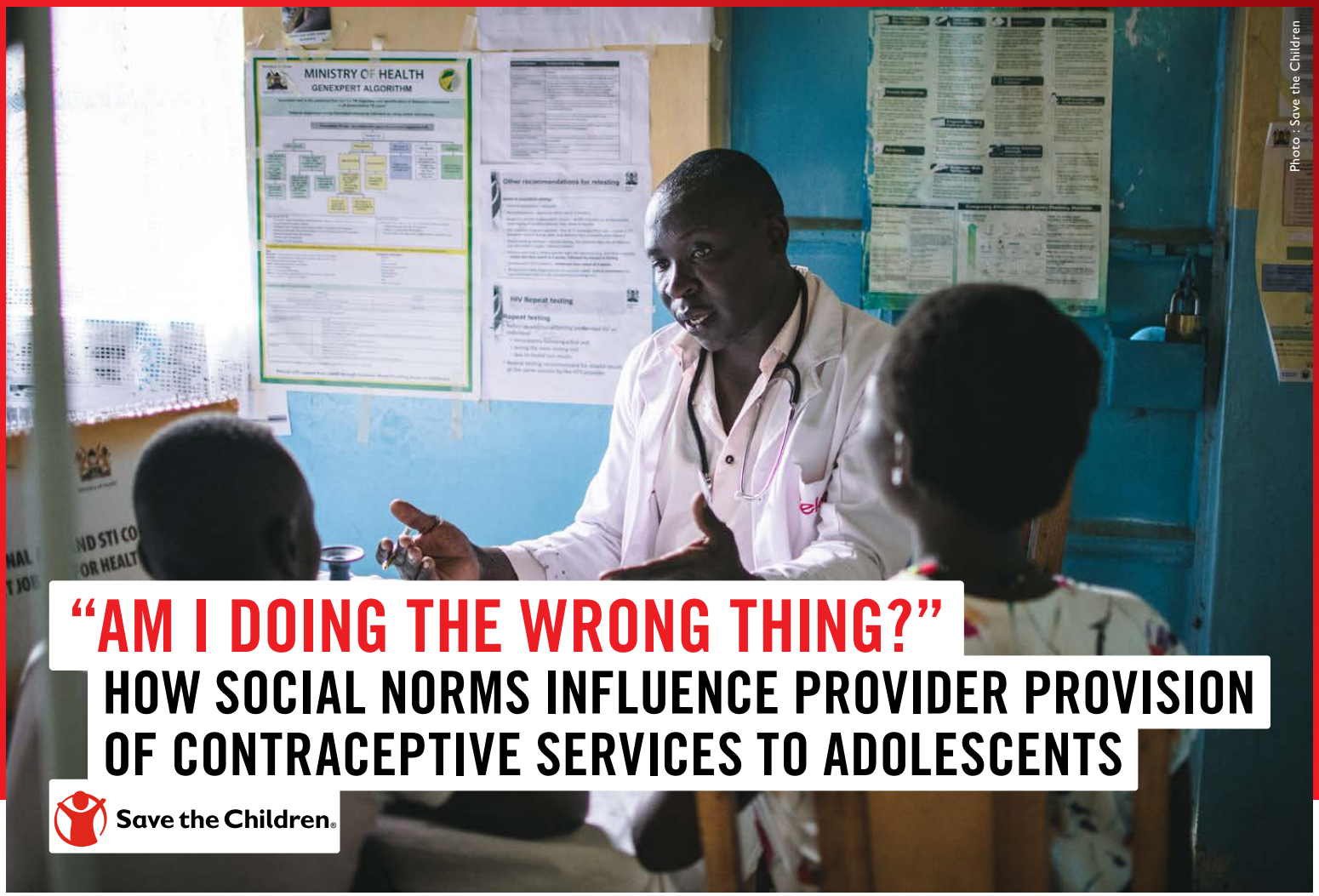

"AM I DOING THE WRONG THING?"

