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HUMAN for Malala Fund

# **NAVIGATING CONTRACEPTIVE USE AMONG MARRIED ADOLESCENTS IN NORTHERN NIGERIA'S CONSERVATIVE CONTEXT**

## ETHNOGRAPHIC RESEARCH AND GENDER ASSESSMENT OF MATASA MATAN AREWA (MMA)



*The OASIS Initiative*  
ORGANIZING TO ADVANCE SOLUTIONS IN THE SAHEL  
ORGANISER L'AVANCEMENT DES SOLUTIONS AU SAHEL



# INTRODUCTION

In Northern Nigeria, poverty is widespread, compounded by less developed markets and a less well-educated populace in this region of the country. A third of the total population in Nigeria – 36% of women and 27% of men – receives no formal education. This number is starker in the country's northeast and northwest zones where 55-57% of females and 40-47% of males receive no formal schooling.<sup>1</sup> Northern Nigeria is populated mainly by the Hausa-Fulani, an ethnic group of 70 million people living in the north, Niger, and surrounding countries.<sup>2</sup> Strong religious and cultural norms and beliefs shape the health and wellbeing of the people inside and outside their homes.<sup>3</sup> Hausa society is patriarchal; the husband is expected to provide for the material needs of the family and to make key decisions within the household.<sup>4</sup>

As in many parts of the world, the demand for and use of health services in Nigeria is correlated with women's empowerment.<sup>5,6,7</sup> Gender inequality affects access to healthcare, control over health-related decision-making, and subsequent health outcomes in fundamental ways. These include the timing of seeking healthcare, the ability to physically reach a health center, as well as the uptake of certain service offerings, like contraception. Use of health services by women in rural northern Nigeria is low, and reproductive health outcomes are poor.

Nigeria has one of the highest maternal mortality ratios (MMR) in the world at 512 deaths per 100,000 live births.<sup>1</sup> In some states, particularly in the north, maternal mortality is estimated to be much higher.<sup>8</sup> There are a number of factors driving the high MMR, particularly in the country's north. These include early marriage and childbearing, high fertility, closely-spaced pregnancies, unsafe abortion, and low skilled attendance during pregnancy and delivery. Health outcomes are made worse by poor service quality, as well as cultural norms related to empowerment, including restrictions on women's movement.<sup>9,10,11,12</sup> Nigeria's high total fertility rate (TFR) has declined only slightly over the past 30 years, from 6.0 children per woman in 1990 to 5.3 in 2018.<sup>1</sup> There is significant variation by region – TFR is 6.6 in the North West compared to 3.9 in the South

West zone.<sup>1</sup> The contraceptive prevalence rate (CPR) is only 17% among married Nigerian women 15 to 49 with 12% relying on modern methods of contraception and 5% on traditional methods. Again, there is stark differentiation between urban and rural areas, and between northern and southern Nigeria. Use of any contraceptive method among married women is nearly three times higher in urban areas compared to rural (26% vs. 10%), and modern CPR hovers around 29% in the southern state of Lagos, but only 2% in the northern states of Yobe and Sokoto.<sup>1</sup> Economic hardship, lack of opportunity, and cultural and religious beliefs and practices all underpin Nigeria's low CPR and high TFR.

The Government of Nigeria has signaled commitment to gender equality and women's empowerment via its laws and policies, and by being signatory to key treaties and international conventions.<sup>1</sup> Still, early marriage persists, and deeply entrenched gender norms in Nigeria shape women's and couples' use (or nonuse) of contraception and other health services.

## A360 BACKGROUND IN NORTHERN NIGERIA

In 2016, Population Services International (PSI), with funding from the Bill & Melinda Gates Foundation and the Children's Investment Fund Foundation (CIFF), launched Adolescents 360 (A360), a 4.5-year project designed to increase demand for, and voluntary uptake of, modern contraception among girls aged 15-19 in Ethiopia, Nigeria, and Tanzania. A360 undertook a design process to better understand the unique needs and desires of married and unmarried Nigerian adolescents, and to identify ways for the project to develop more resonant and effective adolescent sexual and reproductive health (ASRH) programming. Led locally by the Society for Family Health (SFH) in Nigeria, A360 brought together a consortium of experts and partnered directly with young people to understand and address contributing factors to poor reproductive health outcomes and to support healthy timing and spacing of pregnancy.

Matasa Matan Arewa (MMA), 'Adolescent Girls from the North,' is A360's project implemented in two northern Nigerian states, Kaduna and Nasarawa. Launched in January 2018, MMA is modeled after the work carried out in 9ja Girls, A360's project focused on unmarried girls in southern Nigeria.<sup>i</sup> MMA represents an adaptation of 9ja Girls, tailored to meet the needs of married adolescents in northern Nigeria. Using one-on-one outreach, MMA engages married adolescent girls through female mentors, as well as their husbands using male interpersonal communication agents (IPCAs). Acknowledging the role of husbands as key influencers in girls' lives, male IPCAs work to generate support from husbands for their wives to participate in the program. Husbands' support is often critical, both in the decision to adopt contraception and in the ability to continue method use, especially in a context where consent may be required to access care, even in a health emergency.<sup>13</sup> Married adolescent girls who are interested in participating in MMA are invited to attend a series of four mentored '*Life, Family, Health*' (LFH) group sessions, including visiting a health center for voluntary one-on-one counseling and contraception. Both government and SFH-embedded providers at MMA participating health centers receive training on youth-friendliness and contraceptive technology to build technical skill and address bias.

