# QUALITY OF CONTRACEPTIVE COUNSELING FOR ADOLESCENT GIRLS IN ETHIOPIA, KENYA, AND NIGERIA: METHOD INFORMATION INDEX PLUS FINDINGS FROM ADOLESCENTS 360 PROGRAMS

MARCH 2026

A360

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# SUMMARY

In this brief, we present findings from the Method Information Index Plus (MII+) based on three rounds of annual client exit interviews in Ethiopia, Kenya, and Nigeria. These findings illustrate how Adolescents 360 (A360) interventions performed on this measure of contraceptive counseling quality over time. All data was gathered from public health care facilities, with varying levels of programmatic support provided by A360 depending on the survey round and geography. Taken together, this data provides insight into existing levels of counseling quality for adolescents and how that quality was maintained and strengthened over time with targeted technical assistance. This data is unique in that it is all gathered from adolescent girls aged 15-19 from three sub-Saharan countries.

## KEY MESSAGES

- Quality of contraceptive counseling is an important driver of method adoption and continuation. Measuring and improving the quality of contraceptive counseling is essential to ensure programming successfully supports reductions in unintended pregnancies, especially among adolescents.
- Adolescents 360 uses MII+ – a set of 4 questions on the information received during contraceptive counseling – to assess quality of counseling. MII+ captures the recall and understanding of the information received during counseling.
- We present findings from 3 annual rounds of surveys from Nigeria, Ethiopia, and Kenya, with adolescent girl clients between the ages of 15-19.
- Individual choices around contraceptive uptake reflected a broad method mix, with most girls selecting injectables, followed by implants and pills.
- Quality of counseling, as measured by the MII+, increased over time in Ethiopia and Kenya, reaching 87% and 67% of clients reporting quality counseling, respectively, and remained stable in Nigeria over the survey period, with 87% reporting quality counseling in the most recent survey year. Across all three countries, these results exceeded national benchmarks for quality counseling among women of reproductive age.
- Gaps remain in providing quality counseling to younger adolescents (ages 15-17) when compared to older adolescents (ages 18-19). More work is needed to ensure consistent, high-quality services for younger girls.
- To achieve and maintain quality contraceptive counseling for adolescents, we recommend the following: interventions must be designed with girls' needs in mind, providers need training and support to deliver adolescent-responsive services, strong supportive supervision systems are needed at scale, and improved contraceptive counseling approaches, such as Counseling for Choice, should be introduced.

# BACKGROUND

## ADOLESCENTS 360

Achieving and sustaining high-quality contraceptive counseling is an important part of ensuring contraceptive adoption and continuation.[1] Adolescents 360 (A360), a project of Population Services International, supports governments in sub-Saharan Africa in strengthening health systems to improve adolescent contraceptive uptake. The project's goal is to reduce adolescent pregnancy, an urgent need, given that an estimated 21 million adolescents become pregnant each year.[2] A360's interventions tap into girls' aspirations and position contraception as a tool that can support them in pursuing their life goals. For more information on the interventions, see Box 1.

### BOX 1. A360'S INTERVENTIONS BY GEOGRAPHY

**In Ethiopia**, Smart Start uses financial planning as an entry point for discussions with married adolescent girls and their husbands around delaying and spacing births. Smart Start is delivered by Health Extension Workers and is fully integrated within the national Health Extension Program. Under the leadership of the Ethiopian Ministry of Health and with technical assistance from PSI Ethiopia, Smart Start has been scaled to over 9,500 health posts across seven regions in Ethiopia.

**In northern Nigeria**, Matasa Matan Arewa (MMA) integrates contraceptive service delivery with concepts around skill-building and family health. MMA engages girls' key influencers - particularly their husbands and religious and traditional leaders - with messages that build an enabling environment for their contraceptive use and decision-making. The Nigerian Ministry of Health, with support from Society for Family Health Nigeria, has scaled MMA to over 1,750 primary health centers across four states in northern Nigeria.

**In Kenya**, Binti Shupavu engages girls in dynamic goal-setting sessions to position contraceptive use as relevant to achieve their aspirations and delivers on-the-spot, stigma-free contraceptive counseling. The Kenyan Ministry of Health is implementing Binti Shupavu with technical assistance from Population Services Kenya across 402 health facilities in four counties in Kenya.

Starting in 2020, A360 has focused on supporting governments in Ethiopia, Kenya, and Nigeria to own and scale the respective interventions in each geography. By providing technical assistance, A360 is strengthening public health systems to deliver adolescent-responsive services at scale. Since the project's inception in 2016, A360 has supported nearly 2.4 million adolescent girls to voluntarily adopt a modern method of contraception.

## QUALITY IN A360 PROGRAMMING

Ensuring high-quality contraceptive services is a priority for A360. Not only does quality support uptake and continuation, but it is also a girl's right to access safe services and respectful care. Given the project's focus on adolescents, we were attuned to their heightened need for privacy and confidentiality as well as higher-touch counseling that introduces methods and supports girls' decision-making processes, since they are often less familiar with the full range of contraceptive methods than older women.

Our approach to quality prioritizes technical competence, client safety, continuity of care, information exchange, and interpersonal connection. This person-centered quality of care approach emphasizes the importance of a respectful client-provider interaction, where information exchange is comprehensible and available to all, and where providers are well-equipped to support clients and clients can actively participate in their own care.

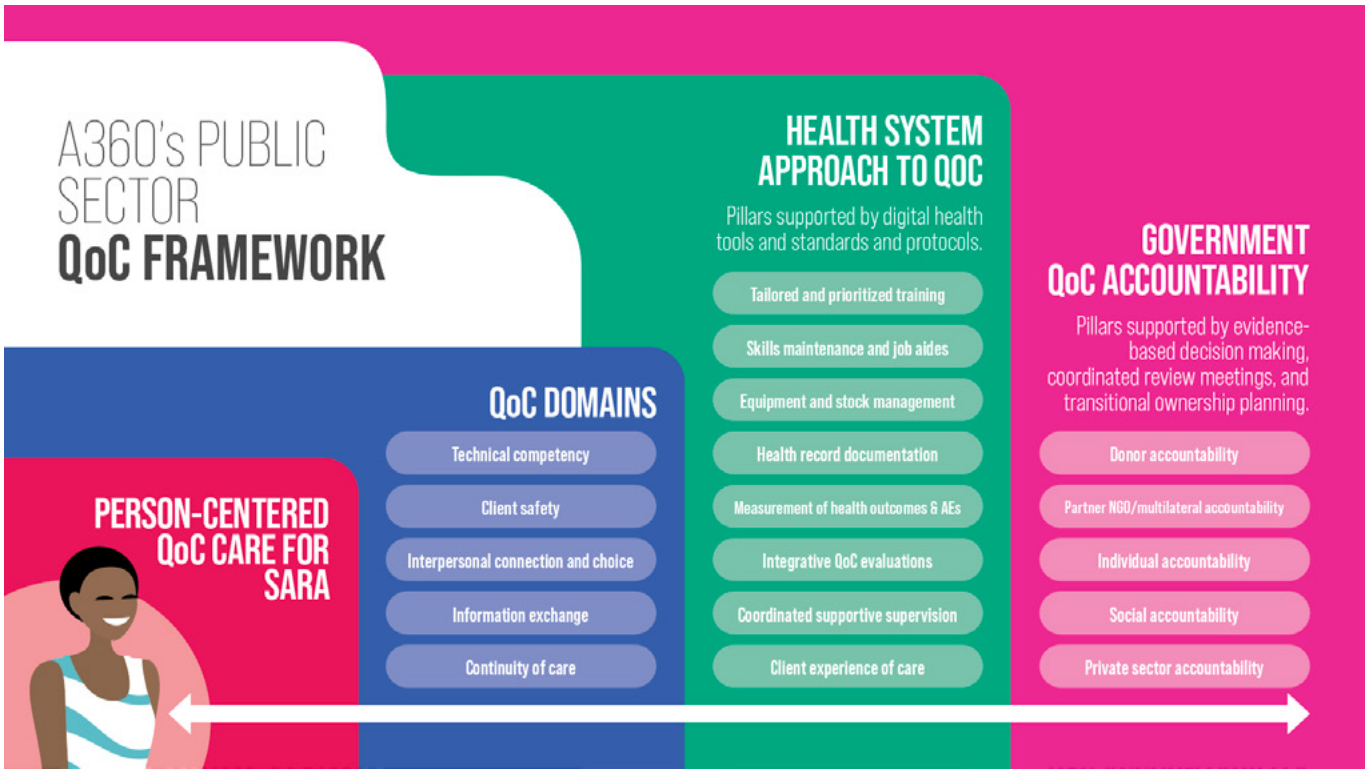



**Figure 1. A360 Quality of Care Framework**

Across all A360 geographies, contraceptive counseling and services are offered through government providers. As such, we take a health system approach to quality of care. We evaluate and strengthen health system standards including provider training and job aids, stock management and adverse event management, with the ultimate goal of ensuring health system accountability for high-quality services (Figure 1). In practice, this means A360 conducts quality audits in partnership with Ministry of Health officials to identify gaps and develop approaches to improve the quality of contraceptive services. In addition, joint supportive supervision visits with Ministry of Health officials enable direct provider coaching for immediate quality improvement. For recurring issues, we work with Ministries to develop action plans designed to improve workflows, build capacity, and use data more effectively.


