

# Connecting Contraception to Girls' Lives and Aspirations in Southern Nigeria:

## The Case of 9ja Girls

December 2020



## Introduction

In the past three decades, global health programs aiming to improve adolescent sexual and reproductive health (ASRH) have yielded a number of notable successes. As the field of ASRH evolves, however, questions remain about how to best design and implement girl-centered programming—demonstrably responding to the needs and experiences of youth, allowing them to equally partner in programs aimed at their health and wellbeing, and ultimately enabling their meaningful advancement in health, livelihood, and development. At the same time, the ASRH field continues to advance its understanding of how to shape and refine these girl-centered programs to be implemented sustainably at scale.

In 2016, with funding from the Bill and Melinda Gates Foundation and the Children's Investment Fund Foundation, Population Services International (PSI) launched Adolescents 360 (A360), a 4.5-year program that works directly with young people to develop and deliver interventions that aim to increase demand for, and voluntary uptake of, modern contraception among girls aged 15-19 in Ethiopia, Nigeria, and Tanzania. This technical brief presents the case of 9ja Girls, A360's intervention in southern Nigeria, offering lessons for similar ASRH programs seeking to design and implement scalable, sustainable, community-based programming with and for adolescents.

## Background

### Adolescence Globally

Adolescence, the stage of life between ages 10-19, is defined by paradoxes. During this period, adolescents develop vital behaviors, skills, and mindsets that will endure throughout their lives—at a time when they are also at heightened vulnerability to adverse outcomes. During this period, the dynamic, developing brain is primed for learning, presenting programs with a unique opportunity to support development of lifelong positive beliefs, knowledge, skills, and behaviors.<sup>12</sup> Yet, adolescents face a range of social, systemic, economic, and political barriers that prevent them from accessing critical information, services, and support—inclusive and beyond sexual and reproductive health (SRH)—when they need it the most.<sup>3</sup>

For 21 million girls aged 15-19 in developing regions, pregnancy is a major risk to a healthy, stable future.<sup>4</sup> Pregnancy can be fatal for girls—pregnancy and childbirth complications are the leading cause of death among girls 15-19 globally.<sup>4</sup> Children born to adolescent mothers are at higher risk for low birth weight, neonatal complications, and other long-term adverse effects than children born to women aged 20-24.<sup>5</sup> Even when girls give birth safely, adolescent mothers and their children can experience significant negative social and economic consequences. Girls who become pregnant before age 18 are more likely to experience intimate partner violence, and unmarried adolescents

may face social costs including rejection by their families.<sup>6,7</sup> Adolescent pregnancy and childbearing often lead girls to drop out of school, jeopardizing future education and employment opportunities, and limiting their access to the social supports they need for healthy development and a safe and successful transition to adulthood.<sup>7,5</sup>

To reach that stable future, global evidence demonstrates the importance of strategies that are multisectoral, as adolescents' health needs do not exist in a vacuum.<sup>8,9</sup> Healthy behaviors can be linked to attitudes and skills that reach beyond traditional health sector offerings alone. For example, adolescents who have educational, economic, and interpersonal aspirations are more likely to use modern contraception and avoid the consequences of early and unintended pregnancy.<sup>10,11</sup> Acknowledging this, global ASRH programming now increasingly pursues more holistic approaches. The growing global evidence-base for positive youth development (PYD) approaches demonstrates the protective factors offered by skills acquisition, positive beliefs, motivation, and confidence. Developing these assets can normalize healthy behaviors and help young people to apply knowledge learned, leading to increased use of contraception.<sup>12</sup> Such programs, for instance, can foster young people's confidence in their support networks, as well as their sense of belonging—modeling and normalizing pro-social relationships that reinforce beneficial behavior and choices. Meaningful, structured activities with peers and adults, targeted efforts to encourage girls' optimism in the future, and opportunities for girls to build new skills and exercise self-efficacy, are all relevant to positive health outcomes. Yet, a myriad of hurdles impedes adolescents' future orientation, self-efficacy, and competence, from high levels of unemployment, to resource scarcity, and inadequate support networks.<sup>13</sup>