## GENDER ASSESSMENT AND ETHNOGRAPHIC RESEARCH STUDY

As a project focused on adolescent girls, A360 is committed to building its understanding of the challenges northern Nigerian girls face in accessing health services and making health-related decisions within their families and households. A360 recognized its inattention to gender as a specific disciplinary lens during the design process for its interventions. In 2019, findings from the project'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. In response, A360 contracted with a local northern Nigerian organization, the [Centre for Girls Education \(CGE\)](#),<sup>ii</sup> to conduct an independent assessment of MMA in 2020. This research generated a rich body of evidence on how girls' interactions with the project are mediated by the norms and realities that inform their attitudes and shape their experiences, supplying valuable feedback to PSI and SFH.

## OBJECTIVES

This study aimed to assess the relevance and effectiveness of MMA's mentorship groups as well as to understand how married adolescent girls in Kaduna State were experiencing MMA in light of the gendered context that influences their lives. A critical step to achieving this goal was to engage directly with adolescent girls who had participated in MMA, as well as project personnel, parents, husbands, and other stakeholders.

### The three components of the study were:

1. Literature review and ethnographic research to gain a better understanding of the gender and social norms in the context in which MMA is being implemented;
2. Assessment of the effectiveness of MMA LFH mentorship groups;
3. Exploration and documentation of the user journey of girls participating in the MMA intervention.

i. More information on 9ja Girls can be found in [Connecting Contraception to Girls' Lives and Aspirations in Southern Nigeria: The Case of 9ja Girls](#), and for MMA, see [Aligning Contraception with Family and Life Goals of Married Adolescent Girls in Northern Nigeria: The Case of Matasa Matan Arewa \(MMA\)](#).

ii. Since 2007, CGE, based in Kaduna State, has worked to advance adolescent girls' education, vocational training, and empowerment in northern Nigeria through implementation of a range of safe space programs, advocacy, applied research, and partnerships. [The OASIS Initiative at the University of California, Berkeley](#), provided technical support to the CGE research team as part of its work advancing education and choice for women and girls in the Sahel.

## CENTRE FOR GIRLS EDUCATION (CGE) AND RESEARCH TEAM

- Daniel Perlman (Principal Investigator): Director for Girls Education and Evaluation at the OASIS Initiative, School of Public Health, University of California, Berkeley, and founder of CGE.
- Mardhiyyah Abbas Mashi (Co-Principal Investigator): Lecturer in Islamic and Arabic Studies at Ahmadu Bello University. Co-founded CGE with Daniel and serves as the Chair of its Board of Trustees.
- Tessa Fujisaki and Daisy Valdivieso: Ethnographic data analysts for the study.
- Made David: Led the CGE Research and Evaluation Team and supervised the fieldwork for this research.
- Aisha Abubakar, Hajara Abubakar, Aminu Bello Gurin, and Alex Gata Kumar: Members of the CGE Research and Evaluation Team; conducted ethnographic fieldwork for the study.

## METHODS

Five members of CGE's evaluation and implementation research team (three women and two men) conducted the research between February and August 2020 under the close supervision and support of the Principal Investigator (PI).

### OBJECTIVE 1 CONTEXT AND GENDER ASSESSMENT

Within this first objective, CGE conducted ethnographic research—participant observation, in-depth interviewing, casual group conversations, and the writing of daily field notes—to understand the social, cultural, and gender context within select sites in northern Nigeria. Ethnographic research was conducted in two communities in Zaria, Kaduna State where members of the CGE research team had lived for at minimum six months each during a previous study in 2018. These were not MMA implementation communities, though assessed to be demographically similar to MMA implementation sites, and the findings therefore applicable to MMA's implementation context. The researchers built on the rapport and trust they had developed within these communities to explore the sensitive topics that served as the focus of this

component of the study. The research team lived in the two study communities for three and a half weeks for data collection. They began with open-ended interviews and then progressed to semi-structured interviews, all conducted in Hausa. The researchers provided prompts and participants were encouraged to speak freely. The team also conducted life histories with a focus on courtship, marriage, and first birth.

The CGE team drew on their significant prior experience and training, which included research ethics emphasizing the rights of research participants, the voluntary nature of participation, informed consent, and confidentiality. The team sought consent from traditional, religious and other community leaders prior to beginning the research in order to obtain broad agreement for the researchers to participate in community activities and have informal discussions with community members. Informed consent was obtained from all respondents before interviews were conducted.