In general, A360's approach is to work to strengthen existing approaches and systems and limit the introduction of new or parallel approaches, given our goal of program sustainability. However, one exception has been the introduction of Counseling for Choice (C4C) as a recommended counseling protocol in all three countries, based on its potential to improve counseling outcomes and client satisfaction. C4C is an evidence-based approach to contraceptive counseling that helps clients decide which method is right for them.[3] The C4C approach encompasses a set of counseling techniques and principles to assist providers in addressing many of the root causes of unmet need for contraception: gaps in free and informed choice, dissatisfaction with side effects and bleeding changes, and discontinuation among users who wish to prevent pregnancy. Over the survey period, the scale of C4C varied across countries. By Round 3, C4C had been implemented in the majority of health facilities in Nigeria, while it remained in a pilot phase in Kenya and Ethiopia.

## A360 TRANSITION TO GOVERNMENT OWNERSHIP

The pace of transition from project-led to government-led implementation has differed by geography due to the timing of initial intervention development, government structure and priorities, and available resourcing. We define a project-led site as one where A360 provides direct financial support to bolster existing public sector resources, for example, through the provision of stipends to government mobilizers or health workers, printing materials, or per diems for training. Over time, A360 phases out financial assistance, shifting to technical assistance only, supporting governments to implement using their existing resources, at which point the site becomes government-led. A360's technical assistance approach is based on the World Health Organization's health system building blocks and seeks to strengthen core elements of the system, including program delivery, leadership and governance, and health financing.[4] The emphasis is on building the capacity of government actors and systems to successfully deliver on critical functions. In the quality domain, A360 technical assistance strengthens supportive supervision practices, data quality, and health worker training. In both project- and government-led sites, contraceptive services are provided by the public sector. As the programs scaled across geographies, many sites were government-led from the outset and did not include a project-led phase.

# MEASURING QUALITY

We have been using Client Exit Interviews (CEIs) to track individuals' experience with contraceptive counseling provided through the A360 interventions. A key quality metric in these surveys is the Method Information Index plus (MII+). The Method Information Index originally comprised three questions; a fourth was added in 2019.

**Method Information Index Plus consists of the following four yes or no questions:**

1. During your counseling session, were you informed about other methods one can use to delay or avoid getting pregnant?
2. Were you informed about possible side effects or problems that you might experience when using the method?
3. Were you told what to do if you experience any side effects or problems?
4. Were you told about the possibility of switching to another method if the method you selected was not suitable?

As a self-reported measure, MII+ captures the recall and understanding of the information received during counseling.[5] Viewed as a composite score, the value of interest is the percentage of women responding 'yes' to all four questions. MII+ asks about elements known to be important for contraceptive uptake and continuation, including supporting informed method choice, expected side effects, how to manage side effects, and the possibility of switching methods. Responding 'yes' to all four questions has been shown to be a predictor of contraceptive continuation for all methods.[6] See Box 2 for a brief discussion of the limitations of the MII+.

## BOX 2. LIMITATIONS OF THE METHOD INFORMATION INDEX PLUS

MIIplus is an efficient, easy way to collect quantitative perspectives on quality of contraceptive counseling. However, some limitations include:

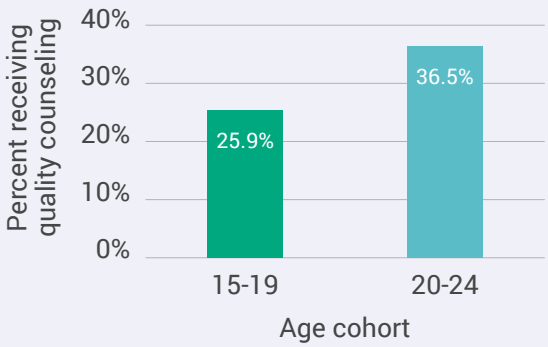
- The indicator does not capture all domains of quality of care, such as respectful treatment or access to a full range of methods.
- The metric relies on client recall, which can be subject to bias.
- The binary nature of the questions limits depth of understanding, such as how well the topic was explained or the level of understanding attained by the client.

The MII and MII+ have now been used in many nationally representative surveys in low- and middle-income countries, including the Demographic and Health Surveys and Track20 and Performance Monitoring for Action. It is therefore a metric that allows for analysis of contraceptive quality across multiple dimensions, including time, geographic location, demographic characteristics, and method. Analysis of MII responses from Demographic and Health surveys in sub-Saharan Africa shows that adolescents aged 15-19 experience lower quality of counseling than young women ages 20-24 (See Box 3).[7]

## STUDY PURPOSE AND METHODS

All data is drawn from annual CEIs in each geography. CEIs are designed to provide a representative snapshot of the types of clients accessing A360 services, the services they use, and their experience with the services provided. CEIs were conducted approximately annually in each geography, for a total of three rounds of surveys (Table 1).*

### BOX 3. MII ANALYSIS SHOWS ADOLESCENTS ARE LESS LIKELY TO EXPERIENCE QUALITY COUNSELING THAN OLDER WOMEN




Data from 20 countries in sub-Saharan Africa.

Table 1. Timing of CEIs by geography

| | ROUND 1 | ROUND 2 | ROUND 3 |
|---|---|---|---|
| **Nigeria** | Nov 2021 | May 2023 | Dec 2024 |
| **Ethiopa** | Nov 2022 | Dec 2023 | Feb 2025 |
| **Kenya** | May - Jun 2022 | Excluded | Oct 2024 |

The MII+ was included in the CEIs to establish baseline levels of counseling quality among adolescent girls and to track changes over time.

* Due to data quality issues, results from Round 2 in Kenya have been excluded from this brief.

The CEI sampling approach included a mix of project- and government-led sites in varying proportions depending on geography. Because we hypothesized that quality would differ between these models, we examined MII+ results across both, with particular attention to whether quality was maintained as the transition progressed. In Nigeria, state governments have been taking on greater ownership of sites under a phased transition plan. While in our initial survey round, implementation across all sites was led by A360, by Round 3 that number had dropped to 30%. In the broader project context, implementation was government-led in 95% of sites by Round 3. Because the majority of sites were initiated as government-led, we oversampled project-led sites to ensure a sufficient sample size for comparative analysis. In Ethiopia, an early investment in government scale-up enabled A360 to transition to a technical assistance role starting in 2020, with implementation in all survey sites led by the government. Since quality metrics from A360-led sites were unavailable, we aimed to understand quality in government-led sites and to assess the extent to which this quality could be maintained or improved as the program scaled nationally. Programming in Kenya started later than in other countries, with an initial investment to design the approach in 2020. The transition to government ownership is still in progress and has therefore followed a different timeline, with government-led sites making up 18% of surveyed sites in Round 3. The data from Kenya, therefore, primarily reflect counseling quality under A360 programming and will serve as a benchmark for maintaining quality during further expansion (Figure 2).