### Adolescence in Nigeria

Nigeria is home to 50 million adolescents whose transitions to adulthood are complicated by economic pressures exacerbated by rapid population growth.<sup>14</sup> With an estimated 205 million people, Nigeria is not only one of the world's most populous countries but also one of the most youthful—more than half the population is under age 24 and more than one in four are adolescents aged 10-19.<sup>15</sup> Although Nigeria has demonstrated impressive economic growth in the last 20 years, wealth inequality remains extreme.<sup>16</sup> Poverty rates are high and climbing. The total number of Nigerians living below the poverty line increased by over 70 million between 1992 and 2010.<sup>15</sup> Labor force participation rates among young people aged 15-24 have stagnated in the past 10 years, leading many to seek employment in informal sectors. 55% of young women in this age category are considered “working poor.”<sup>17</sup> Poverty and limited economic opportunity will likely continue to grow without expanded access to and use of modern contraception, particularly among harder to reach populations. In 2013, only 16% of all women of reproductive age (15-49) were using any contraceptive method and only 11% were using a modern method.<sup>18</sup>

Even with some fertility reductions, Nigeria is expected to grow from the seventh to the third most populous country in the world by 2050.<sup>19</sup>

Adolescent girls aged 15-19 remain a key population in need of access to modern contraceptive services—Nigeria must address contraceptive needs among adolescents if the country is to achieve better health and development outcomes at a national level.\* Though modern contraceptive prevalence (mCPR) among all women of reproductive age has tripled over the past three decades, adolescents have largely been left behind. Modern contraceptive prevalence rate among girls aged 15-19 has remained largely the same over the past thirty years, moving from 1.9% in 1990 to just 2.4% in 2018.<sup>17</sup> At 145 births for every 1,000 girls, Nigeria's adolescent birth rate is nearly 30% higher than that of its neighbors in West and Central Africa.<sup>†</sup> Adolescent girls in Nigeria are more than twice as likely to be sexually active than their male peers, with a median age at first sex at 17.<sup>20</sup> To meet the needs of this population, ASRH service provision must be relevant and responsive to Nigerian adolescents' diversity of experiences. Nigeria is comprised of 36 autonomous states, and fertility varies by North-South and urban-rural divides, as well as by economic status. Given this significant diversity, to effectively reach adolescents with responsive modern contraceptive services, programs must take a sub-national approach.

This publication focuses on A360's work in southern Nigeria, where girls live and make choices about their SRH against a backdrop of cultural and social factors that often limit their ability to shape the lives they desire. Social

norms place pressure on girls to demonstrate their alignment with virginity until marriage. But there are indications that girls' lived experiences often do not mirror these norms: while the average age of marriage has risen in the last 30 years (from 17.8 to 19), the age at sexual debut (17) has stayed the same.<sup>21</sup>

These data imply a lengthening period of sexual activity prior to marriage for girls and young women, introducing heightened need for protection from unintended pregnancy—amidst a normative environment that restricts, rather than supports, girls' ability to seek and access accurate, effective information and services.<sup>22</sup> Nearly two thirds of sexually active girls aged 15-19 in southern Nigeria report that a pregnancy now would be mistimed, even as the rate of childbearing among all girls aged 15-19 hovers around 10% (12.3% in South-South zone and 8.2% in South-West zone).<sup>17</sup> Among sexually active adolescents, fewer than one in two currently uses a contraceptive method.<sup>23</sup> Unsafe abortions and their ramifications are common—primarily due to a hostile legal environment—suggesting that adolescent pregnancy is often unplanned.<sup>24</sup> Taken together, these data show that young women in southern Nigeria often lack safe, appealing options to act on their fertility desires. See Table 1 for detail.