HOW SOCIAL NORMS INFLUENCE PROVIDER PROVISION OF CONTRACEPTIVE SERVICES TO ADOLESCENTS

Save the Children

INSIGHTS FOR PROVIDER BEHAVIOR CHANGE FROM QUALITATIVE RESEARCH IN NAIROBI

BACKGROUND

For adolescent girls, the ability to delay pregnancy can be key to achieving their life goals. Early pregnancy is a key factor for school desertion by girls, and women who have children in adolescence have fewer educational and well-paying job opportunities.[1] Childbirth can be risky for adolescents, and adolescents under age 16 are at higher risk of maternal death than mothers in their late teens and early twenties.[2] Babies born to adolescent mothers face higher risks of low birth weight, preterm delivery and severe neonatal conditions.[3]

Helping adolescents to delay pregnancy until they are ready includes making quality contraceptive services available. When adolescents have access to a wide variety of contraceptive methods, they are more likely to find an option that suits their needs. As part of a full range of contraceptive options, long-acting reversible contraceptive methods (LARCs) can be particularly well-suited for adolescent clients.[4]

A range of available contraceptive methods and health worker skill to deliver those methods is just one part of the equation. Adolescent girls face particular challenges in accessing contraception; those who seek information about how to protect themselves from pregnancy are often shamed, scolded, or sent away by health workers. These barriers have been well-explored from adolescents' perspectives; evidence shows that harsh, judgmental treatment is a key deterrent to adolescents' use of contraception.[5,6] A

growing body of literature has called for increased attention to and understanding of the drivers of unwelcoming attitudes and behaviors among health workers.[7]

There is growing recognition within the reproductive health field that behaviors are shaped by social norms, the implicit, informal rules that most people accept and follow (see Box 1). Community and household level efforts have seen promising results from approaches that seek to shift social norms. However, few programs have applied the evidence on social norms to address the factors that drive health workers' behaviors or to foster supportive workplace norms in health facilities to support provision of RH services to adolescents. Health workers are community members with their own network and social standing that drive their behaviors, and efforts to intervene with health workers without addressing their own normative reality would not be as effective as efforts that address the drivers of their behavior.

BOX 1: HOW DO SOCIAL NORMS SHAPE BEHAVIORS?

Norms are:

- Often in conflict with individual attitudes and beliefs
- Influenced by beliefs, values, and economic systems
- Enforced by perceived rewards and sanctions for adherence or disobedience
- Powerful within families, communities, and institutions such as schools and workplaces

A growing body of evidence shows that effective programming can shift norms.

Source: Advancing Learning and Innovation on Gender Norms (ALiGN). 2019. Frequently asked questions.

Photo : Fredrik Lernerud / Save the Children

STUDY PURPOSE AND METHODS

In 2018, Save the Children conducted qualitative research to better understand the influence of social norms on a health worker's decision to provide contraceptive services to adolescents. The objective was to explore the root causes of bias via the following questions:

- What are health workers' attitudes and beliefs related to contraception for adolescents?
- What individuals influence health workers' attitudes and beliefs?
- How are health workers' attitudes and beliefs shaped by those influential individuals?

Data were collected in Kibera, the largest informal settlement in Nairobi, Kenya. Both clinical and non-clinical staff participated. While clinical providers (nurses, physicians, pharmacists) are direct service providers, non-clinical staff (receptionists, housekeeping staff, and security personnel) are often the first facility representatives that an adolescent interacts with. Data collection involved interactive and participatory methods to spark discussions. Table 1 presents the data collection tools, and methods, adapted from the Passages Project-developed Social Norms Exploration Tool.

Table 1: Data collection tools and methods

TOOLS	DESCRIPTION	PURPOSE
Individual exercise with health workers only		
My Social Networks	Individual interviews using a paper-based template to identify influential people (social reference group) who provide guidance, information, advice, or support on relevant issues	Identify social reference groups
Group discussions with separate groups of health workers and social reference groups		
Vignettes	The facilitator reads a story about an adolescent girl visiting a health facility to ask about contraception, pausing at key points to ask what health workers would think, feel, and do.	Analyze root causes of behaviors
Pocket Chart Voting	Participants "vote" anonymously on types of behavior by placing a token in a box. The token indicates how many people they believe practice a certain behavior, and what they personally do.	Identify prevalence of behaviors
Problem Tree Analysis	Participants identify the reasons why people do or do not practice a target behavior	Identify root causes and results of behaviors
The Five Whys	In pairs, participants identify reasons for a behavior and prioritize the most important reasons (listing and ranking)	Identify root causes of behaviors

BOX 2: WHO INFLUENCES HEALTH WORKERS?

