

INTERVENTIONS TO REACH MARRIED ADOLESCENTS FOR INCREASED CONTRACEPTIVE USE IN NIGER

TECHNICAL BRIEF
SEPTEMBER 2019

During adolescence and youth, individuals experience significant physical, emotional, and social changes. Notably, they begin to explore their sexuality. Sociocultural and structural barriers often make sexual and reproductive health and support services unavailable to adolescents and youth at a time when they need them most. This is particularly true for young, married adolescent girls in Niger—a country with the highest rate of early marriage and among the highest rates of adolescent fertility in the world. In 2016, Pathfinder International began implementation of the Bill & Melinda Gates Foundation-funded Reaching Married Adolescents—a project that draws upon past Pathfinder global experience to increase contraceptive uptake among married adolescents in Niger. The project intends to build upon past lessons learned by generating evidence on how these interventions work in the Nigerien context, the relative effectiveness of three different intervention approaches, and the cost effectiveness of these interventions. This technical brief explores the project's strategy, experience, and findings, and offers lessons learned from Niger's first cluster, randomized-controlled trial of interventions designed to increase contraceptive use among young, married adolescent girls.



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PHOTO: Tagaza Djibo, 2016

Counseling session in Loga district



Context

Adolescents and youth form a special population: adolescence is a time of transition, during which human beings experience a range of physical, emotional, and social changes. It is a time when individuals begin to explore sexual relationships and mature sexually. Therefore, it is a time during which there is great need for quality sexual and reproductive health information and services. However, adolescents and youth often face barriers to the very services they need most urgently to ensure their ability to exercise their rights to healthy sexual and reproductive lives. As a result, adolescents and youth often experience disproportionately poor sexual and reproductive health.

Young, married girls in Niger are particularly vulnerable to poor sexual and reproductive health outcomes. Sexual activity and reproduction typically happens early and within the context of marriage. Though human rights standards call for 18 as the minimum age for marriage, the median age for first marriage is 15.7¹ and 76 percent of young, Nigerien girls are married by the age of 18 (the highest early marriage rate in the world).² After marriage, girls face pressure to bear children immediately—the median age at first sexual intercourse is 15.9³—resulting in one of the highest rates of early childbearing in the world.⁴ The social norms supporting early and frequent childbirth put young, married girls and their infants at risk. Modern contraceptives could prevent early and closely-spaced pregnancies, however, only 5.9 percent of married adolescents between the ages of 15 and 19 use a modern method of contraception.⁵

The leading cause of death for girls, worldwide, between the ages of 15 and 19 is complications due to pregnancy and childbirth.⁶ Access to and use of quality contraception not only reduces health risks associated with early and closely-spaced pregnancies, it can also positively affect socioeconomic health by preventing girls from leaving school and the workforce prematurely for childbirth and childcare.⁷ Finally, access to and use of contraception supports girls’ and women’s right to decide the number and spacing of their children.

There are broader sociocultural norms and institutional systems that impact access to quality contraception. For example, there is a shortage of skilled health workers in Niger. While the WHO recommends 4.45 physicians, nurses, and midwives per 1,000 people to meet Sustainable Development Goal 3,⁸ Niger reports

TABLE 1: Epidemiological context, Niger. Data from 2012 Demographic and Health Survey

Total fertility rate	7.6
Percent of women between 15 and 19 years old who are married	61
Median age at first marriage, women between ages 25 and 49	15.7
Median age at first sex, women between ages 25 and 49	15.9
Median age at first birth, women between ages 25 and 29	18.1
Median age at first birth, women between ages 20 and 49	18.2 (rural), 19.9 (urban)
Percent of women between the ages of 20 and 24 giving birth before age 18	33*
Percent of total population living in urban settings	16.3

*Data from Population Reference Bureau, 2019 Family Planning Data Sheet <https://www.prb.org/2019-family-planning-data-sheet-highlights-family-planning-method-use-around-the-world/>

approximately 0.31 nurses and midwifery personnel per 1,000 people.⁹ Further, persisting gender inequality (in the UNDP’s 2017 Gender Inequality Index, Niger ranked 151 of 160 countries measured)^{10,11} negatively impacts young, married girls’ abilities to fully exercise and enjoy their rights to sexual and reproductive health. For example, of married women in Niger, only 21 percent report having decision-making power about their own health. This percentage fluctuates with age and number of children—16.2 percent of married girls between 15 and 19 years old and 18.5 percent of women with no children report having decision-making power about their own health care versus 23.9 percent of women with five or more children.¹¹

One half of Niger’s 22.2 million people are under the age of 15.¹² There is an urgent need to reach Niger’s adolescents and youth—particularly its young, married girls—with quality sexual and reproductive health information and services.