\* The 2nd National Strategic Health Development Plan (2018-2022) references poor reproductive health outcomes among adolescents and commits to increasing by 50% the utilization of adolescent reproductive health services by 2022. For more information see: [nipc.gov.ng/product/national-strategic-health-development-plan](http://nipc.gov.ng/product/national-strategic-health-development-plan)

† The average adolescent birth rate in West and Central Africa is 114 out of 1000 girls.



**Table 1. Sexual and Reproductive Health Landscape in Southern Nigeria**

Adolescent mCPR (15-24) in southern Nigeria is low, where the need for contraception is high. Analysis of A360 implementation zones shows early sexual initiation and rates of childbearing around 10% among young women aged 15-19. Mothers in this cohort report high rates of unplanned birth. In addition, abortion rates are high suggesting that additional unintended pregnancies may be managed through abortions which are likely to be unsafe given the restrictive legal environment in Nigeria.

Youth trends in southern Nigeria (averages for South South and South West zones) <sup>§</sup>		
Modern contraceptive prevalence rate (mCPR), youth aged 15-24 <sup>‡</sup>	11.8%	
% in need of contraception, married and sexually active youth aged 15-24 <sup>‡</sup>	64%	
% unmet need for modern contraception, married and sexually active youth aged 15-24 <sup>‡</sup>	50%	
% of contraceptive demand satisfied by male condom use, married and sexually active urban youth aged 15-24 <sup>‡</sup>	70%	
Trends by selected southern zones	South-South	South-West
% of young women age 15-24 who had sexual intercourse before age 18 <sup>**</sup>	45.7%	33.7%
% of young women age 15-19 who have begun childbearing <sup>**</sup>	12.3%	8.2%
% of young women age 15-19 who report their first child was unintended <sup>**</sup>	74.8%	50.7%
% of pregnancies ending in abortion (all women) <sup>**</sup>	17%	11%
Total fertility rate (all women) <sup>**</sup>	4.1	4.5

<sup>‡</sup> Analysis of 2013 Nigeria Demographic and Health Survey data using Population Services International Contraception Use Need Explorer Tool [Excel Tool]

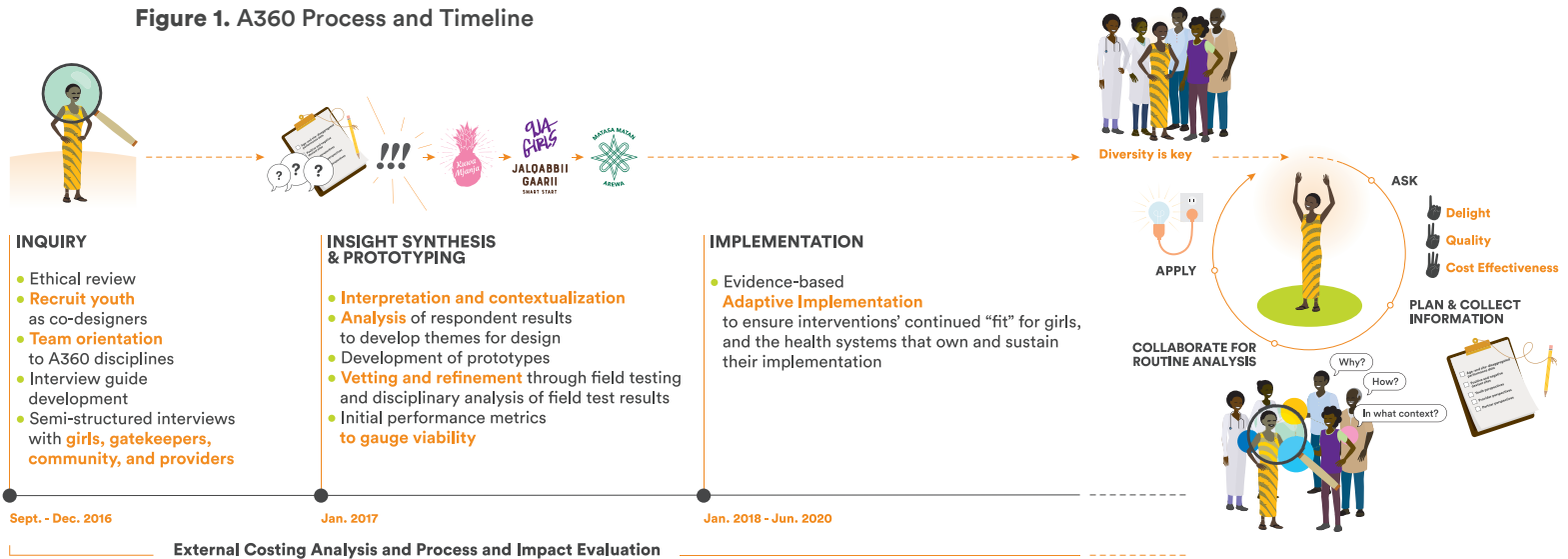
<sup>§</sup> Zones included in the table represent the two implementation zones in southern Nigeria for 9ja Girls