### OBJECTIVE 2 ASSESSMENT OF MMA MENTORSHIP GROUPS

For the assessment of MMA mentorship groups, researchers conducted structured observations of 15 LFH sessions in four urban sites in the Sabon Gari and Zaria Local Government Areas (LGAs) of Kaduna State. These observations were triangulated with the 185 interviews with MMA participants and mentors. The research plan called for five additional observations in Zaria and then continuation to the venues in Jaji for observations of 20 group sessions there. However, the observations came to a halt due to the COVID-19 lockdown, and the MMA groups did not resume in person during the study period. Thus, the team was unable to complete the observation component of the research as the observations in Jaji could not take place. At the time of this study, MMA had been implemented in Jaji for two years and in Zaria for less than one year. The structured group observations focused on mentor preparedness, presentation, responsiveness, and ability to encourage active participant engagement. The researchers similarly documented attendance, whether the sessions started on time, and whether the space itself assured privacy.

## OBJECTIVE 3

### DOCUMENTATION OF THE USER JOURNEY

Researchers explored and documented the MMA user journey, a term that A360 uses to describe a girl's experience with MMA, via in-depth interviews and life histories with current and former participants who agreed to be contacted. This included girls who adopted contraception through their participation in MMA and those who decided not to adopt contraception. Interviews also took place with participant's husbands, and other key influencers, such as relatives, community members, and traditional and religious leaders. Discussions with girls and influencers explored perceptions of birth spacing, girls' and influencers' experiences with MMA, as well as girls' agency and decision-making within their household and community. After concluding these interviews, the research team additionally followed up with 59 girls whom they had previously interviewed who had adopted a contraceptive method to learn about their experience and whether they had continued method use, and if not, their reason(s) for discontinuing.

Sampling was purposive, with a focus on ensuring representation of important sub-populations, including married adolescents, their husbands, and other community members such as religious and political leaders. This assessment was designed to be systematic and reduce bias by triangulation through the use of multiple research methods, diversity in research team composition, types of respondents, and characteristics of the communities serving as research sites in order to enhance confidence in the findings.

The Nigerian National Research Ethics Committee reviewed and approved the research protocol. All research participants supplied informed consent, with assurance that the researcher would not note down their observations during MMA sessions without consent. Following Hausa norms, female participants were only interviewed by female interviewers, and males by male interviewers. Researchers assured participants that collected data would contain no identifying information to ensure confidentiality, and that participants could opt out at any time (or

decline to respond to anything that made them feel uncomfortable or unsafe). Researchers also explained that refusal to participate would in no way affect involvement in the MMA program and activities. Participants were not offered remuneration but were encouraged to participate and to answer truthfully, as their input would support the important aim of better serving young married women who wish to space the births of their children. The team stored all data from questionnaires, interview transcripts and field notes in password-protected computers. Only the PI, the five researchers, and two data analysts had access to these materials.

Data analysis using grounded theory began early in the data collection process and continued until after the completion of data gathering. The PI met with the researchers once a week, first in person and then by Zoom after the COVID-19 lockdown, for ongoing, iterative, qualitative data analysis. ATLAS.ti qualitative analysis software was used for the coding and analysis of the interview transcripts and fieldnotes. The data analysts had been previously trained and mentored by the PI over a period of two years as part of the Research Apprenticeship Program at the University of California, Berkeley. As the study progressed, preliminary categories and insights were tested against data from new interviews, observations, and analysis meetings. This led to the refinement, abandonment, or redevelopment of themes and generated research questions for the next series of interviews. The interviewing of each category of people continued until the information and descriptions provided no longer generated new information.

### COVID-19 IMPACT

Data collection started in February 2020 and was halted the last week of March 2020 due to a statewide COVID-19 lockdown. The CGE research team shifted their approach and interviewed roughly 60 girls by phone in Zaria and Sabon Gari. The research team then did face-to-face follow-up interviews with the 60 girls once travel restrictions were lifted in early June 2020, adhering to strict COVID-19 related protocols including social distancing, hand washing, and the

wearing of face masks. They then interviewed other MMA participants, husbands and key influencers. The team was unable to resume observation of MMA sessions, as group gatherings were still restricted. As a result, direct observation of MMA sessions was conducted in Zaria and not in Jaji. The team addressed this challenge by increasing the number of interviews with participants, husbands, and stakeholders in Jaji, expanding the total number of interviews from the 113 called for in the research protocol to 286 (Table 1).