In 2016, Pathfinder International began implementation of Reaching Married Adolescents (RMA)—a research project

TABLE 2: Modern contraceptive prevalence rates (mCPR) and unmet need for married women, married adolescent women, urban and rural women. Young, married women and rural women tend to report lower mCPR when compared to all married women and women who live in urban areas. Data from 2012 Demographic and Health Survey.

	AGE		URBAN VS. RURAL	
	MARRIED WOMEN, BETWEEN AGES 15 AND 19	MARRIED WOMEN, BETWEEN AGES 15 AND 49	URBAN WOMEN, BETWEEN AGES 15 AND 49	RURAL WOMEN, BETWEEN AGES 15 AND 49
mCPR	5.9	12.2	27.0	9.7
Unmet need	13.1	16.0	17.3	15.8

^a The UNDP Gender Inequality Index reflects gender-based inequality in reproductive health, empowerment, and economic activity.

nested within IMPACT,^b a Bill & Melinda Gates Foundation-funded project to increase access to quality family planning services by supporting the roll-out of Niger’s National Family Planning Strategic Plan, including expanding delivery at both the facility and community levels within Niger’s Dosso region. Reaching Married Adolescents complements IMPACT’s service delivery focus by working primarily at the community level to generate demand for family planning information and services. Specifically, RMA aims to (1) increase the modern contraceptive prevalence rate among married adolescent girls between the ages of 13 and 19 in three districts in Dosso, and to (2) generate evidence around the effectiveness and cost of adolescent and youth sexual and reproductive health interventions in Niger.

Project design and implementation plan

Reaching Married Adolescents represents one of the first efforts in Niger to compare the ability of different interventions to increase the number of married adolescents who use a method of contraception. The project was developed with lessons learned from years of programming among similar populations in different contexts. Pathfinder led the PRACHAR project^c in Bihar, India, between 2001 and 2012, which sought to increase contraception use among adolescents and youth for healthy timing and spacing of pregnancies. Key strategies from PRACHAR included home visits for young, married couples and first-time parents, small group meetings, and community-wide activities to create an environment supportive of contraception use and healthy timing and spacing of pregnancies for those who choose it. Results showed that young, married women in intervention areas were more likely to use contraception than young, married women in comparison areas and that use of contraception among first-time parents to lengthen intervals between births increased.^d

The GREAT project^d in Uganda—led by Georgetown’s Institute for Reproductive Health and implemented in partnership with Pathfinder and Save the Children—aimed to transform gender norms among youth at individual, community, and structural levels. Whereas PRACHAR prioritized household visits, GREAT

prioritized small group meetings as a means to transform gender norms and to better meet the sexual and reproductive health needs of adolescents and youth. Other interventions included capacity strengthening for community leaders and training sessions for village health teams. Results showed an increase in self-efficacy to use contraception and actual contraception use.¹²

Following programming in India and Uganda, and due to global recognition of the challenging sexual and reproductive health landscape in West Africa, Pathfinder’s Board of Directors approved use of institutional funds to begin work in West Africa, with a focus on reaching married adolescents and first-time parents. This work began in Burkina Faso and Guinea and has since expanded to Niger.

RMA intervention approaches

Experience from India, Uganda, and Burkina Faso suggests that a socioecological approach—with interventions targeting individuals, gatekeepers, communities, and institutions at a structural level—is critical to shifting behaviors as well as social and gender norms around contraception use among married adolescents and first-time parents. Specifically, using *household visits* to reach individuals, *gender-synchronized approaches* that target and involve partners, and *community activities* to create an environment that supports married adolescents and first-time parents to exercise their rights to sexual and reproductive health, contributes to increasingly positive sexual and reproductive health practices and behaviors among adolescents. While these interventions have yielded positive results in different contexts, Pathfinder implementers know less about their comparative effectiveness and cost, particularly in the Nigerien setting.

Reaching Married Adolescents was designed to generate evidence around three intervention approaches that target individual, social, and structural factors contributing to uptake and use. Specifically, the project aims to compare the effectiveness and the cost of implementing 1) household visits, 2) small group sessions, and 3) a combined package of household visits and small group sessions among married adolescents in three health districts: Dosso, Doutchi, and Loga.