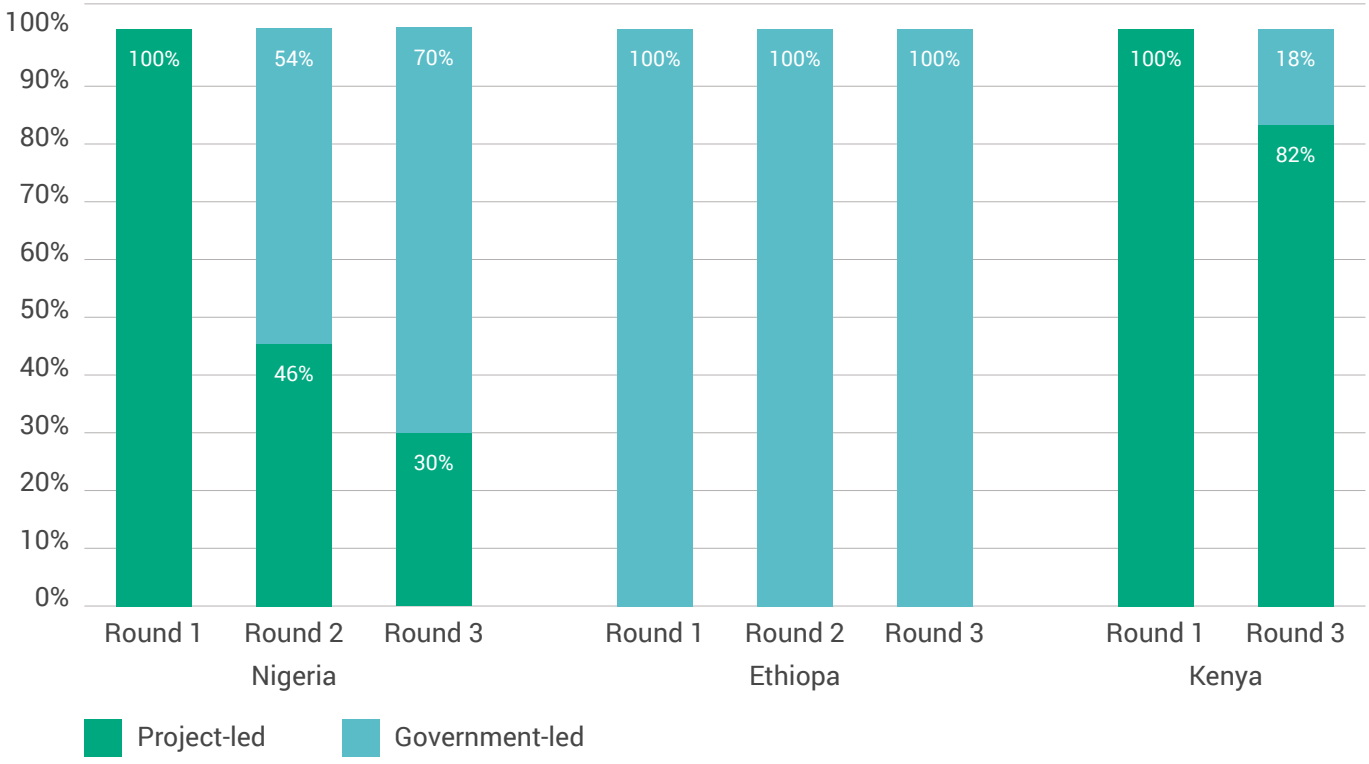



**Figure 2. Proportion of clients from project-led sites and government-led sites by round**

CEIs employed a cross-sectional design to gather data from clients receiving services in health facilities where the A360 interventions are provided. Interviewers conducted quantitative surveys with eligible adolescent girls as they exited service delivery points. Sample sizes varied across countries based on national benchmarks for MII data. A multi-stage sampling approach was employed to select sites and participants to ensure geographic representation, including random selection of health facilities at the sub-national level and consecutive recruitment of up to 10 clients from each participating health facility. To account for the ongoing scale-up of the interventions, this selection process was repeated for each survey wave to accommodate newly added geographies.


Data was collected by trained female enumerators to increase the surveys' cultural and gender sensitivity. Young women were screened and recruited using a script, which provided a summary of the survey and eligibility questions. If eligible, participants were asked for and provided written consent before proceeding with the interview. The questionnaire consisted of socio-demographic information, previous contraceptive use, and experiences during the visit, including the MII+ questions, which were only asked of those participants who received a contraceptive method during the visit. Data was collected in SurveyCTO and then downloaded and cleaned. Descriptive analysis yielded summaries of participant characteristics, the nature of service received, and responses to individual MII+ questions. A composite variable was generated from the four MII+ questions, whereby individuals who responded 'yes' to all four questions were coded as meeting the MII+ criteria, and those who responded 'yes' to three or fewer questions were coded as not meeting the MII+ criteria. This brief includes only data from participants who received a modern method at the visit and were asked the MII+ questions. Following the example of Jain et al., male and female condom adopters were excluded from the analysis.*

Ethical approval was provided by the PSI Research Ethics Board and local institutional review boards in the respective countries (Ethiopia Public Health Institute and Ethiopia Midwives Association Ethics Review Committee; Amref Health Africa Ethics and Scientific Review Committee in Kenya; and the Nigeria National Health Research Committee). Permission was also obtained from the Ministry of Health departments in all the sub-national geographies where the surveys were conducted. A waiver of parental consent was granted by the ethics review boards for minors aged 15 -17, as only legally emancipated girls in this age group (i.e., married or parenting) were surveyed. This approach was adopted in accordance with the ethical guidelines for conducting sexual and reproductive health research involving minors in the three countries.[8,9,10]

* Condom users made up a small proportion of contraceptive users, with 38 exclusive condom users over the survey period or approximately 1.6% of all method uptake.

# RESULTS

## PARTICIPANTS' CHARACTERISTICS

The surveys collected MII+ data from 2,333 participants. These included 937 clients from Ethiopia, 536 from Kenya, and 860 from Nigeria. Two-thirds (66.7%) of participants were from rural areas, and the majority (76.7%) were aged 18 or 19 years, with those aged 19 years making up 43.3% of all participants. Overall, the majority (83.5%) of participants were married, or were living as if married (6.6%). In northern Nigeria and Ethiopia, all participants were married or living as married, reflecting program eligibility criteria that restrict participation to married adolescent girls. In Kenya, survey eligibility included clients aged 18 or older (married or unmarried) and those aged 15 –17 who were married or parenting, consistent with applicable emancipation requirements. Thus, while Kenya is the only geography with unmarried girls, the unmarried sample is skewed towards older girls, as compared to the general population served by the program. A quarter (24.6%) of participants were in school, with 44.1% in primary school, 39.6% in secondary school, and 16.3% in college or university. Among participants out of school, most had primary education (42.9%), followed by a slightly smaller group with secondary education (32.3%). Nearly three-quarters (75.6%) had given birth. The participant characteristics are summarized in Table 2.

Table 2: Participants' socio-demographic characteristics (n=2,333)

| PARTICIPANT CHARACTERISTICS | | |
|---|---|---|
| **VARIABLE** | **Categories** | **Number (%)** |
| **Country** | Ethiopia | 937 (40.2%) |
| | Kenya | 536 (23.0%) |
| | Nigeria | 860 (36.9%) |
| **Residence** | Rural | 1,556 (66.7%) |
| | Urban | 777 (33.3%) |
| **Client's age** | 15 | 63 (2.7%) |
| | 16 | 128 (5.5%) |
| | 17 | 352 (15.1%) |
| | 18 | 780 (33.4%) |
| | 19 | 1,010 (43.3%) |
| **Marital status** | Single (never married) | 220 (9.4%) |
| | Married | 1,949 (83.5%) |
| | Living as married | 155 (6.6%) |
| | Divorced or separated | 9 (0.4%) |
| **Currently in school** | Yes | 574 (24.6%) |
| | No | 1,759 (75.4%) |
| **Current level in school*** | Primary | 252 (44.1%) |
| | Secondary | 226 (39.6%) |
| | Tertiary/College | 93 (16.3%) |
| **Highest education level completed** | None | 327 (18.6%) |
| | Primary | 754 (42.9%) |
| | Secondary | 569 (32.3%) |
| | Higher education | 32 (1.8%) |
| | Islamiyah | 77 (4.4%) |
| **Ever given birth$** | Yes | 1,739 (75.6%) |
| | No | 562 (24.4%) |

Note: *no response provided for 3 records; $ no response provided for 32 records

# METHOD UPTAKE

The predominant method adopted during the visit was the injectable (n=1,395, 59.8%), followed by the implant (n=565, 24.2%) and the pill (n=333, 14.3%). Trends were similar in all geographies, except for Kenya, which had a far greater share of implant users (46.6%) than Ethiopia (17.9%) or Nigeria (17.1%). Correspondingly, Kenya had a lower proportion of pill users (7.6%) than Ethiopia (11.9%) or Nigeria (21.1%). IUD was adopted by 33 clients (1.4%) with a similar trend across all geographies. Other infrequently used methods were Emergency Contraception (0.2%) and cycle beads (<0.1%) (Figure 3). Condoms have been excluded from this analysis.