<sup>\*\*</sup> 2013 Nigeria Demographic and Health Survey

<sup>\*\*</sup> Girl Effect. State of the Girl Report. August 2016.

<sup>##</sup> "Abortion in Nigeria." Guttmacher Institute

**Figure 1. A360 Process and Timeline**



## Technical Strategy

Given the puzzle of high unintended pregnancy rates and low rates of contraceptive use among adolescent girls in southern Nigeria, the A360 team undertook a design process to better understand girls' unique needs and desires and to identify ways to improve responsiveness to these needs. Led locally by the Society for Family Health (SFH) Nigeria, A360 brought together a consortium of experts in public health, adolescent developmental science, anthropology, and human-centered design (HCD) to work in partnership with young people to design solutions to low contraceptive service reach and uptake in southern Nigeria. The project was structured in a three-part design phase, followed by adaptive implementation. During design, A360 partners focused on inquiry, followed by insight synthesis, and finally prototyping to field test and refine intervention components. This structure allowed the project's varied disciplines to interrogate and test ideas, maintaining curiosity and commitment to respond in real-time to the insights that emerged about girls' experiences and desires.<sup>§§</sup> See Figure 1 for detail.

## Methods

A360's design process worked to uphold two key principles: meaningful youth engagement and design rigor. The project recruited young people to work as co-researchers and program designers alongside disciplinary experts, ensuring that youth perspectives were an integral part of research, synthesis, and program design. Eight young people were recruited as "youth researchers"<sup>\*\*\*</sup> to work with the team throughout the inquiry phase. They were given training in systematic data collection methods, including in-depth interviews and direct observation. In the full design team, the "adult" consortium members and youth researchers participated in power sharing exercises to build skills in youth-adult partnership, encouraging all participants to effectively foster and respect young people's contributions.

The A360 team gathered insights from girls using methods that were intentionally designed to generate empathy with respondents. In addition to in-depth interviews, the team employed a variety of supplemental design research methods including photo narratives, identification of trusted sources, storytelling, and direct field observation.<sup>†††</sup> The intent of inquiry approaches was to better understand respondents' lived experiences—inclusive and beyond SRH—probing to explore the motivations and feelings behind girls' behaviors and decisions.

Working together the multi-disciplinary youth-adult design research teams conducted 94 semi-structured interviews across two representative local government areas in Lagos State, southern Nigeria. Respondents included adolescent girls, their key influencers (mothers, fathers, adolescent boys, and male partners), community stakeholders (imams or other religious leaders and local government leaders), and service providers. As part of its commitment to ethical engagement with young people, the project obtained Institutional Review Board approval for all design research activities.

Data analysis was conducted through collaborative theming workshops in which youth-adult teams worked to build consensus on the meaning and significance of findings. A360 facilitators encouraged balanced contributions, aiming to ensure the resulting synthesized insights reflected both the disciplinary expertise of the project's consortium as well as youth researchers' perspectives.

## Findings: Insight Synthesis

Design research findings were distilled into the following insights.