Within the health facility:

- Health facility owners
- Facility in-charges
- Community health volunteers/workers

Beyond the health facility:

- Religious/community leaders
- Local administrators
- Community elders
- Teachers
- Women's groups (chamas)
- Family members
- Police

First round of data collection: Data were first conducted with health facility staff in December 2018. A total of 20 health facilities in Kibera were purposively sampled. The sample included public, private and faith-based organizations (FBO) and non-governmental organizations (NGO) health facilities. Sampling also took into consideration the volume of clients served in the facilities per day, including both low- and high-volume facilities. In each facility, the facility in-charge identified staff who were most likely to have direct contact with adolescents seeking contraceptive services. At least one clinical staff and one non-clinical/support staff from each health facility were sampled.

A total of **39** health facility staff participated. Of these, 23 (59%) were clinical staff[1], (physicians, nurses, pharmacists) while the other 16 (41%) were non-clinical staff. As part of this exercise, health facility staff used a participatory influence mapping exercise to identify individuals, within and outside of the health system, who are influential in their decision-making.

1 In some small facilities, clinical staff also serve as front desk managers, resulting in lower numbers of non-clinical staff.

Photo: Save the Children

Second round of data collection: Following collection with health workers, the study team paused to analyze data from the influence mapping exercise to identify the "types" of individuals most influential for health facility staff (see findings in Box 2). Individuals representing these "types" were then purposively recruited for participation in focus group discussions, with **44** individuals representing reference groups sampled.

FINDINGS

This technical brief presents the main findings and programmatic insights that emerged from the study. Findings comprise two broad categories of factors: knowledge gaps, and social norms, focusing on an exploration of the latter.

KNOWLEDGE GAPS SHAPE PRACTICES

Many of the sampled health workers had incomplete or inaccurate information about contraceptive method options even when they offered contraception to adolescent clients. In particular, LARCs were described as unsuitable for adolescents due to inaccurate perceptions that they cause infertility and that they have side effects that adolescents cannot tolerate. As a result, many providers would only discuss short-acting methods, particularly condoms, with adolescent girls.

HEALTH WORKERS' PERSPECTIVES CONFLICT WITH DOMINANT SOCIAL NORMS

The health workers sampled often were supportive of providing contraception to adolescents in principle. These supportive attitudes stem from their professional training, and from their first-hand perspectives about the reality of early childbearing and the associated risks in the community in which they work. The health workers were pragmatic about sexual activity among adolescents.

Yet these supportive attitudes did not translate into supportive provider behaviors. Despite describing supportive attitudes, the same providers described limiting provision of contraception to adolescent girls. Their behaviors were influenced by their own knowledge and experiences *(what they themselves believe and want)* outweighed by views of those outside the health facility walls *(what they believe others believe)*. Although some did provide contraceptive services to adolescent girls, many health workers in the study described refusing to do so, or limiting the range of methods that were offered, fearing community backlash.

> *"At the end of the day, you have to think about it. She [an adolescent seeking contraception] is still young at 15. But again, they are giving birth as early as 10 or 12 years. So long as she is (sexually) active, you just have to give (contraception) to them."*
>
> **–Non-Clinical Staff**

> *"I think the other staff will support [the provider's] decision to discuss contraceptives. Because the girl is still in school uniform, so when she prevents pregnancy here, she will promote (the) education of this girl. But (the) community will still think negatively about it. It will be seen as if she is encouraging her to be sexually immoral."*
>
> **–Reference Group Member**

Several key social norms transcend the health facility walls, overriding professional training to limit provision of contraceptive services to adolescent clients.

- **Sex is for married adults.** Adolescents (particularly girls) should not be sexually active before marriage.
- **Contraception is for married women.** This perception is exacerbated by the use of the term "family planning", which suggests child spacing in the context of marriage, not for delaying first pregnancy.

Each of these norms is shaped by, and often intertwined with, fragmented knowledge as well as attitudinal factors further described below.

HEALTH WORKERS' ROLE IS TO PROTECT ADOLESCENT GIRLS

Both health workers and community members described health workers' main role as protecting adolescent girls. The health workers sampled, particularly older providers, were empathetic to adolescent girls; they described perceiving them as their daughters and wanting to protect them from harm. The effect of this normatively driven protective role is exacerbated by the pervasive norms about sex and contraception being only for married women.