FIGURE 1: RMA interventions

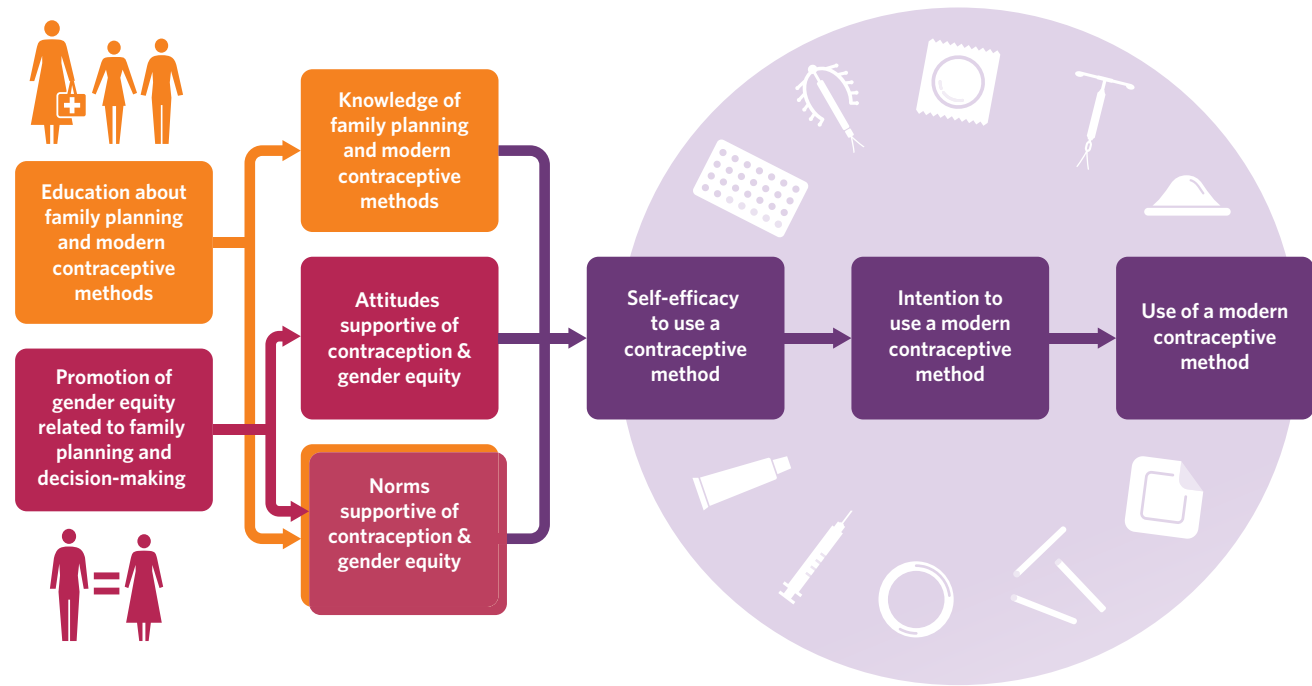
PROJECT SITE	INTERVENTION			
	COMMUNITY-BASED INTERVENTIONS			FACILITY-BASED INTERVENTIONS
	HOUSEHOLD VISITS	SMALL GROUP DISCUSSIONS	COMMUNITY DIALOGUES	SERVICE DELIVERY IMPROVEMENTS
DOSSO REGION				
Dosso district, 12 villages	■	■	■	■
Doutchi district, 12 villages		■	■	■
Loga district, 12 villages	■		■	■
12 control villages in Dosso district, Doutchi district, and Loga district				■

^b During IMPACT (Initiative de mobilization pour l'accès à la contraception pour tous, or, promoting access to contraception for all) implementation, it became clear that research was needed to further understand demand-generation interventions among this population. The Bill & Melinda Gates Foundation granted Pathfinder additional funds to conduct this research within the context of IMPACT to ensure that demand generated was met with quality services—the kind supported by IMPACT.

^c For more on the PRACHAR project, visit <https://www.pathfinder.org/projects/prachar/>

^d For more on the GREAT project, visit <https://www.pathfinder.org/projects/great/>

FIGURE 2: Theory of change for RMA. Through education about contraception and promotion of gender equity, the project intends to increase actual use of modern contraceptive methods.



The project’s theory of change^e hypothesizes that a combination of information on contraception methods and promotion of gender equity will contribute to improved knowledge of, attitudes towards, and norms regarding gender equity and contraception. Improved knowledge, attitudes, and norms should in turn contribute to increased perception of self-efficacy to use contraception, increased intention to use, and finally, increased use (see Figure 2). Each project intervention targets stages within this theory of change but does so by focusing on different levels of the socioecological framework (individuals through household visits, social groups through small discussions, and the wider community through community dialogues).

Household visits

Household visits were intended to increase demand for contraception by creating a safe space for discreet, confidential, and open discussions about sexual and reproductive health. Over repeated visits, a community health volunteer builds trust with married adolescents, to increase comprehension and acceptance of contraception counseling, engagement with the health system, and uptake of contraception.

