy Otsanya Ede
Oyebukola T. Tomori-Adeleye
Matthew Wilson

Contribution to the research team at the Center for Girl Child Education for the results of the MMA gender assessment. Including Dr. Daniel Perlman, Mardhiyyah Abbas Mashi, Tessa Fujisaki, Made David, Aminu Bello Gurin, Aisha Abubakar, and Hajara Abubakar.

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References Cited

1. Denno DM, Hoopes AJ, Chandra-Mouli V. Effective strategies to provide adolescent sexual and reproductive health services and to increase demand and community support. *J Adolesc Heal.* 2015;56(1). doi:10.1016/j.jadohealth.2014.09.012
2. United Nations Children's Fund (UNICEF). *Adolescent Demographics*. data.unicef.org/topic/adolescents/demographics. Published 2019. Accessed December 3, 2020.
3. World Health Organization (WHO). *Health for the World's Adolescents: A Second Chance in the Second Decade*; 2014. apps.who.int/iris/handle/10665/112750.
4. World Health Organization (WHO). Why invest in adolescent health? www.who.int/maternal_child_adolescent/topics/adolescence/why-invest/en. Published 2020. Accessed December 1, 2020.
5. Morris JL, Rushwan H. Adolescent sexual and reproductive health: The global challenges. *Int J Gynecol Obstet.* 2015;131. doi:10.1016/j.ijgo.2015.02.006
6. Jain A, Ismail H, Tobey E, Erulkar A. Stigma as a barrier to family planning use among married youth in Ethiopia. *J Biosoc Sci.* 2019;51(4). doi:10.1017/S0021932018000305
7. Adams MK, Salazar E, Lundgren R. Tell them you are planning for the future: Gender norms and family planning among adolescents in northern Uganda. *Int J Gynecol Obstet.* 2013;123(SUPPL.1). doi:10.1016/j.ijgo.2013.07.004
8. Dynes M, Stephenson R, Rubardt M, Bartel D. The influence of perceptions of community norms on current contraceptive use among men and women in Ethiopia and Kenya. *Heal Place.* 2012;18(4). doi:10.1016/j.healthplace.2012.04.006
9. Kane S, Kok M, Rial M, Matere A, Dieleman M, Broerse JE. Social norms and family planning decisions in South Sudan. *BMC Public Health.* 2016;16(1):1-12. doi:10.1186/s12889-016-3839-6
10. World Health Organization (WHO). *Married Adolescents: No Place of Safety*; 2006. www.who.int/maternal_child_adolescent/documents/9241593776/en. Accessed November 30, 2020.
11. De Vargas Nunes Coll C, Ewerling F, Hellwig F, De Barros AJD. Contraception in adolescence: The influence of parity and marital status on contraceptive use in 73 low-and middle-income countries. *Reprod Health.* 2019;16(1). doi:10.1186/s12978-019-0686-9
12. World Health Organization (WHO). *Adolescent Pregnancy Fact Sheet*; 2020. www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy. Accessed November 30, 2020.
13. Raj A, Boehmer U. Girl Child Marriage and Its Association With National Rates of HIV, Maternal Health, and Infant Mortality Across 97 Countries. *Violence Against Women.* 2013;19(4). doi:10.1177/1077801213487747
14. United Nations Population Fund (UNFPA). *Girlhood, Not Motherhood: Preventing Adolescent Pregnancy*; 2015. www.unfpa.org/sites/default/files/pub-pdf/Girlhood_not_motherhood_final_web.pdf.
15. World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF). *Action for Adolescent Health: Towards a Common Agenda*. World Health Organization; 1997.
16. World Health Organization (WHO). *Global Accelerated Action for the Health of Adolescents (AA-HA!) Guidance to Support Country Implementation*; 2017. www.who.int/maternal_child_adolescent/topics/adolescence/framework-accelerated-action/en.
17. Gavin LE, Catalano RF, Markham CM. Positive Youth Development as a Strategy to Promote Adolescent Sexual and Reproductive Health. *J Adolesc Heal.* 2010;46(3 SUPPL.). doi:10.1016/j.jadohealth.2009.12.017
18. Save the Children. *Beyond the ABCs of FTPs: A Deep Dive into Emerging Considerations for First Time Parent Programs | Resource Centre*; 2019. resourcecentre.savethechildren.net/node/15314/pdf/ftp-tech-brief_print_update-web.pdf