**TABLE 1 MMA IN-DEPTH INTERVIEWS IN 10 IMPLEMENTATION COMMUNITIES IN KADUNA STATE**

Current and former participants	173
Married adolescents (not MMA)	26
MMA participants' husbands	18
MMA mentors & SFH staff	12
Service providers	6
Traditional and religious leaders	7
Community members	44
<b>Total interviews</b>	<b>286</b>

## FINDINGS

### OBJECTIVE 1 CONTEXT AND GENDER ASSESSMENT

#### HOUSEHOLD STRUCTURE AND LIFE IN A RURAL HAUSA COMMUNITY

Gender, age, wealth, and parity are key factors in Hausa social hierarchies. Amongst respondents, there was consensus around the belief that the husband is traditionally responsible for the material needs of the family, and in return, the wife is expected to bear children and to care for them and the home. Polygyny is more common in rural areas than urban (37% vs. 21% respectively), and far more common in northern than southern Nigeria. Men and women often occupy largely separate physical and social spheres. Strong female kinship networks are developed and cultivated through social visits and gift exchanges, both expanding women's social circles and their mobility within the community. Islam is the predominant religion and

exerts a powerful influence on daily life in northern Nigeria. While men provide financial security for their families as a point of pride and religious obligation, women have the right under Islamic and Hausa custom to engage in income generating activities at home. Women depend on their daughters to secure raw materials from the market, take part in processing, and then to sell the finished goods given the limited mobility of married women outside of the home.<sup>14</sup> Women are expected to have control over the income that they generate, though often contribute to family expenses in times of economic hardship.

#### MARRIAGE AND FERTILITY RELATED DECISION-MAKING

Hausa women's decision-making authority is often constrained in matters concerning education, marriage, and childbearing. Girls' educational attainment is low, and girls frequently terminate education to enter into marriage. The father, along with his brothers, are typically the main decision makers about a girl's marriage. A girl and her mother are almost always consulted, though tend to have less power in the final decision.<sup>15</sup> While most parents see the value of education, they also view marriage as a protective measure, necessary to prevent pregnancy outside of marriage, which could have serious social consequences for both the girl and her family. Marriage is viewed as the primary avenue for securing a daughter's future, and a way to forge strategic alliances that could offer socio-economic benefits to the family. In most cases, there is an expectation, from the husband, family, and the young wife herself, that she will become pregnant within the first year or two of marriage.<sup>16</sup>

An adolescent girl enters into marriage at the bottom of an extended family hierarchy, expected to defer to her husband, mother-in-law, and senior wives in a polygynous union. A sizeable age difference between spouses also often creates complex power dynamics for newly married adolescent girls. Even when given some autonomy over decision-making, a host of social norms and limited educational and economic opportunities inevitably shape northern Nigerian girls' choices. Some married girls in polygynous households also fear that their husband might marry another wife if they do not bear children during the first or second year of marriage. With her first birth, a girl gains status

and standing in the household. Combined, these and a range of other factors result in high adolescent fertility. Adolescents in the northwest are almost five times more likely to have begun childbearing than their peers in the southwest (29% vs. 6%).<sup>1</sup>

“

I'm happy now that I am a mother and have given birth just like any other woman...I have earned self-respect and dignity and have shown that I am fertile.

–Married adolescent  
(not in the MMA program)

“

If a woman without children dies today everyone will forget about her in a few days. A woman with six children will be remembered in this house forever.

–Middle-aged woman  
with seven children

Married adolescent girls face particular challenges around contraceptive access and use, often a result of restrictions on movement, cost, limited reproductive autonomy, misinformation, and generally constrained agency in decision-making.<sup>17</sup> Several male respondents stated that since the husband is ultimately responsible for the needs of the family, he should have the final say on the timing and number of children. Men also agreed that women should seek approval prior to considering birth spacing, and to do otherwise would be unacceptable. Many felt that no proactive decision-making was required, leaving the size of their household up to God.

“

There was nothing like negotiation on when to get pregnant. We left the decision in the hands of our Creator. He decided to bless us with our children.

–Husband of MMA participant

“

A woman should give birth to as many children as the Almighty has given her.

–Older man and father  
of eight children

In Hausa culture, mothers-in-law also often influence household decision-making, sometimes even intervening in decisions related to their daughter-in-law's fertility. Some husbands were supportive of contraceptive use, for instance for the health of their wife and child or because of the costs of maintaining a large family, but most were reluctant to express this support openly except with family and close friends. While there exists genuine pride and deep satisfaction in having children, misinformation and social norms constrain the use of modern contraceptives for those who might want to space births. In addition, some health providers (though the number is decreasing) require spousal consent before supplying a contraceptive to a married adolescent, even though this is not legally required.

#### TERMINOLOGY - FAMILY PLANNING VS. BIRTH SPACING

“

I used to take birth control pills...But people in the community gossiped that in order to do so I was controlling my husband. So, I stopped taking them to maintain his reputation.

–A mother of six from one of the  
research communities

“

These days there are men who want to take good care of their children and even send them to school but lack the money to do so if they have a large family. They'd prefer to have fewer children but don't let their wives know because of shame.

–Woman from one of the research  
communities

Birth spacing to protect the health of the mother and child is an acknowledged reproductive strategy in the Hausa worldview.<sup>18</sup> Postpartum abstinence, prolonged lactation, medicinal herbs, and other traditional methods are considered acceptable ways of maintaining intervals between births. Such indigenous methods are more openly discussed, and deemed safer than modern contraception, given pervasive myths and misconceptions about modern methods. However, some respondents did acknowledge that traditional methods were less effective. Though birth spacing is upheld as a key strategy for protecting maternal and child health, use of contraception to delay first birth or limit births was not generally accepted.