To conduct these household visits, the project recruited 48 relais^f (community health volunteers)—female relais to meet with wives and male relais to meet with husbands. Relais were members of the community and selected based on age (20 to 30), literacy, marital status (must be married), capacity to work on a team, views on contraception (must support), and attitudes supportive of adolescent sexual and reproductive health. The project designed a one-week training program to cover sexual and reproductive health issues, contraceptive methods, healthy timing and spacing of pregnancies,

knowledge of attitudes towards adolescent rights, gender equity, reporting methods, and, finally, provision of quality counseling. To conduct these sessions, trainers relied on presentations, debates, group work, and role-playing games.

The project was designed so that relais would visit household members each month for one hour. During these visits, relais were supported by project-developed tools (a guide for tailoring household visits to adolescents with specific behaviors and attitudes, and a tool with illustrations to support counseling) to counsel on healthy timing and spacing of pregnancy, contraceptive methods, and discuss healthy marital relationships.

Small group sessions

In addition to household visits, the project designed small group discussions to foster social cohesion, build trust, and create dialogue on contraception and adolescent sexual and reproductive health among married adolescents and their husbands. The project planned for 12 discussions to take place over 12 months with young women in Dosso and Doutchi districts, and 12 discussions over 12 months with their husbands. These groups were led by mentors, who were members of the community and selected based on literacy, ability to lead discussions, and input from other community members. The project recruited 48 mentors—24 women and 24 men—and offered a five-day training with modules on leading group discussions and facilitation skills, gender and power, contraceptive methods, the reproductive system, and healthy timing and spacing of pregnancies. Similar to the methods used for relais, mentor training also relied on group work, presentations, debates, and role-playing games. Groups consisted of ten to thirteen participants and were typically hosted at a health center.

^e The theory of change is adapted from: Fishbein, M. and Yzer, MC. Using Theory to Design Effective Health Behavior Interventions. *Communication Theory*. 2003;13(2):164-183.

^f Pathfinder partnered with Lafia Matassa—a local NGO—to supervise all frontline workers and to collect data through March 2018. At this point, Pathfinder assumed these responsibilities.

Community dialogues

Community dialogues were designed to create an enabling environment for adolescents’ sexual and reproductive health by engaging all members of the community in discussions of healthy timing and spacing of pregnancies and contraceptive use. This intervention was implemented in each project district and was available to all community members as a complement to small group discussions, household visits, or both interventions.

Community dialogues were held once a month, over a twelve-month period, at the village mosque or village center. Participants included adolescents, traditional and community leaders, parents and in-laws, and co-wives. Community facilitators (FACOMs)—a mix of men and women—led these sessions. Four FACOMs were recruited per district by a local NGO partner and in collaboration with community and political leaders. They also received a one-week training and monthly supervision visits from RMA project staff.

Collecting data to determine intervention effectiveness and cost

To answer the project’s questions of interest—whether these intervention approaches can increase contraceptive use and the cost effectiveness of these interventions—the project partnered with the University of California San Diego’s Center for Gender Equity and Health to implement a household survey before project start and again after participants received interventions over 18 months.* This midline survey was designed to collect quantitative data on: knowledge of modern contraception, attitudes supportive of contraceptive use, norms supportive of contraceptive use, self-efficacy to use contraception, intention to use contraception, and current use of contraception. In addition, the project planned to assess cost effectiveness through a retrospective analysis of financial reports to estimate

overall costs and determining the cost per intervention per new contraception user per year.

To complement data collected by the household survey and to deepen implementers’ understanding of how and why RMA interventions worked (or didn’t), the project designed three cycles of qualitative inquiry with frontline implementers: relais, mentors, FACOMs, and supervisors.

Implementation experience: What actually happened

At three points along the project’s timeline, frontline implementers gathered to reflect on challenges and successes and how the project needed to adapt to the context in which it worked. The project’s qualitative inquiry served two purposes: complementing quantitative data collected to explain how and why the intervention yielded certain results, and providing a record of implementation experience in near real-time.

Household visits

Focus group discussions (FGDs) with relais revealed both successes and challenges experienced during household visits. In some cases, small adaptations—in response to these challenges and successes—made by the frontline workers also came to light in these discussions. In other cases, information from these discussions became evidence for future changes to implementation. Some relais benefited from the support of community leaders, who encouraged community members to participate in project activities and to permit access to their homes. Relais reported that many young, married girls seemed more at ease to discuss sensitive topics because of the privacy offered by household visits. Relais also observed that young, married girls’ engagement in visits increased over time and repetition of visits.

While in general, husbands were receptive to participating in household visits and accepting that their wives participated in household visits, some relais found that husbands could act as barriers to participation due to beliefs that the project intended to prevent childbearing and that some contraceptives (implants) get lost in a woman’s arm and cause infertility. Another barrier to regular participation from husbands was seasonal migration. Often, work in the fields left husbands with limited time to participate in household visits. Further, between January and June, many husbands—and some wives—left villages to find work closer to cities and were unable to continue participation in the interventions. Finally, migration affected districts differently based on proximity to economic opportunities and the border with Nigeria (i.e., those closer to the town of Dosso and the Niger River saw less migration while those closer to Nigeria experienced more migration).