> *"I think there is the feeling of, suppose it is my daughter (15-year old girl seeking contraceptive services) how would I feel… if this could be my daughter?... like am I doing the wrong thing?"*
>
> **–Clinical Staff**

> *"On top of that, there is this behavior when this counsellor is 'not young at heart' (older). So, if this girl walks in and now she (counsellor) starts saying, "my child", now you (the adolescent girl) forget about everything."*
>
> **–Reference Group Member**

The need to protect girls, while well-intended, may manifest as counselling adolescents to abstain from sexual activity, or offering them a contraceptive method they judge to best suit the needs of adolescent clients. This protective role can also deter adolescents from disclosing that they are sexually active or even asking about contraception.

This protective role coalesces with social and gender norms, knowledge gaps, and attitudes in five different ways, described below. Health workers' protective role entails protecting girls from multiple risks:

A) Protectors against bad decisions by immature adolescents

Adolescent girls were described by health workers and reference groups as too young and immature to make decisions about their own sexuality and health. Health workers' perceived role includes protecting adolescents from making "wrong" decisions in matters that should not concern them to begin with. By contrast, older and married women were seen as sufficiently mature to make decisions about sex and contraception.

Photo : Fredrik Lerneryd / Save the Children

"For a married person, because she knows what she wants, she is not confused. Maybe she has kids or not, but she knows exactly what she wants. So, the counselling and even the tone with the doctors or the nurses will also be different. Because they will be talking about real issues and not fiction. And why, why will it be like that? Her age and life permit her to [make decisions about contraceptive use])."

–Reference Group Member

"Maybe she [unmarried adolescent seeking contraception] doesn't know what she wants."

–Reference Group Member

Gender norms also influence participants' views about adolescents' decision-making related to sex and contraception; they explained that preventing pregnancy was the responsibility of girls, and boys could not be expected to think about contraception. While adolescent girls who sought contraception would be seen as immature, conflictingly, boys who seek contraceptive services would be seen as responsible.

"(his concern will not be to) prevent pregnancy. Because he is male. So, he wants to explore about sex, so he will leave that part to the girl."

–Reference Group Member

"I think in Kibera when we get this guy asking for information, the community will see this boy as a very responsible boy who doesn't want to impregnate girls. So, in short, this is a responsible boy. Yes."

–Reference Group Member

B) Protectors of adolescents' future fertility

Both health workers, including trained clinical staff, and community members associated contraceptives with infertility. By limiting access to contraception, health workers were thus seen as protecting girls' future fertility.

> *"The community will demonstrate and say that hospital is the one that encourages and misleads girls. That is where girls go for the contraceptives. And also, they have that negative mentality. They say these medicines make girls infertile. So, they will believe that those nurses are the ones who do not want their girls to have children later. So, it will bring some hatred between the clinic and the community."*
>
> **–Reference Group Member**

> *"Because some of the facilities they believe if they start young adolescents on family planning – then you cannot even give birth in your future."*
>
> **–Clinical Staff**

When providers did offer contraceptive methods to adolescent clients, this association with infertility, combined with the protective role, often had the effect of limiting method choice. Providers in the study described tailoring counselling based on client age, with decisions about which methods are appropriate for adolescent clients shaped by a desire to protect girls' future fertility. LARCs and hormonal methods (pills and injectables) were described as not appropriate for adolescents, in part due to concerns about protecting adolescents' future fertility. For some clinical staff, this meant that condoms were the only option offered to adolescents.

> *"Since we are healthcare providers and we are in the field of giving contraception, we will also be having something in mind that if I give this child a long-acting method, maybe it can cause infertility. So, we have to counsel, but also to some extent we can also choose for her."*
>
> **–Clinical Staff**

> *"[For a 15-year-old girl], not necessarily must I inject Depo, but as you are still young, you can use a female condom. Those are the kinds of discussion that [a provider] is supposed to offer [an adolescent client]."*
>
> **–Clinical Staff**

C) Protectors against the spread of immorality

Respondents, including clinical, non-clinical, and social reference group members, described sex outside of marriage as immoral. They expressed concerns that if health workers support unmarried adolescents in accessing contraception, those adolescents may also inform friends and peers. This would encourage others to become sexually active, which would "spread immorality". Health workers were seen as having an important role in protecting the adolescent herself as well as avoiding the spread of immorality to others.