19. Norton M, Chandra-Mouli V, Lane C. Interventions for preventing unintended, rapid repeat pregnancy among adolescents: A review of the evidence and lessons from high-quality evaluations. *Glob Heal Sci Pract.* 2017;5(4). doi:10.9745/GHSP-D-17-00131
20. United Nations Department of Economic and Social Affairs (UNDESA). *World Urbanization Prospects: Highlights*; 2018. population.un.org/wup/Publications/Files/WUP2018-Highlights.pdf.
21. National Population Commission - NPC/Nigeria and ICF. *Nigeria Demographic and Health Survey 2018*. Abuja, Nigeria, and Rockville, Maryland; 2019. dhsprogram.com/publications/publication-FR359-DHS-Final-Reports.cfm.
22. Roser M, Ritchie H. Maternal Mortality. Our World Data. 2013. ourworldindata.org/maternal-mortality. Accessed November 30, 2020.
23. Meh C, Thind A, Ryan B, Terry A. Levels and determinants of maternal mortality in northern and southern Nigeria. *BMC Pregnancy Childbirth.* 2019;19(1). doi:10.1186/s12884-019-2471-8
24. PMA2020 Abortion Survey Results: Nigeria; 2018. www.pma2020.org/sites/default/files/AbortionModule_Brief_111518.pdf. Accessed November 30, 2020.
25. Mercer LD, Lu F, Proctor JL. Sub-national levels and trends in contraceptive prevalence, unmet need, and demand for family planning in Nigeria with survey uncertainty. *BMC Public Health.* 2019;19(1). doi:10.1186/s12889-019-8043-z
26. PMA2017/Nigeria Adolescents and Young Adults Health Brief | PMA2020. www.pma2020.org/reports/pma2017nigeria-adolescents-and-young-adults-health-brief. Accessed December 3, 2020.
27. Bell SO, Omolubi E, Olaolun F, Shankar M, Moreau C. Inequities in the incidence and safety of abortion in Nigeria. *BMJ Glob Heal.* 2020;5(1). doi:10.1136/bmjgh-2019-001814
28. World Health Organization Regional office for Africa, Federal Ministry of Health Nigeria. *Assessment of Barriers to Accessing Health Services for Disadvantaged Adolescents in Nigeria*; 2019. apps.who.int/iris/handle/10665/324926. Accessed November 30, 2020.
29. PMA2020. *Family Planning Brief: Kaduna, Nigeria*; 2018. www.pma2020.org/sites/default/files/PMA2020-NG-Kaduna-R5-FPbrief.pdf. Accessed November 30, 2020.
30. PMA2020. *Family Planning Brief: Nasarawa, Nigeria*; 2018. www.pma2020.org/sites/default/files/NGR5-Nasarawa-v2-20180928.pdf. Accessed November 30, 2020.
31. World Health Organization (WHO). Handbook for Conducting an Adolescent Health Services Barriers Assessment (AHSBA) with a Focus on Disadvantaged Adolescents; 2019. www.who.int/gender-equity-rights/knowledge/adolescent-health-services-barriers-assessment/en. Accessed November 30, 2020.
32. World Health Organization (WHO). Making Health Services Adolescent Friendly: Developing National Quality Standards for Adolescent Friendly Health Services; 2012. www.who.int/maternal_child_adolescent/documents/adolescent_friendly_services/en. Accessed October 19, 2020.
33. Guttmacher Institute. *Fact Sheet: Abortion in Nigeria*; 2015. www.guttmacher.org/sites/default/files/factsheet/fb-nigeria.pdf. Accessed September 2, 2020.
34. Lane C, Joof YM, Hassan AA, Pryor S. Promoting healthy timing and spacing of pregnancy with young married women in Northern Nigeria: a short report. *Afr J Reprod Health.* 2012;16(2).
35. British Council, Department for International Development (DFID). *Promoting Women's Rights through Sharia in Northern Nigeria*; 2006.
36. Yeager DS, Dahl RE, Dweck CS. Why Interventions to Influence Adolescent Behavior Often Fail but Could Succeed. *Perspect Psychol Sci.* 2018;13(1). doi:10.1177/1745691617722620
37. Perlman DD, Mashi M, Fujisaki T, et al. *Matasa Matan Arewa (MMA) Gender Context, Program Effectiveness, and the User Journey*; 2020.



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