Age occasionally acted as a barrier to reaching married adolescents through household visits. Older relais had difficulty reaching younger married adolescents due to cultural norms: it is generally considered inappropriate for an older, married woman to visit a younger, married woman in her home.

To address these challenges, many relais made a point of wearing the project logo (women wore head scarves with the logo and men wore vests with the logo), carrying identification, and presenting themselves to heads of household to first ask for permission to engage with young, married adolescents. Relais explained that good self-presentation and asking permission helped them persuade initially mistrusting heads of households. Other relais shared that they met with young, married adolescents outside the home and that trust was built between older relais and younger women over time. Finally, in response to migration for work, some relais increased the frequency of their visits over the periods during which husbands were in the villages. Others reduced the length

of each visit from one hour to thirty minutes, and others offered to hold visits in the evenings so as not to burden married couples with being away from income-generating activities.

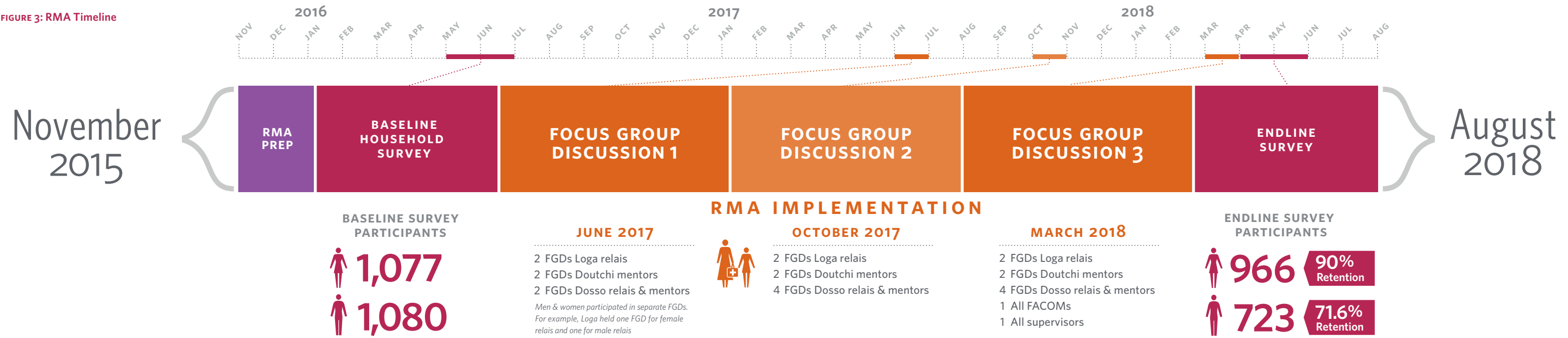
Small group sessions

Mentors shared that by explaining to women that they have a responsibility to their daughters, mothers, sisters, and friends to address their own health challenges, women agreed and actively participated in small group discussions. Further, mentors also reported that adolescents not targeted by the project were receiving information shared in small group discussions because participants would leave the discussions and share their experiences with others.

Mentors also experienced challenges during small group discussions. For example, some mentors were unable to find appropriate spaces to hold group discussions. They also reported a lack of resources to support these discussions, such as access to bathroom facilities, mats, and water. Other mentors expressed that young, married adolescents often questioned what they would receive in return for their participation (e.g., material and financial compensation). Mentors also shared that, though uncommon, prejudices and misconceptions about the project’s objectives contributed to some mothers-in-law and husbands discouraging participation in these groups.

To address discouragement from mothers-in-law and husbands, male mentors who led groups for men, and female mentors who led groups for women, worked together to develop messaging that focused on the health benefits of contraception and the risks of early and closely-spaced births. This way, they were able to present mothers-in-law and husbands acting as gatekeepers with consistent messaging about the benefits of participation. In addition, mentors sought support from nearby health facilities to dedicate spaces for small group discussions.

FIGURE 3: RMA Timeline



* While the time between first and second data collection was 24 months, participants were exposed to interventions for 18 months.

Community dialogues

FACOMs shared that they felt that they had built significant relationships with community members, which was beneficial to participation in community dialogues. For example, FACOMs report that religious and community leaders helped identify places to hold community dialogues and would also encourage participation of community members. In addition, the project identified thirty-six religious leaders—one in each intervention village—to serve as a network of champions for community dialogues. These leaders drew upon Quranic verses to support healthy timing and spacing of pregnancy and to explain the negative health effects of early and closely-spaced pregnancies. Similar to mentors, FACOMs found that individuals not targeted by the project still benefitted from it—many adolescents not targeted chose to participate in community dialogues, for example.