Some respondents said they viewed 'family planning' as an external (Western) intervention intended as a means of population control. This sentiment was reflected in the controversy over the polio eradication campaign in 2003, when a number of Nigerian religious leaders and Islamiyah schoolteachers advised parents not to vaccinate their children out of fear that the polio vaccine covertly contained contraceptives.<sup>19,20,21</sup> The religious and political leaders argued that the Nigerian president at the time, a Christian, was collaborating with the West to use the polio campaign to limit the number of Muslims. The terminology of birth spacing is therefore far more acceptable to communities in the north than other terms or concepts such as family planning, limiting, or delaying of first births. Many Nigerian physicians and nurses practicing in the north understand these cultural preferences related to modern contraception and stress the use of contraception to space births for the health of mother and child.

## OBJECTIVE 2

“  
Spacing is nothing but giving a gap  
between your children and keeping  
you and them healthy...It will not  
stop you from giving birth when you  
are ready...  
–Female nurse

## ASSESSMENT OF MMA MENTORSHIP GROUPS

Adolescent girls and their husbands generally spoke highly of their experience with MMA and of their interactions with the female mentors. Girls appreciated how their mentor created a safe environment and fostered discussion within MMA groups. Many felt connected to their peers within their mentorship cohort, especially those close to them in age, and felt at ease sharing personal stories. Girls especially enjoyed the range of interactive methods that the sessions employed. Importantly, participants frequently said they felt comfortable asking their mentor questions that they previously would have been too embarrassed to ask (particularly related to sexually transmitted infections [STIs], contraception, and menstrual hygiene).

While there existed widespread satisfaction with the

“  
At the first meeting, our mentor created  
a warm and respectful relationship  
with us. It seemed as if we had been  
together for a long while and we always  
looked forward to our group.  
–MMA participant

MMA mentorship sessions, researchers noted some areas for improvement. There were instances where the researchers observed that mentors were late or unprepared for group sessions, and that ongoing supportive supervision was lacking.

The choice of venues in Zaria was problematic, and

“  
The mentor didn't understand the lesson and had  
to keep looking at the curriculum. So, the girls  
didn't understand what she was saying. When she  
read the story for the session it was if she was  
seeing it for the first time.  
–CGE researcher, MMA mentorship  
group observation notes



generated complaints that the rooms were small, and overly crowded. The spaces lacked privacy, and health personnel and patients could at times overhear the discussion. Some girls indicated that they left the session or stopped attending as a result, though this was not the norm among those interviewed. Many of the difficulties were isolated to the implementation sites in Zaria, which were newer. The research team did not hear such concerns about the mentorship group sites in Jaji, though they did not have a chance to observe sessions there as the groups were temporarily suspended due to the COVID-19 pandemic. Despite these logistical hurdles, the LFH mentorship groups were popular and well-attended.

## DEMOGRAPHICS OF GIRLS AND INFLUENCERS INTERVIEWED

Research was carried out in urban communities in the Sabon Gari and Zaria Local Government Areas (LGA) and in rural MMA communities near Jaji town in the Igabi LGA. Those enrolled in MMA who participated in interviews were married between 13-17 years of age. Most had given birth within their first two years of marriage and had more than one child by the time they attended MMA. Husbands of participants ranged in age from 22-55. Most of the young women were a first and only wife. A few had tertiary education. In Zaria, many had completed secondary education. In Jaji, most had attended primary school, but the majority did not graduate. Most of the participants were not earning an income and were of lower to middle socioeconomic status.

### OBJECTIVE 3 EXPLORATION AND DOCUMENTATION OF THE MMA USER JOURNEY

This third research component explored girls' experience with the MMA user journey, or the intended experience that MMA was designed to create for girls. This intended user journey against which the research findings were compared and contrasted is presented in Table 2.

**TABLE 2: MMA USER JOURNEY**

<b>MOBILIZATION</b>	A married adolescent girl learns about MMA from a female mentor or from her husband. She agrees to attend a mentored LFH course or counseling session with support from her partner to attend.
<b>ASPIRATIONAL ENGAGEMENT</b>	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 nutrition, child spacing, interpersonal communication, and financial management. She gains life and vocational skills to apply in her daily life, possibly to generate income.
<b>CONTRACEPTIVE COUNSELING &amp; SERVICE DELIVERY</b>	She feels comfortable with the service providers and feels that what she says will remain confidential (including during private walk-in appointments). LFH sessions provide opportunities for her to meet with a provider in a confidential setting unless she opts out. Contraception is positioned as a tool that can help her achieve her plans. She can be supplied with a contraceptive method of her choice, for free, and on the spot.
<b>FOLLOW UP</b>	She is invited to return to the health center whenever she has questions, experiences side effects, or needs a resupply of contraceptives. Follow up with a provider can also take place by phone.