### Anxiety and uncertainty about how to secure a stable future

In southern Nigeria, girls and community members expressed doubt about whether young people could achieve their self-defined, desired futures. Reflecting on the effects of rapidly changing social and economic landscapes, respondents discussed increased pressure on girls to financially support themselves. Despite high levels of secondary school enrollment, girls understood there were few clear paths to higher education or employment. Girls recognized that their parents' ability to financially support them decreased as they matured, bringing girls to place increased importance on their ability to provide for themselves, including their own sources of income. Community members, including girls themselves, noted that this economic pressure can result in heightened proclivity toward transactional sex, or increased risk for coercive and forced sex.

"My parents give me N100 (\$0.26) for breakfast, lunch, and dinner – it's not enough. Not even enough for breakfast. So how do I eat? I need to take care of myself."

*Unmarried girl, Surulere*

"The world has changed; civilization is here. The children of these days are exposed very early."

*Father, Surulere*

§§ For further details see Pursuing Youth-Powered, Transdisciplinary Programming Across Three Countries: The Case of Kuwa Mjanja and Supporting Scalable, Youth-Powered Programming at the Community Level in Ethiopia: The Case of Smart Start.

\*\*\* SFH hired youth researchers between the ages of 18-24 who were residents of the intervention area, conversant in English and the local language, demonstrated strong verbal and written communication skills, and were holders of a senior secondary level certificate at minimum. Following the inquiry phase, SFH adjusted the title of "youth researcher" to "young designer" to reflect their ongoing role in the co-design of the program's technical strategy and implementation model.

††† For further details see Series: Research Guides on the Adolescents 360 Learning Hub

### Despite these uncertainties, aspirations remain high

Even as girls acknowledged these challenges, in southern Nigeria adolescent girl respondents demonstrated a clear and optimistic vision for their future. Respondents discussed making plans for how they would weather their changing social and environmental situations, proactively considering their prospects and pathways toward a stable future. Girls discussed goals of marriage and childbearing alongside ambitions that extended beyond family and domestic life. Girls spoke powerfully of the importance of earning their own income and attaining self-reliance, often through the aspiration of becoming small business owners.

“I’ll be the light of my generation.”

*Unmarried Girl, Epe*

“If you work you can have freedom, then you don’t have to rely on your husband.”

*Unmarried girl, Surulere*

### Misalignment between sexual behavior, contraceptive use, and identity

Adolescent girl respondents did not perceive the relevance or value of contraception to their lives. This centered on a tension between adolescent girls’ desire to self-identify with socially held values of virginity and achievement, versus the reality of sex in their lives—something they struggled to navigate. Girl respondents raised questions about what was and was not permissible when it came to sexual behaviors and contraceptive use and sought guidance on the tensions they felt between parents’ and communities’ expectations of them, versus their individual needs and desires. At the same time, girl respondents frequently indicated their strong intent to delay sexual debut and/or marriage to focus on career and educational aspirations. Sex and boyfriends were frequently labeled as “distractions.” All respondents viewed unmarried girls seeking contraception as promiscuous, even as respondents sought to understand SRH information. The perception of contraception as linked with sexual activity, and therefore unacceptable outside of the context of marriage, was pervasive.

“Is it compulsory to be a virgin?”

*Unmarried girl*

“If the urge for sex comes on, how can I control it?”

*Unmarried girl*

“It’s not that I don’t want to get married, but I shouldn’t think about it now... education first.”

*Unmarried girl, Surulere*

“Family planning is for women who are done giving birth and prostitutes who don’t want children.”

*Unmarried girl, Surulere*

### Contraception as a threat to dreams

Girls perceived contraceptive use as a potential threat to social standing and future aspirations. In part, this threat stemmed from girls’ misconceptions about modern contraceptive methods, which they believed would risk their future fertility. Girls’ strong and immediate aspirations for education and financial security were often rooted in a long-term vision of success in which they could sustain themselves and their families. Although few girls wanted to become mothers soon, the possibility that contraception could lead to infertility meant that, for many girls, contraception was an undesirable option.