FACOMs also reported similar challenges to those experienced by relais and mentors: myths and misconceptions about the project and its goals and migration for work negatively impacted participation in community dialogues. Often, FACOMs worked with religious and community leaders to support community dialogues and to dispel misconceptions.

...leaders drew upon Quranic verses to support healthy timing and spacing of pregnancy and to explain the negative health effects of early and closely-spaced pregnancies.

Project performance

Between May and July 2016, the project conducted its baseline household survey to measure knowledge of contraception, attitudes supporting contraception use, perceived community support for contraception use, perceived community support for equitable gender roles, self-efficacy to use contraception, intention to use, and actual use by the randomly selected 1,200 young married adolescent girls (ages 13–19), and their husbands,^h across the 48 project villages (including 12 control sites). After 18 months of exposure to interventions, the project conducted the same survey with the same individuals and couples from baseline. Using collected data, project staff measured the change in outcomes between baseline and midline—for example, increase in use of modern contraception—the contribution of each intervention to the observed change, and the cost effectiveness of each intervention.

Changes in outcomes of interest: knowledge, attitudes, intention, and use

YOUNG, MARRIED GIRLS

Data show that across all intervention approaches, females’ knowledge of modern contraception increased. For attitudes supportive of contraception, the only statistically significant increase was seen within sites receiving household visits. Regarding females’ social norms as measured by perceived community support for contraceptive use, positive statistically significant changes were observed in sites receiving household visits and both intervention approaches. Finally, results show that all three intervention approaches resulted in increased self-efficacy and intention to use.

TABLE 3: Change in key outcomes from baseline to follow-up among female participants, by intervention approach (relative to control group, adjusting for sociodemographic variables and clustering). * p<0.05

INTERVENTION PACKAGE	HOUSEHOLD VISITS	SMALL GROUPS	BOTH
Knowledge (out of 14 points)	+2.0*	+0.9*	+2.5*
Attitudes (out of 2 points)	+0.49*	-0.03	+0.06
Norms (out of 2 points)	+0.45*	-0.04	+0.30*
Self-efficacy (out of 6 points)	+0.8*	+0.4*	+1.1*
Intention to use (out of 100%)	+31.1%*	+18.5%*	+44.7%*

MALE PARTNERS

Survey data suggest that all three interventions contributed to male participants’ increased knowledge of modern contraception. With regard to attitudes supportive of contraception, data show an increase across male participants in each intervention approach, though the increase among men receiving both interventions combined was not statistically significant. Results from the survey indicate that hat equitable social norms decreased in sites receiving household visits, but improved among sites with small groups.

TABLE 4: Change in key outcomes from baseline to follow-up among male participants, by intervention approach (relative to control group, adjusting for sociodemographic variables and clustering). * p<0.05