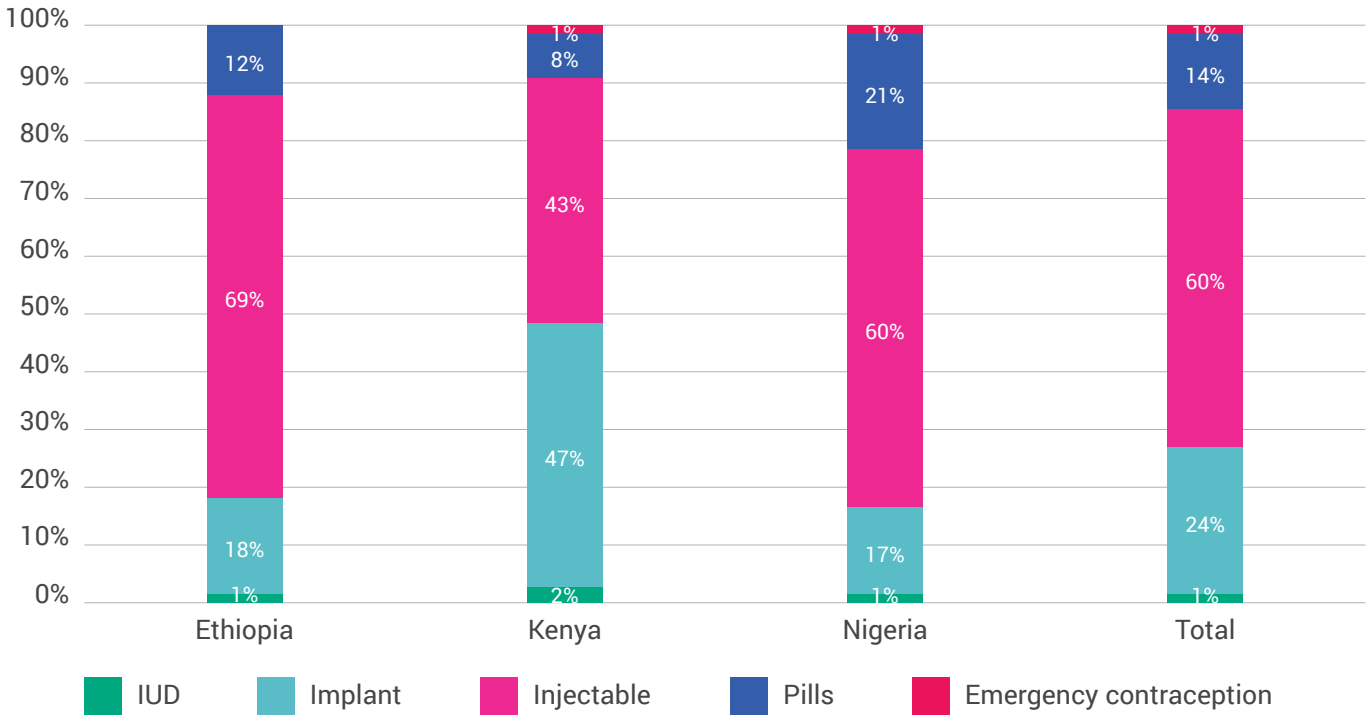



**Figure 3. Method Mix**

Note: responses totaling less than 1% have been excluded.

This method mix compares favorably with nationally representative survey data. In Ethiopia, the 2019 Mini DHS reports 16% implant use and 76% injectable use among married girls aged 15–19, closely aligning with the method mix observed in A360 sites.[11] In Nigeria, the 2024 DHS shows that national method use among married girls aged 15–19 is dominated by the Lactational Amenorrhea Method (48%), with injectable (11%) and pill (7%) use substantially lower than in A360 sites; implant use, however, is higher at 30%.[12] These differences between national data and program data likely reflect regional variations in contraceptive preferences and availability between northern and southern Nigeria. In Kenya, the 2022 DHS indicates that implant use among girls aged 15–19 (49%) is similar to levels in A360 sites, while national injectable (30%) and pill (5%) use are lower.[13]

The robust method mix across the A360 sites suggests that clients have access to a range of methods and feel comfortable choosing the one that is most suitable for them. Across all countries, longer-acting methods that do not require daily adherence, particularly injectables and implants, represent the largest share of use. This is especially promising for continued method use among adolescents, who may struggle more to return regularly to the clinic, consistently negotiate condom use, or remember to take a daily pill.[14,15] These longer-acting methods support spacing in line with girls' desired fertility.

# METHOD INFORMATION INDEX PLUS

## COMPOSITE RESULTS

Figure 4 shows the percentage of clients responding 'yes' to all 4 questions over time by country. Nigeria's positive response rates started at and remained just below 90% for all three rounds. Results in Ethiopia improved consistently over time, with the total percent responding 'yes' to all four questions moving from 68% to 87% from Round 1 to Round 3. Kenya showed a slight improvement in the percentage responding 'yes' over the rounds, starting at 64% in Round 1 and rising to 67% in Round 3. Nigeria's positive response rates started at and remained just below 90% for all three rounds.