Additionally, researchers noted immense social stigma surrounding girls’ contraceptive use. For adolescent girl respondents, the risk of association with contraception—and, thereby, with promiscuity—was such a significant threat to their social stability and security, that an unintended pregnancy was at times deemed preferable to seeking contraceptive services.

“They say contraception is good, but for me, it’s not good. It will destroy your womb.”

*Unmarried girl, Epe*

“Don’t tell the good ones about contraception, but it’s ok to tell girls who are already promiscuous.”

*Mother, Surulere*

“If the pregnancy happens, it happens.”

*Unmarried girl, Surulere*

### Isolation and mistrust, and a complex connection to mothers

Adolescent respondents in southern Nigeria could name few people in their lives that they trusted. Even when girls expressed trust in others, it was conditional. Girls believed their friends would lead them astray and expose them to negative influences. Girls trusted their moms more than friends but indicated that there were clear limits to what mothers would tolerate, especially around sensitive sexual health matters.

“There is no one you can trust 100%”

*Unmarried girl, Epe*

“My mom would understand, but she would scold me.”

*Unmarried girl, Surulere*

“...I don’t feel free with anybody, especially my mom...”

*Unmarried girl*



**Table 2. How insight synthesis shaped the 9ja Girls technical strategy**

**Insight Synthesis**

**Technical strategy**



**Anxiety over how to secure a stable future**

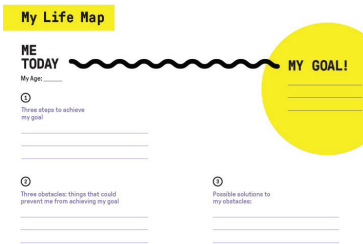
In southern Nigeria, girls and their influencers felt uncertain about how to secure financial stability. As girls get older, economic pressures increase the likelihood of coercive and transactional sex, as they increasingly work to provide for their needs.

Despite uncertainty, many girls remained optimistic about the future, which they hoped would include earning their own income and achieving self-reliance, often through entrepreneurial means.

Girls' desire for income generation skills aligns with Positive Youth Development approaches that focus on developing protective factors for adolescents. Interventions that foster positive beliefs about the future, positive self-concept, skills acquisition, and supportive influencers in adolescents' lives have all been shown to support healthy decision-making, including around contraceptive use.<sup>11,12</sup>

9ja Girls supports girls to set plans and build skills to advance toward their goals for the future. Through goal-setting, income-generating skills trainings, and targeted and engaging dialogue sessions focused on "Love, Life, and Health (LLH)," providers and local women small business owners come together to respond to girls' and communities' desire to support adolescent girls to transition to a stable adulthood.

9ja Girls' support of girls' skills acquisition, future-orientation, and positive beliefs aligns with the evidence on healthy decision-making, while also positioning contraception as a service similarly in support of girls' ability to advance toward the future they desire.



**Misalignment between sexual behavior, contraceptive use, and identity**

The tension between socially held expectations of abstinence before marriage and girls' own sexual exploration created inconsistencies between girls' self-identities and their actual behaviors. Most girls expressed a desire to abstain from relationships, sex, and contraception despite the pervasive nature of sex among adolescents in southern Nigeria and the corresponding risk of pregnancy.

Adolescents are primed for social learning, which can reinforce positive behaviors including SRH information and service seeking, but few pro-social opportunities exist to shift to norms that support adolescents to adopt these healthy beliefs and standards for behavior.<sup>11,25</sup>

9ja Girls providers acknowledge the reality of sex in girls' lives, including the challenging landscapes many girls face. Mobilizers and providers offer girls a credible and judgement-free outlet through which SRH information and service seeking is normal and healthy. By linking discussions with girls' goals for their lives, providers help girls see the risk unintended pregnancy poses to their aspirations for the future, and the importance of taking control of this aspect of their lives, just as they do for their income generation. Using the Life Map, girls make a plan for the future that includes contraceptive uptake as a behavior that protects their future. By engaging as part of a class of girls, participants see their actions as sanctioned by a wider group.