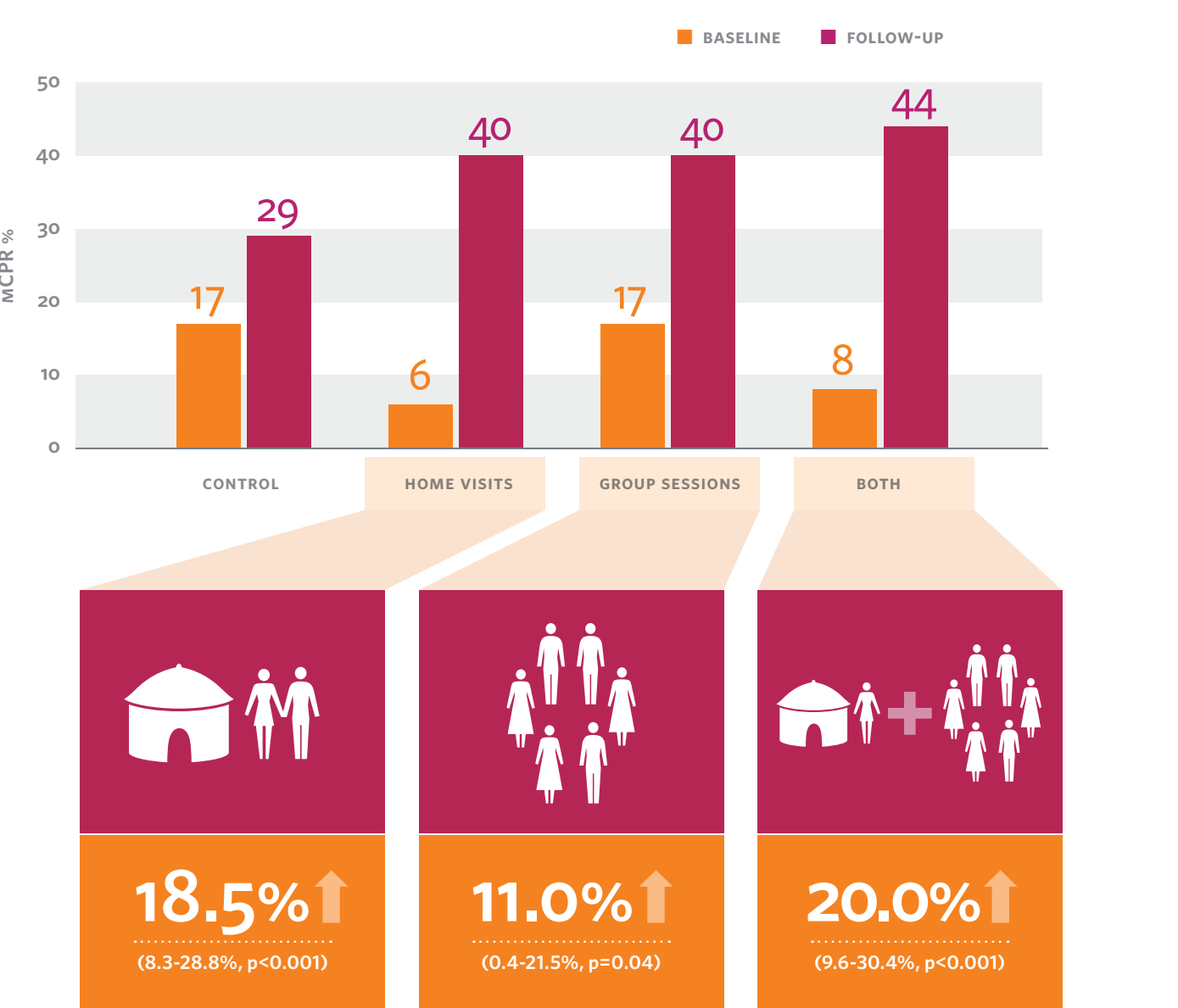
INTERVENTION PACKAGE	HOUSEHOLD VISITS	SMALL GROUPS	BOTH
Knowledge (out of 13 points)	+2.2*	+1.6	+0.9*
Attitudes (out of 4 points)	+0.5*	+0.3*	+0.2
Norms (out of 5 points)	-0.42*	+0.37*	+0.03
Self-efficacy (out of 6 points)	+0.8*	+0.4*	+1.1*

Intervention effectiveness

While all three intervention approaches contributed to an increase in female participants’ use of modern contraception, the degree to which these interventions impacted use differed. After controlling for sociodemographic variables and accounting for changes seen in the control group during the implementation, the project attributed an 18.5 percent increase in modern contraception use to household visits, an 11 percent increase to small group sessions, and a 20 percent increase to both interventions combined.

The project also explored the effect of intervention dosage on outcomes of interest. In looking at how men’s participation in household visits contributed to changes in current use of modern contraception among female participants, results suggest that among men participating in four or more (high dose) household visits, there was an 8 percent increase in contraception use among their female partners when compared to partners of men that did not participate in household visits. No statistically significant differences were detected in current use of modern contraception among female participants for men who had one to three household visits (low dose) in comparison to men that did not participate in household visits.

FIGURE 3: Change in use of modern contraception among female participants. After accounting for sociodemographic variables and the changes seen in the control group, exposure to the household intervention was attributed with an increase in modern contraception use of 18.5 percent compared to 11 percent for small groups and 20 percent for both interventions combined.



^h The project intended to recruit 1,200 wife-husband dyads and was successful in recruiting 1,072 women and 1,080 men.

Cost effectiveness

The costing analysis was conducted from the perspective of *program* costs to capture costs associated with direct implementation and support of the different RMA intervention approaches in Niger. A retrospective costing analysis was performed using Pathfinder financial reports and budgets. In order to develop costing scenarios that would allow implementing organizations to replicate and scale this program in other parts of the country, all costs associated with evaluation activities and Pathfinder US salary costs were removed from the RMA costing analysis. The project calculated both the cost per *beneficiary* (measured as cost of intervention per household) and *cost effectiveness* (measured as cost of intervention per new contraception user) of the different RMA intervention approaches.

To calculate cost per beneficiary, the project estimated the total cost of the RMA intervention across each project district and divided this value by the number of households visited in each district. Results of the costing analysis suggest that the household visits had the lowest cost of implementation, with the small groups costing 3.5 percent more and the combined approach costing 33.6 percent more compared to the household visits.

TABLE 5: Cost of intervention per household per year. Note that each cost includes the monthly community dialogues that occurred across all project districts.