> *"If you give a schoolgirl contraceptives she may start to have, should I talk of aimless sex practice or what? She would go hullabaloo about sex because you are giving her the right channel on how to prevent pregnancy."*
>
> **–Reference Group Member**

"The staff that work with [health provider], they'll pre-judge and even make comments like, "you're promoting immorality." Because having sex is immorality. (Laughter). For this young girl, that is."

–Reference Group Memberr

"I think amongst the consequences is we will end up having a rotten society. Because this girl will tell a friend and the friend will tell a friend."

–Reference Group Member

D) Protectors against the consequences of sexual activity

Reference group members noted that sex among adolescents has adverse consequences such as unplanned and unwanted pregnancy, unsafe abortions, complications during pregnancy and delivery, dropping out of school, and contracting STIs and HIV, among others. Shame and judgment from peers and community members could be another consequence of sexual activity. Both health workers and community members thus felt strongly that adolescents should be discouraged from having sex altogether to avert such shame.

"Regarding the community, they'll mock the young lady. Because they don't expect such a young lady to get involved in such activities like sex."

–Reference Group Member

"the health provider here is already judging the schoolgirl. At this age you are engaging sexually with a boy from your school, how? How did you even start?"

–Reference Group Member

Reference group members feared that if adolescent girls were protected from pregnancy through use of contraception, they would overindulge in sexual activity and forget about school/studies.

"The girl might end up sleeping around and forget about her studies."

–Reference Group Member

E) Protectors from the consequences of being caught with contraceptives

Last, participants also noted that adolescent girls could face punishment if they were found to have contraceptives. By denying access to contraceptives, health workers thus protect girls from facing these consequences.

"And also given the status of our schools, especially if the girl is in boarding school…when the girl is searched, and contraceptives are found in her room… she'll be expelled, and she'll be branded."

–Reference Group Member

Photo : Fredrik Lerneryd / Save the Children

RECOMMENDATIONS

These findings provide insights into the social drivers of health workers' behaviors and point to key program considerations for provider behavior change efforts. Our findings confirm that health workers' behaviors are strongly influenced by social norms.

The following recommendations are for programs and public health practitioners supporting ministries of health to strengthen health worker capacity to provide adolescent responsive RH services:

1. **Redefine the health worker's "protective" role.** The role of the provider as a protector of adolescent girls is inherently well-intentioned but has the effect of curtailing adolescents' reproductive choices. Social and behavior change (SBC) efforts could reframe providers' protective role as protecting the rights of adolescent girls to choose to use contraception in support of their own reproductive, relationship, and livelihoods goals.

2. **Leverage the experience of health workers who defy social norms.** Some health workers *do* defy social norms and provide contraceptive services to adolescents, empowered by their professional training. To support shifts in workplace norms, interventions should seek to leverage the perspectives of those "positive deviants" to influence those who are reluctant. Highlighting health workers who provide welcoming services as high-performing or "model" professionals could further reinforce the norm of respectful services for all clients.

3. **Strengthen accountability systems for health workers.** Identify and incentivize high-performing health facilities that provide welcoming, responsive services to all clients regardless of age. Scalable, non-financial incentives could include certificates and/or public recognition by the Ministry of Health and community. Including "welcoming, responsive services" as a criterion for accreditation of health facilities would contribute to holding facilities accountable. At the same time, to redefine quality services to encompass respectful care for all clients, build respectful services into existing accountability mechanisms, such as supervision checklists and processes.

4. **Identify and leverage existing platforms** to engage health workers in reflection and discussion of social norms on an ongoing basis. In line with global standards, explore opportunities for shifting norms over time; a single training will not produce sustained shifts in complex, deeply held and socially-driven beliefs.[8] Rather, health workers need ongoing time and space to discuss and reflect collectively and as individuals, and to negotiate the conflict between what they personally believe and what they feel that they must do. A sustainable, scalable approach would need to be embedded into existing "touch points" with health workers, including pre-service and in-service clinical training, supervision, mentoring approaches, and/or regular facility staff meetings.

5. **Target influencers of health workers outside the facility walls.** In community-level activities, target the identified influencers of health workers (social reference groups) so that health workers face less community resistance and feel empowered to deviate from the norm, guided by their own beliefs and professional training. Identifying influencers as part of formative work could inform pinpoint targeting of those most influential to maximize resources and impact.