## MOBILIZATION

### COMMUNITY OUTREACH AND PARTICIPANT AND HUSBAND ENGAGEMENT

MMA participants interviewed for this research learned about the program directly from a female mentor during a home visit or from their husbands following interaction with a male IPCA. Decisions about participation in the program were between a girl and her husband, though those interviewed almost always said that the husband was the ultimate decision-maker. Men who withheld permission for their wives' attendance often cited lack of supervision for their wives when leaving the house and potential costs related to attendance (for example for transportation to and from event locations) as the primary reasons. Where husbands were reluctant to support their wives' attendance, engagement from influential traditional or religious leaders proved pivotal in securing their support, particularly when past disappointing experiences with NGO or government programs created skepticism. Some community leaders in the research site in Jaji enrolled their wives in order to set an example, and to demonstrate their support for MMA and its goals. A few girls decided to join the program without their husband's consent, or without disclosing the full scope of the program (i.e., that it covered birth spacing), risking potential repercussions if discovered. Mothers-in-law played varying roles in the decision-making process related to girls' attendance and were generally more reticent about contraception and birth spacing, particularly in the first few years of marriage.

“

**My husband was reluctant to allow me to enroll in the program because of the lack of information but with persuasion he agreed.**

*–MMA participant*

“

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

*–MMA participant*

The content on vocational skills building in the MMA mentorship group sessions was influential in generating curiosity and interest among girls about the program. This component was similarly appealing to girls' key influencers. The ability to contribute to daily expenses would relieve some burden on the husband and allow the woman to meet her social obligations, serving as an important safety net. For adolescent girls, MMA also attracted interest because of the range of topics covered, including hygiene, nutrition, decision making, negotiation, and birth spacing in addition to vocational skills training. However, there was some confusion about the focus of MMA, likely stemming from the attention given to MMA's skills building components in the mobilization messaging. The majority of participants and their husbands interviewed in Zaria, where the program had been operating for just under a year, believed that the program focused on vocational training rather than discussions of birth spacing. In Jaji, participants said that the mentors gave a more thorough explanation of the program content during mobilization.

“

**I decided that I was going to be part of the program with or without my husband's consent.**

**I knew that my husband is not in favor of birth spacing and that he might not allow me to go so [I] hid the fact that it has to do with spacing.**

*–MMA participant*

## ASPIRATIONAL ENGAGEMENT

### LIFE SKILLS, INCLUDING VOCATIONAL SKILLS

MMA is designed to support a participant as she identifies goals for herself and her family, begins to make a plan for achieving these goals, and understands how contraception can be a relevant tool to help realize her aspirations. Though the variety of skills and content within MMA's curriculum was appealing to girls, much of their interest centered around the opportunity to gain a marketable skill that could provide additional income generating opportunities. While a few participants said they were able to sell products they learned to produce, the vocational

content in most cases did not meet expectations. Insufficient time to learn and practice a new skill, a mismatch between the skill offered and the available market, and a lack of capital often prevented girls from applying the skills that they learned in MMA to generate income. Those husbands whose wives were able to generate additional income spoke the most positively about the program. Some husbands were satisfied even when their wives were unable to generate additional income if they learned to make household items that they otherwise would have needed to purchase outside the home, thereby reducing household expenses.

**“**  
**I wasn't able to sell what I made. This wasn't what I wanted to learn. I knew that where I live there is no market for it.**  
**–MMA participant**

**“**  
**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.**  
**–Male shopkeeper in the community**

The time available in the mentoring groups for learning and practicing communication skills was seemingly sufficient to support girls to initiate conversations with their husbands around birth spacing, though girls' increased agency to initiate conversations with their husbands on topics outside of contraceptive use was far less pronounced. Still, some girls reported improved feelings of self-confidence, self-efficacy, and enhanced communication. A number of husbands, particularly those who were more educated, said that they appreciated better overall communication due to their wives' greater ability to 'speak clearly.'

iii. As the study sampling was purposive, these contraceptive adoption rates are not necessarily representative of the overall rates for the MMA program.

**“**  
**Above all, I learned how to initiate the discussion about birth spacing and to defend my views.**  
**–MMA participant**

**“**  
**My husband followed my judgement and followed me to the hospital so we could start spacing our children.**  
**–MMA participant**

Virtually all girls, even those who were disappointed with the vocational skills content, remained in the program. Girls saw intrinsic value in the variety of topics introduced, including learning about STIs, reproductive tract infections (RTIs), and interpersonal communication, in addition to enhanced knowledge about contraceptive methods.