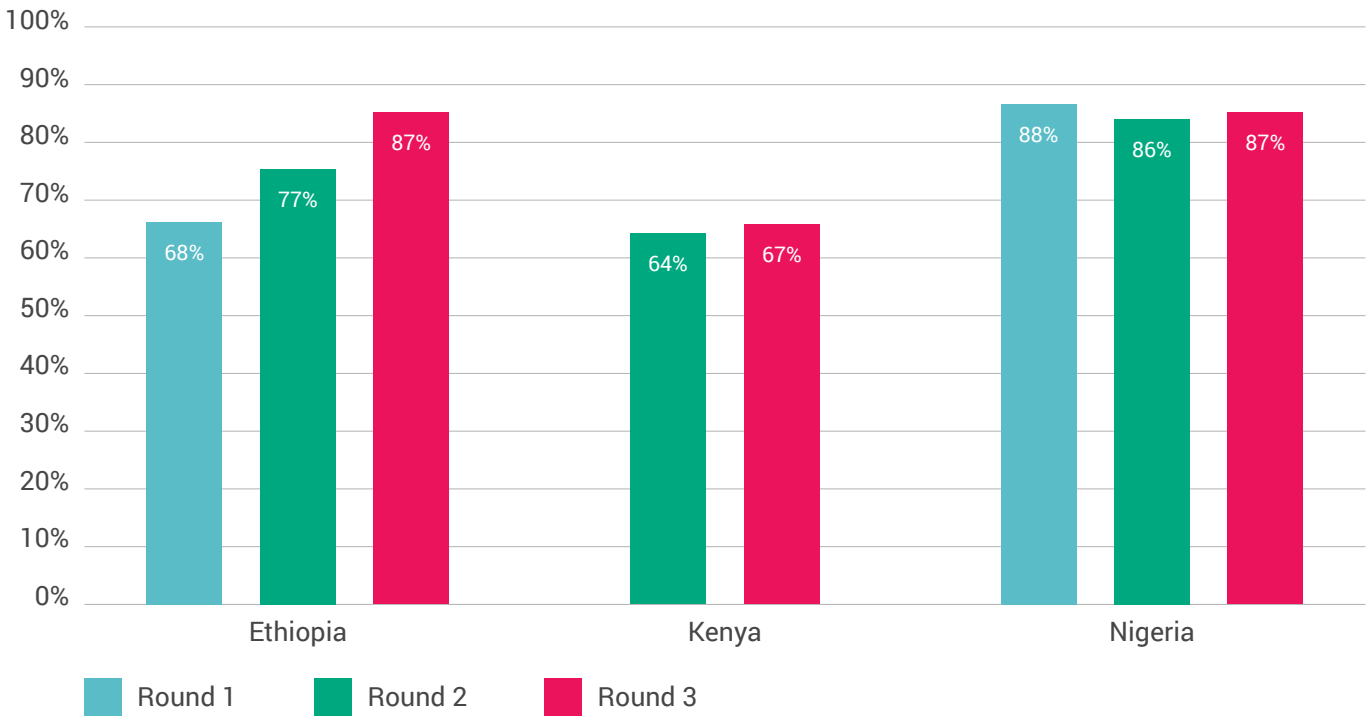



**Figure 4. Percentage of clients responding 'yes' to all four questions by country, by round**

## RESULTS BY INDIVIDUAL MII+ QUESTIONS

In general, 'yes' responses to individual questions were higher than the composite of 'yes' responses to all four questions, as expected. Overall, no single question scored below 80%. Across all four questions, there was a consistent trend upward over the period assessed. 'Yes' responses were highest to whether clients were informed of other methods and lowest to whether clients were informed about the side effects of their chosen method (Figure 5).

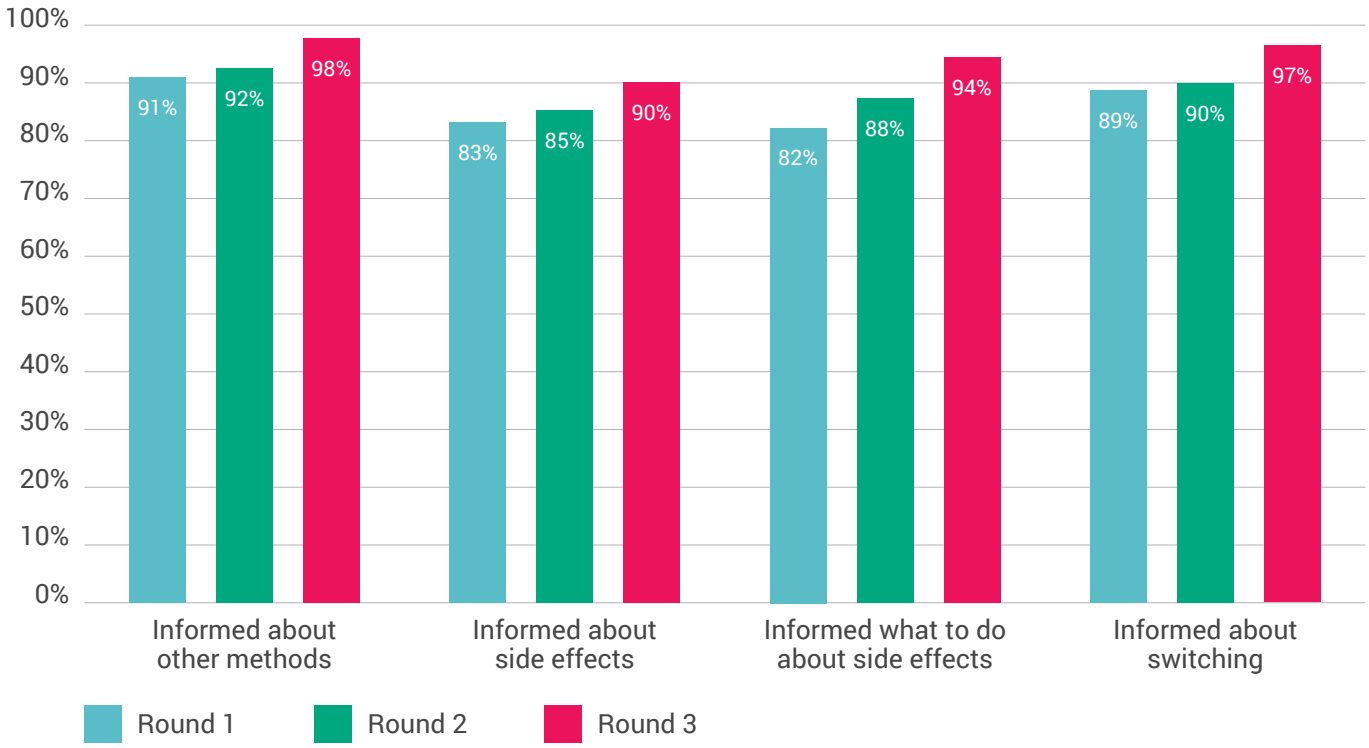



**Figure 5. Total percentage of clients responding 'yes' to each question in the index by round (all countries combined).**

The proportion of 'yes' responses over 80% across the index in Round 1 suggests that sites initially offered quality counseling and were able to sustain and even improve levels of counseling. One area for improvement is informing girls about the side effects associated with their chosen method. More research is needed to understand what is driving this pattern. Studies in other contexts have identified the provision of quality information about side effects as a challenge, suggesting poor provider knowledge or reluctance to discuss them out of concern that clients may opt out of using a method.[16] There may also be specific considerations for adolescents, such as counseling that is not appropriately contextualized to their knowledge or skills or a poor understanding of what constitutes side effects in the first place.

## RESULTS BY COUNTRY

### Ethiopia

'Yes' responses to individual questions in Ethiopia improved over the three rounds, with all questions having 90% or greater 'yes' rates by Round 3. In Ethiopia, knowing what to do about side effects was the lowest-performing question in the index from the outset and remained so, though it showed the greatest improvement over the survey period (Figure 6).

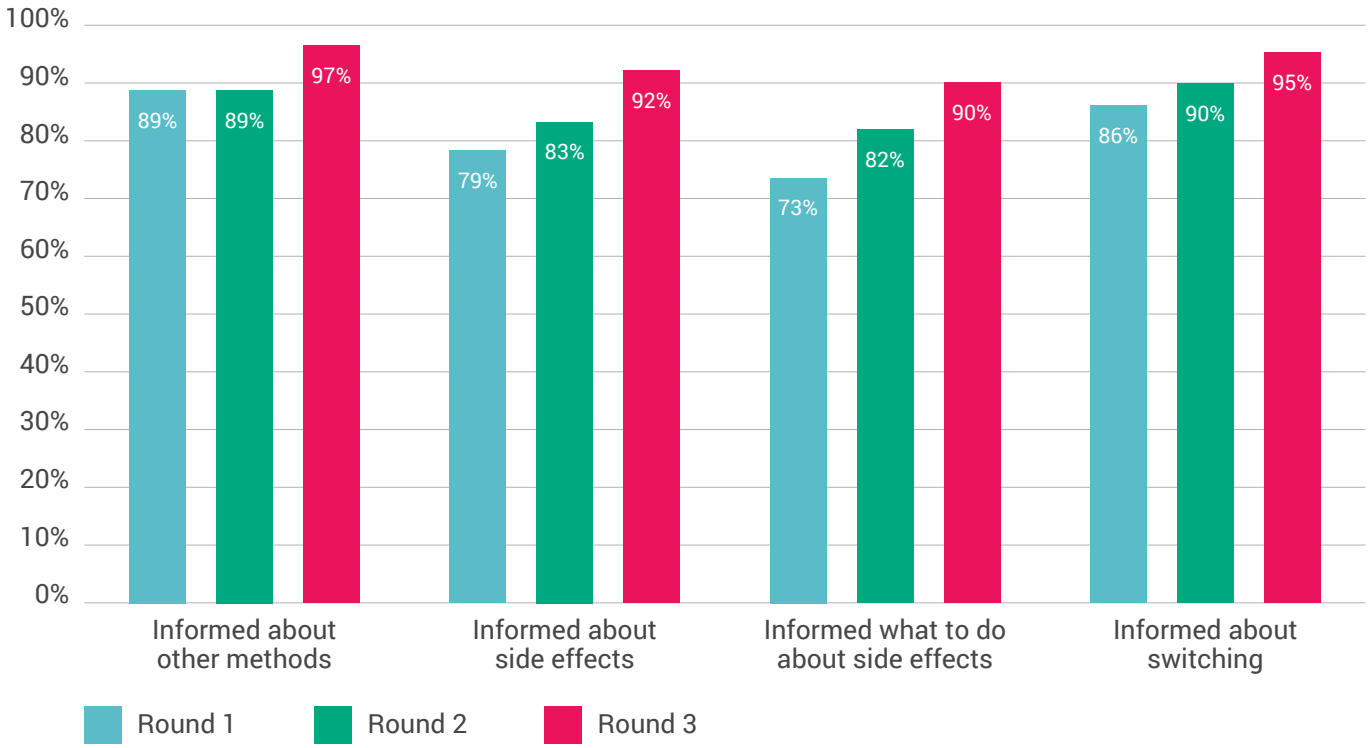



**Figure 6. MII+ results from Ethiopia**

### Kenya

'Yes' responses in Kenya were the lowest across the three geographies, with no question receiving a 90% or higher response rate. All four questions showed positive trends between Round 1 and Round 3 (Figure 7).