6. **Emphasize the return to fertility after discontinuation of contraceptive methods.** In health worker trainings and in communicating about contraceptive methods in community-level activities, focus on providing accurate information about the return to fertility following discontinuation. Recognizing that the association between contraception and infertility may be a deeply seated belief, programs may need to approach this as an attitude or a value to be shifted rather than knowledge to be correct with facts. Programs could consider leveraging the power of testimony of satisfied contraception users that became pregnant following discontinuation of the method.

7. **Reframe the image of adolescent girls who use contraception.** Both health workers and community members feared that contraception would encourage adolescents to become sexually active and derail their achievement of educational goals, and that adolescent girls are not sufficiently mature to make decisions about contraception. SBC efforts could reposition contraception as helping adolescents to achieve their life goals by delaying pregnancy until the right moment, thus presenting adolescents who use contraception as responsible. A shift away from the term "family planning" can help reframe contraception as a tool for "life planning" that can help adolescent girls achieve their education and livelihood goals—while leaving open the possibility of having a child at the best time for her. Reflection on gendered norms—such as seeing boys who ask about contraception as responsible—will also be an important aspect of shifting perceptions of girls who seek contraception.

CONCLUSION

Health workers, both clinical and non-clinical staff, may themselves support providing contraception to adolescent girls in principle; their professional training and experience ground their perspectives about adolescent sexuality in reality. Yet, adolescent girls are often counselled to abstain from sex, offered a limited range of contraceptive options, and/or refused services altogether by those same individuals. Health workers' protective role intertwines with norms around sexual activity among unmarried adolescents and inaccurate information about contraceptive methods and the return to fertility to limit adolescents' access to the full range of contraceptive options. Because health workers' behaviors are socially driven, a single youth-friendliness training for health workers is not likely to produce sustained shifts in attitudes and norms. To increase adolescents' access to welcoming, non-judgmental contraceptive services and a variety of contraceptive options, programs should identify and address the social factors that transcend health facility walls.

REFERENCES

1 World Bank. Economic impacts of child marriage: Global synthesis report. Washington, DC: World Bank; 2017.

2 Woog, G., Kagesten, A. (2017). The Sexual and Reproductive Health Needs of Very Young Adolescents Aged 10-14 in Developing Countries: What Does the Evidence Show? New York: Guttmacher Institute, 2017, https://www.guttmacher.org/report/srh-needs-very-young-adolescents-in-developing-countries

3 WHO. Global health estimates 2015: deaths by cause, age, sex, by country and by region, 2000–2015. Geneva: WHO; 2016.

4 Global Consensus Statement for Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception. Accessed at: https://www.familyplanning2020.org/sites/default/files/Global%20Consensus%20Statement%20-%20Expanding%20Contraceptive%20Choice.pdf

5 Alli, F., Maharaj, P., & Vawda, M. Y. (2013). Interpersonal Relations Between Health Care Workers and Young Clients: Barriers to Accessing Sexual and Reproductive Health Care. Journal of Community Health, 38(1), 150–155. https://doi.org/10.1007/s10900-012-9595-3

6 Bankole, A., & Malarcher, S. (2010). Removing Barriers to Adolescents' Access to Contraceptive Information and Services. Studies in Family Planning, 41(2), 117–124. https://doi.org/10.1111/j.1728-4465.2010.00232.x

7 Solo J, Festin M. Provider Bias in Family Planning Services: A Review of Its Meaning and Manifestations. Glob Health Sci Pract. 2019; 7(3) 371-386 https://doi.org/10.9745/GHSP-D-19-00130.

8 World Health Organization. Global standards for quality health care services for adolescents. Geneva: WHO; 2015. Available from: http://www.who.int/maternal_child_adolescent/documents/global-standards-adolescent-care/en/

Save the Children believes every child deserves a future. In the United States and around the world, we give children a healthy start in life, the opportunity to learn and protection from harm. We do whatever it takes for children – every day and in times of crisis – transforming their lives and the future we share.

501 Kings Highway East
Suite 400
Fairfield, CT 06825

899 North Capitol Street, NE
Suite 900
Washington, DC 20002

1-800 Save the Children
SavetheChildren.org