**“**  
**My husband and I got tested for STIs since it was free. They gave us drugs and told us how we will take the drugs. My husband said he was happy with MMA because of this.**  
**–MMA participant**

**“**  
**I wanted to learn all these things even before I heard of the program. When my mentor came and told me about MMA, I saw this as an opportunity to do so.**  
**–Former MMA participant**

## CONTRACEPTIVE COUNSELING AND SERVICES CONTRACEPTIVE UPTAKE

Sixty-two percent (62%) of participants interviewed in Zaria and 77% of those in Jaji said they adopted a contraceptive method after MMA participation, though a significant number subsequently discontinued.<sup>iii</sup> This reflects an unmet need for more effective methods that are often rejected due to a range of barriers to access and to myths and misconceptions among girls and communities. These rates of adoption can be

attributed to the competency of MMA's contraceptive counseling in addressing some of these barriers. Confidentiality was a key concern for girls interviewed for this research. Health personnel providing services through MMA (both public providers trained by the program and private providers employed by SFH) were viewed as trusted, more discreet and likely to maintain girls' confidentiality. Most girls indicated that MMA provided them with greater knowledge of the benefits of birth spacing. Even those girls who did not adopt a method said they felt that correcting myths and misconceptions related to contraception was important, especially those related to linkages between modern contraceptive use and infertility. Several of those interviewed disclosed that prior to attending their mentoring group they avoided contraception for fear of side effects (in addition to the pressure to have children and concern about gossip). Girls indicated that many health personnel outside of MMA did not adequately explain possible side effects, and as a result, some girls discontinued when they experienced side effects such as bleeding changes. In contrast, MMA participants reported awareness of possible side effects, and knew that they could seek help at the health center to manage them, suggesting that the counseling was increasing knowledge, and allaying some of their concerns.

There is general agreement that contraception is a private matter and that decisions around fertility are best made between a husband and wife. Girls who desired to access and use contraception said their ability to do so was largely dependent on support from key influencers in their lives, primarily husbands, but also in a few cases, mothers-in-law. Some girls said that they were able to convince their husbands that birth spacing was beneficial, either to minimize economic hardship or for the health of their family. Otherwise, IPCAs were able to overcome the reluctance of some husbands to consider birth spacing by highlighting the health benefits of contraceptive use and convincing the husband to accompany his wife to the health center where they could participate in a joint discussion with a health provider. Some MMA participants mentioned conveying their new knowledge and experiences to their closest friends and family members. Despite deep religious, often

conservative roots, husbands in general did not see a conflict between their religious beliefs and birth spacing.

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**My husband is a religious man who is always glued to the Holy Qur'an, but he sees nothing wrong with spacing our children as long as it isn't harmful to me.**

**–MMA participant**

Fearing that they would not receive support to use contraception, some girls interviewed either did not adopt a method, or in a few cases accessed one covertly, often selecting an implant or injectable, which were less detectable and did not require frequent resupply, like pills. A few married adolescent girls indicated that since they bore the health consequences of childbirth, they believed they should have the ultimate say in their health-related decisions.

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**When I told my husband I wanted to wait before having our next child he said that he would divorce me if I did, but I had already made up my mind. I might not have influence over how many children I will have, but I do have influence over my health.**

**–MMA participant**

Girls felt comfortable within their mentorship groups and had relative ease in accessing contraceptive services through MMA compared to traditional service delivery pathways. Having mentors who were trusted within the community to supply information and then refer to an MMA youth-friendly provider was viewed as an effective way to disseminate information and connect to services more seamlessly. This research concluded that through culturally sensitive programming and service delivery, MMA is supporting the gradual shift in attitudes around contraception for birth spacing occurring in these northern Nigerian communities.

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I'm seeing exactly what the nurse told us. The modern (method) we are using now is more reliable. My wife hasn't experienced any of the severe side effects that I was worried about before.

–Husband of MMA participant

#### FOLLOW UP

#### METHOD CONTINUATION

At the end of each MMA counseling session, girls who adopt a modern method of contraception are reminded to return for follow up. Providers supply appointment cards that include their phone numbers. Protocol dictates that providers call adopters two to three days after method uptake, midway through method use, and then 2 to 3 days prior to when resupply would be needed. However, the interviews suggest that not all providers adhere to these follow-up protocols. Interviews with girls who had previously adopted contraception through MMA revealed that 70% of the respondents in Jaji and 30% in Sabon Gari and Zaria discontinued method use. A contributing factor to the difference in discontinuation rates is that girls interviewed in Jaji tended to have adopted a method longer ago than those interviewed in Zaria, given that Zaria is a newer implementation site for MMA where many of the adopters interviewed had been using a method for under six months. These rates of discontinuation do, however, speak to the need to intensify follow up with MMA participants who adopt modern contraception. While participants were generally more well-informed about contraceptive method side effects, this was still the primary reason they cited for discontinuation. Girls were aware that they could visit the health facility, and often did visit the facility once or twice if they had concerns. However, distance to the facility, permission needed to travel, and associated transit cost were still barriers. Despite these barriers, the rate at which girls reported going to the facility for follow-up is significant compared to data on health seeking behavior among rural, married adolescents who did not participate in MMA. These logistical barriers were particularly relevant

in Jaji where the health facility was farther away from girls' homes. If a method-related issue was not resolved within one to two visits to the health facility, many discontinued.