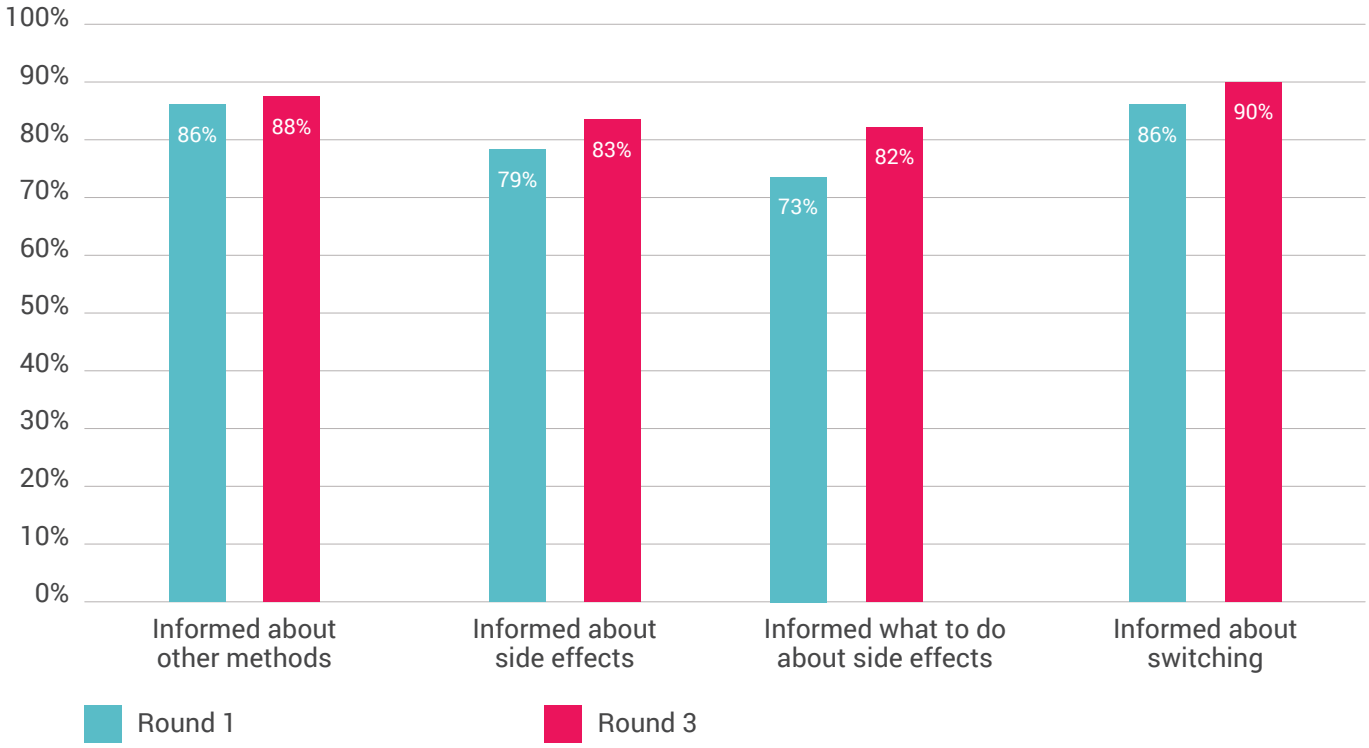



**Figure 7. MII+ results from Kenya**

### Nigeria

'Yes' responses to individual questions in Nigeria were above 90% in Round 1. Three questions: informed about other methods, taking action on side effects, and information on switching, had 99% or 100% 'yes' rates in the final round. As with the combined data, clients were least likely to receive information on their specific method's side effects and, contrary to the trend among the other questions, 'yes' responses dropped from Round 1 to Round 3 (Figure 8).

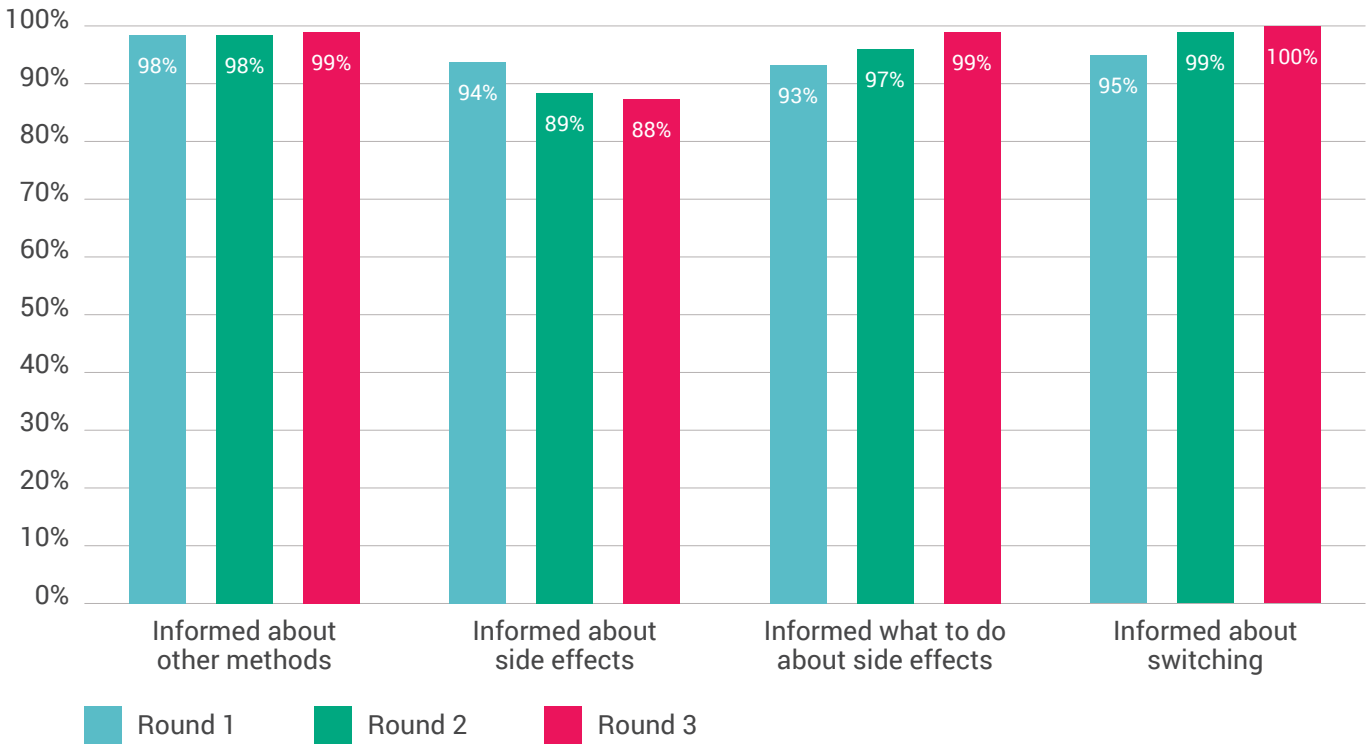



**Figure 8. MII+ results from Nigeria**

The country-level analysis shows that, while performance varied across countries, it was consistently high in all three geographies. Ethiopia data is from government-led sites throughout the rounds. Progress suggests successful application of technical assistance and a dedicated focus on improving counseling at the site level. Performance was relatively lower in Kenya and showed limited change between Round 1 and Round 3. However, the program largely maintained standards over time and outperforms national benchmarks, as discussed in more detail below. The strong performance in Nigeria is likely driven by initially high counseling standards and an early introduction of C4C, which reinforced those standards. It also suggests that, even with a high baseline, improvements are possible.