	COST OF INTERVENTION PER HOUSEHOLD PER YEAR (USD)
Loga (monthly household visits)	342
Doutchi (monthly small group sessions)	354
Dosso (both interventions)	457

To calculate the cost effectiveness of the different RMA intervention approaches, the project used the cost per household and divided this by the number of new contraception users generated per household per year per intervention approach. Results of cost-effectiveness analysis suggest that the household visits had the lowest cost per new contraception user per year with the small groups costing 117.8 percent more and the combined approach costing 15.7 percent more compared to the household visit.

TABLE 6: Cost per new contraception user per year.

	COST EFFECTIVENESS: COST PER NEW CONTRACEPTION USER PER YEAR (USD)
Loga (monthly household visits)	1,890
Doutchi (monthly small group sessions)	4,116
Dosso (monthly both interventions)	2,187

Lessons learned

Household visits as cost-effective way to reach young, married girls to increase contraceptive use

Midline results indicate that household visits outperform other intervention approaches in terms of outcomes of interest. Further, findings suggest household visits are also the most cost-effective intervention approach. Midline findings are consistent with evidence from India and Burkina Faso, which suggests socioecological interventions increased contraception use among youth. The project awaits endline results before making recommendations for future implementation in this context, however, household visits seem to be an effective approach to reach young, married women in Niger to increase contraception use.

Potential of gender-synchronized approaches to impact contraception use in Nigerien context

Midline data also suggest that gender synchronized approaches may have a positive impact on female contraception use in Niger. Though there was imperfect and varied exposure to RMA interventions among male participants, it is interesting to note that exposure to four or more household visits—when compared to no visits—contributes to an 8 percent increase in use of contraception among female partners. Moving forward, implementers may consider that while it is not generally easy to engage men and boys to talk about contraception—particularly in rural Niger—male engagement should be a part of interventions to increase access to and use of contraception.



Male community group in Doutchi

PHOTO: Tagaza Djibo, 2016



Young girls in Dosso Region

PHOTO: Adama Ali Zourkaleini 2017

It takes a village: The importance of engaging the entire community

Findings from qualitative endeavors indicate that an array of community members engaged in project activities to support the sexual and reproductive health and rights of other community members. Religious and community leaders across all intervention villages encouraged participation in project activities, health workers helped mentors find spaces for small group discussions, and community leaders spoke with mothers-in-law and husbands who were hesitant to approve of household visits. This experience underscores the importance of engaging the community as a system, and involving all members in supporting each other to identify and advocate for their own health needs.

In addition, quantitative results indicate that, in some instances, participation in small group sessions with peers contributed to an increase in use of contraception, intention to use, feelings of self-efficacy, and supportive attitudes towards contraception use among men. This suggests that the interaction with peers may be a necessary element to shifting married adolescents’ acceptance and uptake of contraception.

The benefits of multiple reinforcing interventions

Ultimately, project data and experience suggest that there is a significant benefit to implementing multiple interventions that reinforce each other, as household visits, small group sessions and community dialogues do. Feedback from

frontline implementers suggests that if certain barriers prevent them from reaching married adolescents through one intervention, there is a chance of reaching married adolescents through another intervention. For example, while relais perceived that household visits enabled some young, married girls to speak more freely about sensitive issues due to the privacy this intervention provided, other relais found that household visits were challenging because of reticent mothers-in-law and husbands, or taboos around age differences. Small group discussions and community dialogues provided other opportunities for young, married girls to engage with the project and for mothers-in-law, husbands, and community leaders to better understand the goals and messaging of the project.

Similarly, quantitative data show that male participants who only received household visits perceived a decrease in community attitudes supportive of more equitable gender roles. However, men participating in small group discussions with their peers perceived an increase in such community attitudes.

Finally, while the combined intervention approach was more expensive to implement, it also yielded more contraception users. As a result, the combined intervention approach was only 16 percent less cost effective than household visits. Moving forward, implementers should consider the potential for cost effective, reinforcing interventions depending on the heterogeneity of their target population and available resources.



Household visit

PHOTO: Tagaza Djibo, 2016

Next steps

In this first phase of RMA, project implementers generated evidence around the effectiveness and cost of different intervention approaches' abilities to increase contraceptive use among married adolescents. At the end of 2018, RMA ended activities in half of its target villages and is currently focusing on understanding the long-term effects of interventions in a sub-section of 18 villages, as well as understanding the optimal community-based intervention approach for scale-up within Dosso Region, the Zinder region and three districts of the Tahoua region.

Endnotes

- ¹ Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
- ² United Nations Population Fund. "World Population Dashboard." Accessed July 22, 2019. <https://www.unfpa.org/data/world-population-dashboard>.
- ³ Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
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