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I went with my husband to the clinic... Every time we went, they kept telling us the same thing—come back another day. My husband became frustrated and stopped going with me. He gave me money to take a motorcycle taxi but finally I too gave up and stopped going.

–MMA participant

## LIMITATIONS

Due to lockdowns related to the COVID-19 pandemic, and mentorship group suspension, the research team was unable to observe the mentorship groups in Jaji as planned. This impacted the conclusions that can be drawn from the findings of Objective 2, the Assessment of MMA Mentorship Groups. The CGE team relied on data that had been collected in Zaria prior to the pandemic restrictions and bolstered and supplemented this by greatly increasing the number of individual interviews with girls and influencers to garner greater insight.

## CONCLUSION AND RECOMMENDATIONS

CGE's research within the communities in Kaduna State highlighted important areas for further reflection, and opportunities to adapt and strengthen MMA.

**Gender Norms and Girls' Agency.** MMA has been successful in navigating the more conservative northern Nigerian context by aligning messages about contraception with concepts of family care and financial stability. Through the program, girls do seem to have gained enhanced agency and voice within SRH and contraceptive decision-making. A significant number of participants shared what they learned with their husbands and were at times pleased by their husbands' receptiveness. Yet the research did

not suggest that this contributed to girls' increased control over decision-making in other life spheres. A two-hour session on negotiation or communication is unlikely to shift deeply rooted gender norms and entrenched patterns of power within relationships. These findings provide a point of reflection as A360 considers what it might mean to improve girls' agency and voice in its next phase and engage in more gender-transformative programming.

**Involvement of the Community and Key Influencers.**

Traditional and religious leaders who have the respect of the community can be extremely effective advocates for birth spacing. In areas where MMA actively engaged these key community gatekeepers, community members were more familiar with the program and more likely to participate. There is a gradual shift in attitudes about contraception occurring in the north as some recent efforts show.<sup>22,23,24</sup> It is important for MMA to support and to capitalize on these efforts. Given past controversy over family planning efforts, the lack of community backlash regarding MMA's contraceptive programming reflects this gradual shift in attitudes and is a credit to MMA's culturally sensitive design and implementation. As girls and their husbands share their experiences with contraceptive use with close friends and relatives, others could likely see the benefits of birth spacing and seek out information and services themselves.

**Vocational Skills.** The skills-building aspects of MMA's programming were critical in building girls' curiosity about the program and support from their influencers. Yet, most participants and their husbands felt the training was far too short and the skills not as relevant as they could be. Virtually all requested that MMA increase the intensity, depth, and length of this program component. Participants shared an interest in learning what they deemed to be more valuable and relevant trades such as tailoring, shoe and bag making, or animal husbandry. The dilemma for MMA would be how to provide such training within the scope of its mandate and budget.

**Mentor Supervision and Support.** Though girls portrayed their interactions with mentors as overwhelmingly positive and respectful, the quality

of mentor's facilitation of MMA sessions still proved a concern in some research sites. The research suggests the need for systematic mentor support and supervision. From CGE's prior experience with mentor supervision, the research team recommended that mentorship be implemented in a careful, supportive, and collaborative way to prevent the supervision from being top-down or punitive.

**Follow-up.** A360 is wrestling with the same issues as the broader sector, where there is clear evidence that youth (15-24) discontinue contraceptive use at rates much higher than all women of reproductive age.<sup>24</sup> It is an accomplishment that MMA is linking girls with local health services, and that some girls are returning to a facility once or more when they have issues with their chosen method. Still, follow-up protocols must be strengthened to ensure that girls are continually supported after initial uptake of contraception.

**MMA Mentorship Group Venues.** It is essential that the groups be held in a private space where participants feel comfortable discussing their lives and reflecting on some of the more sensitive topics in the curriculum.

**An Opportune Time.** MMA's experience so far suggests that meeting married adolescents' contraceptive needs in a culturally sensitive way is feasible, even within a challenging social, cultural, and religious context. The general lack of controversy MMA encountered also suggests that perceptions of birth spacing through modern contraception might be at a tipping point within certain communities in northern Nigeria. With concrete improvements in implementation—a revised approach to vocational training, enhanced follow-up of participants, increased mentor supervision, improved choice of venues, and closer involvement of key decision makers, and traditional and religious leaders—the researchers concluded that this could be an opportune time for the expansion of MMA and potentially for integration into other programs supporting married adolescents.

## CONTRIBUTING AUTHORS

*Italics indicate authorship*

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- *Daniel Perlman*
- *Mardhiyyah Abbas Mashi*
- *Tessa Fujisaki*
- *Meghan Cutherell*
- *Sara Malakoff*
- *Abednego Musau*
- Made David
- Aisha Abubakar
- Hajara Abubakar
- Aminu Bello Gurin
- Daisy Valdivieso
- Joy Otsanya Ede
- Fifi Ogbondeminu



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