## METHOD INFORMATION INDEX PLUS BY AGE

CEIs included girls aged 15-19, with just under a quarter of respondents aged 18 or younger. The data on contraceptive quality for younger girls is especially limited, as most national surveys group girls between the ages of 15 and 19. However, it is important to understand the quality of counseling among this sub-population, given the particularly high barriers younger adolescents face, including legal barriers and provider bias, when accessing sexual and reproductive health services. We disaggregated results by age 15-17 and 18-19 to see if there were observable trends. Younger girls were less likely than older girls to report responding 'yes' to all four MII+ questions, although the overall proportion trended upward over time and the gap between the age groups narrowed (Figure 9).

These age-related patterns in counseling quality merit further investigation. They may reflect younger clients' perceptions, as girls with less prior counselling experience may expect more information than providers have time to offer. Alternatively, the observed patterns may indicate persistent provider bias against younger clients or challenges in communicating effectively with this age group. In either case, greater attention is needed to ensure that services are responsive to the needs of this younger cohort of family planning clients.

## COMPARISONS WITH NATIONAL METHOD INFORMATION INDEX PLUS DATA

We compared A360 MII+ data to Performance Monitoring for Action (PMA) data to understand how the program performed against existing benchmarks.[17] Comparison data varied slightly across countries, due to differences in PMA survey timing and methodology. In all cases, A360's most recent survey year is compared to the most recent PMA data available. We compare A360 data, which is limited to clients aged 15-19, with data from all women of reproductive age. Additionally, in Nigeria, PMA surveys are not nationally representative but are representative at the state level; therefore, we use data from Kano State, one of A360's implementation states (Figures 10a-10c).

A360 consistently outperformed existing benchmarks. Results were particularly notable in Ethiopia, where A360 'yes' responses were over 40 percentage points higher than comparable national data for three of the four questions.

These comparisons reflect the high standard set by A360 programming for quality counseling. The comparison data suggest that even when A360 could build on an existing strong counseling foundation, such as in Nigeria, the program improved the consistency with which core counseling elements were addressed. This is especially significant in Nigeria, where successive rounds of survey over time indicate increasing government ownership. In Ethiopia, the much higher rates of 'yes' response in program data when compared to national averages are likely a reflection of the greater diversity in the PMA sample, which includes underserved pastoralist regions. However, it is also a reflection of the degree to which A360 has invested in strengthening the capacity of health extension workers, who have an extensive geographic reach but often struggle with skills gaps in family planning counseling. In Ethiopia, the program has targeted this cohort of providers and worked to improve their capacity to counsel on family planning methods effectively. Notably, the difference between national and A360 data is likely to be underestimated as quality tends to be lower among adolescents than in older age groups, and national data may obscure greater quality gaps among this age cohort.

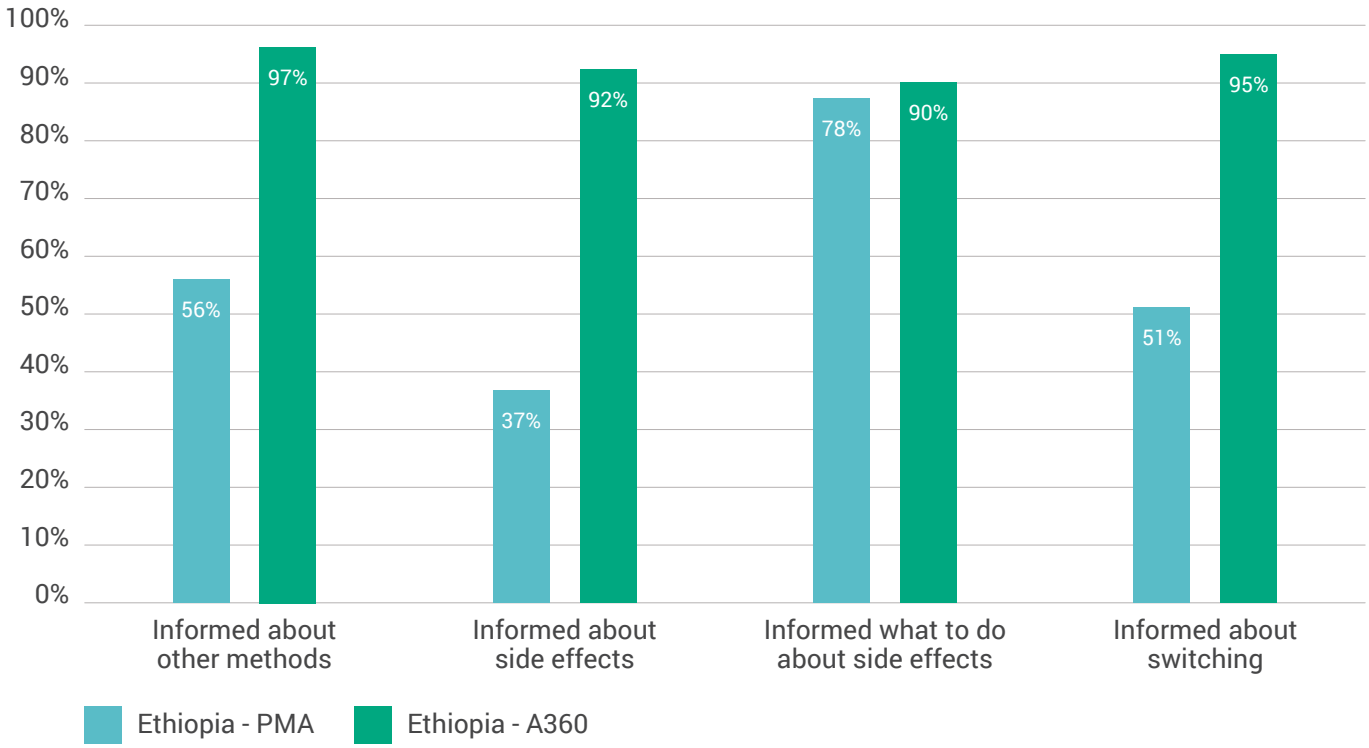



Figure 10a. Ethiopia MII+: A360 vs. PMA 2023

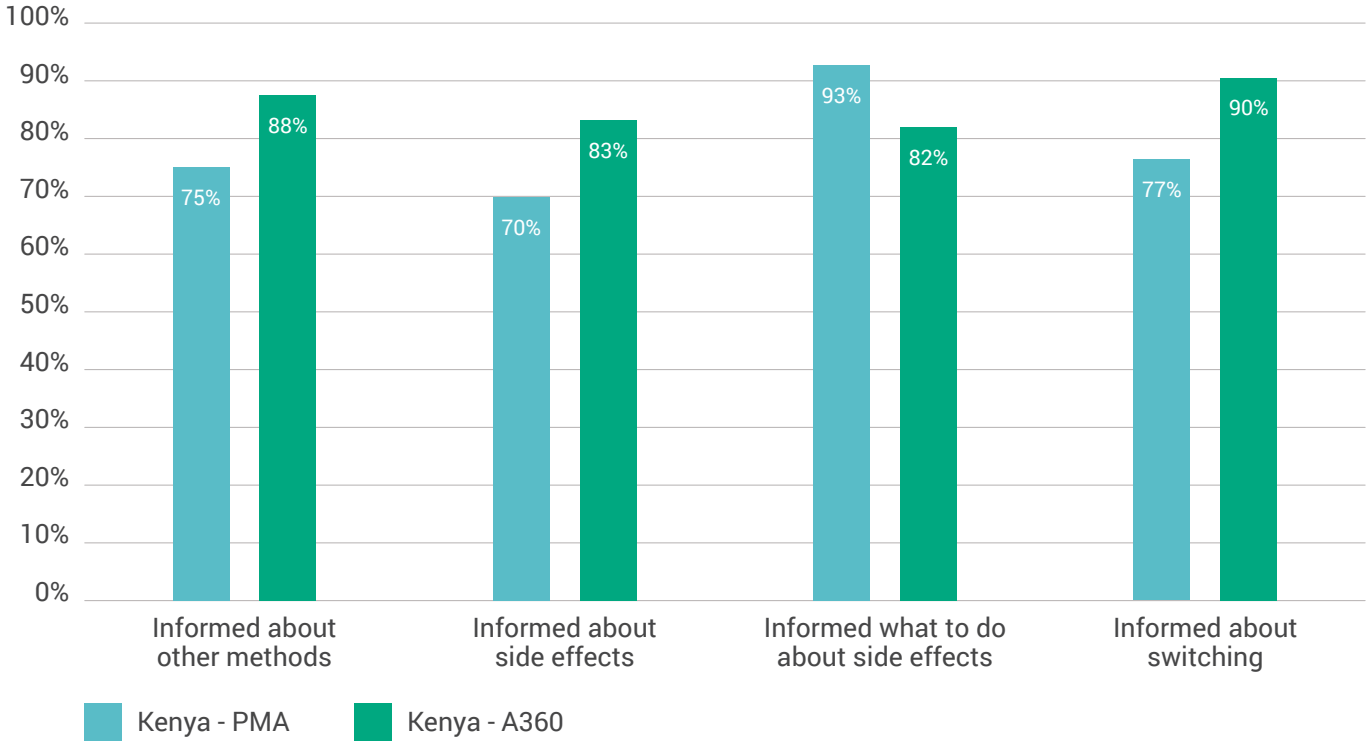



Figure 10b. Kenya MII+: A360 vs. PMA 2022

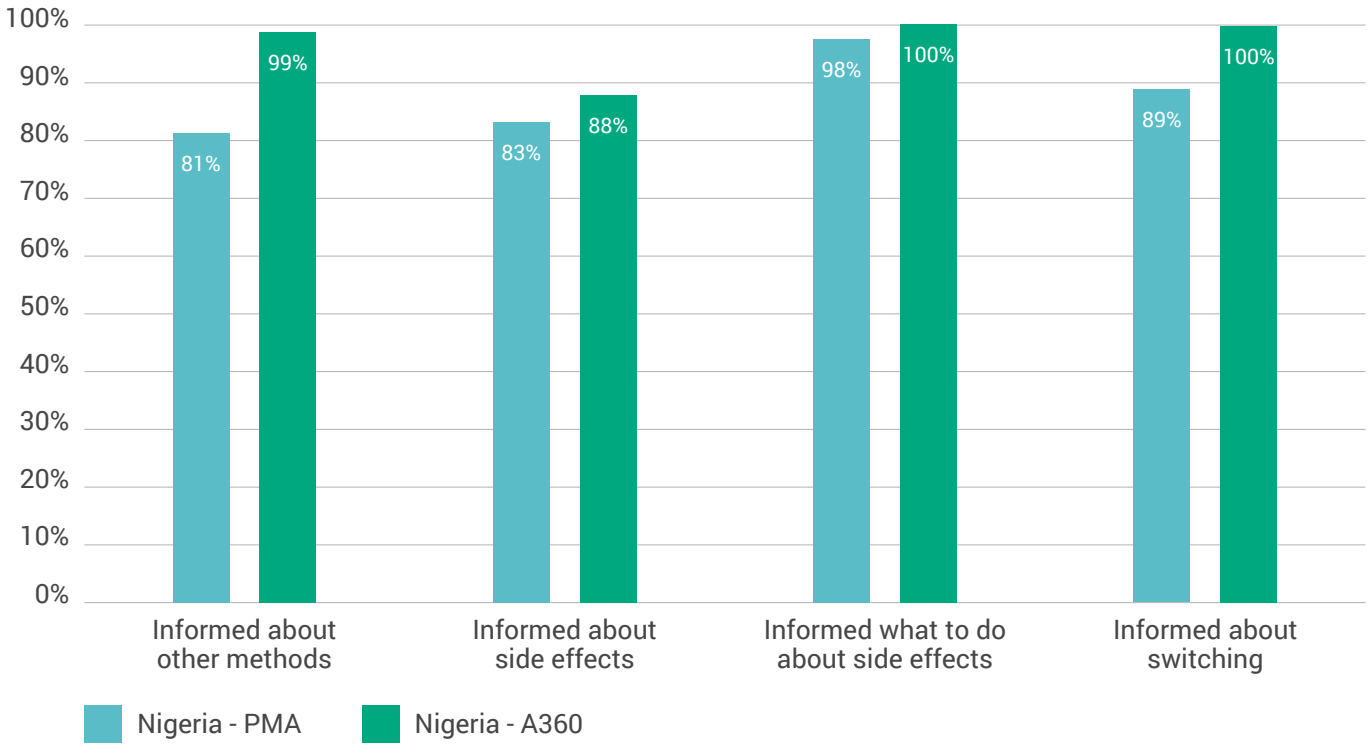



Figure 10c. Nigeria MII+: A360 vs. PMA 2024

# REFLECTIONS AND RECOMMENDATIONS

**These results show the consistency with which A360 has been able to achieve and sustain high levels of quality contraceptive counseling.** All contraceptive clients, not just adolescents, benefit from this work. High-quality counseling is a critical enabler of sustained contraceptive use and supports women to delay and space pregnancies in ways that align with their own reproductive goals.

**Although true for all women, negative experiences with side effects may be an even stronger driver of discontinuation among adolescents.** Younger clients may need to feel confident in and trust the contraceptive methods available to them and may be more concerned about the physical or emotional experience of side effects than older women. In addition, given girls' limited autonomy, side effects are more likely to generate conflict with key influencers -- increasing the risk of backlash and making consistent method use more difficult.

**Quality counseling is an important part of the puzzle to reduce unintended adolescent pregnancies.** While work must continue to shift social norms, strengthen supply chains, and expand access to contraception, these improvements must be accompanied by quality counseling if girls are to sustain method use for as long as they desire.

## TO ACHIEVE AND MAINTAIN QUALITY FOR ADOLESCENTS, THE FOLLOWING IS NEEDED:

**Design interventions with girls in mind, addressing their unique needs and preferences, and making the counseling process as girl-centered as possible.** This includes responding directly to girls' needs for reassurance about method safety and side effects, as well as providing information to support method switching. Counseling protocols such as C4C can reinforce this approach.

**Continue efforts to develop a cadre of adolescent-friendly providers.** This does not imply exclusively young providers; rather, it requires that the health system builds the capacity of all provider cadres to engage effectively with adolescents and deliver care with respect. Direct communication with providers about the importance of spending additional time counselling first- time, young users is an important step. Positive interactions with providers increase the likelihood that girls will return to services and seek information and reassurance when concerned about side effects.

**To achieve quality service delivery at scale, robust systems of supportive supervision are required.** One-off provider trainings are insufficient, given the time needed for behavior change and the frequency of staff turnover in public health systems. On-the-job support and real-time feedback reinforce positive behaviors and motivate providers to perform well. Targeting supervision to high caseload and low-performing facilities can help make investments in supportive supervision more cost-effective.

**The C4C approach, which reduces information overload for clients by presenting a limited set of methods more likely to meet their needs, has accelerated quality improvement.** It saves time for both providers and clients and is designed to address known drivers of discontinuation, including concerns about side effects and changes in menstrual bleeding patterns.

## THE FOLLOWING GAPS REMAIN

**More attention needs to be given to the youngest clients, who consistently experience lower-quality counseling.** This can be achieved through improved provider training, task-shifting to cadres with more time for counseling or leveraging digital tools.

**The ability of a health system to consistently deliver quality is determined by elements beyond the client-provider interaction.** Supply chain breakdowns and low or unsustainable levels of funding for contraceptive commodities limit the method mix available to all women, including adolescent girls. A lack of method options reflects a lack of choice for women and is a marker of lower overall quality.

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