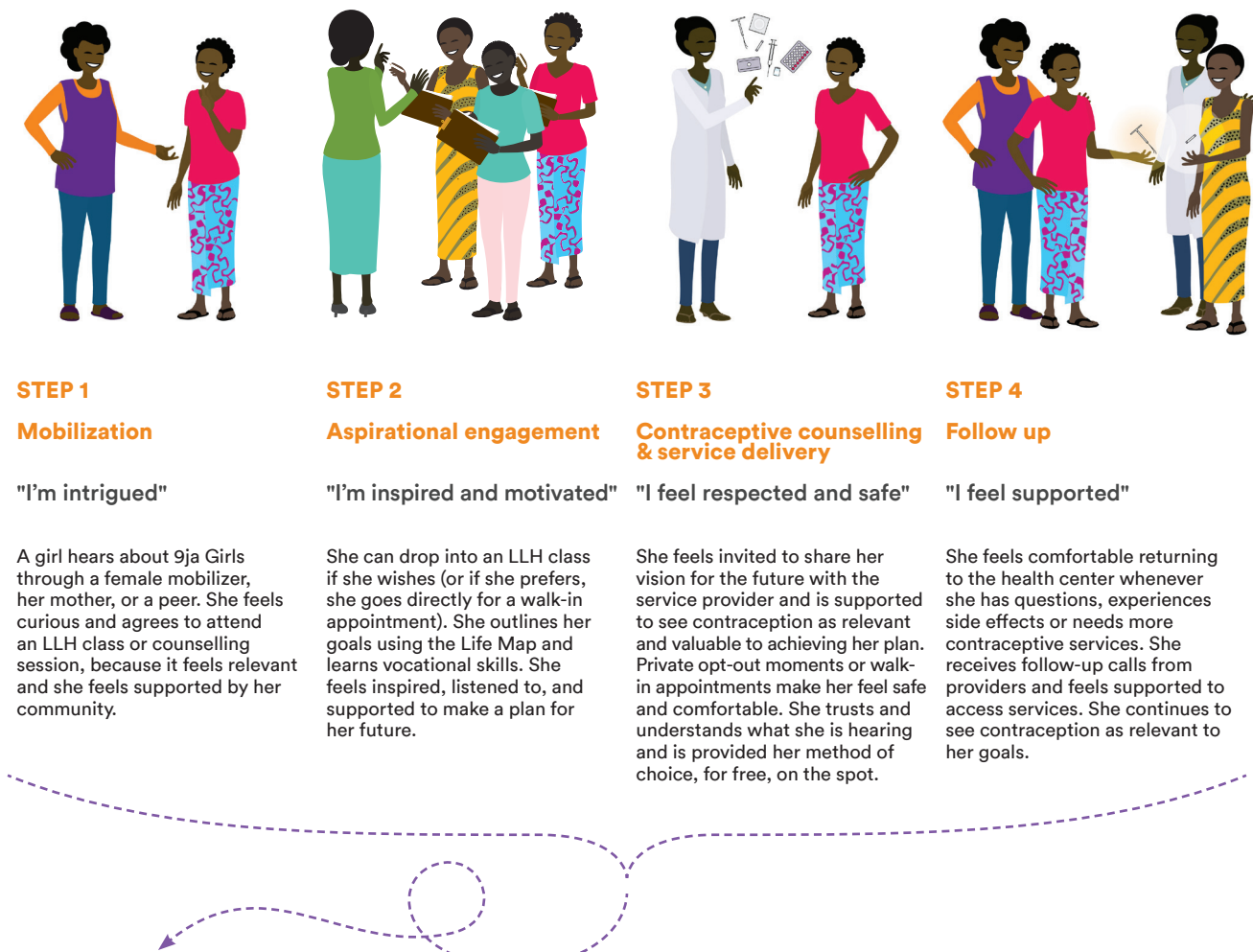
**Table 2. How insight synthesis shaped the 9ja Girls technical strategy (cont.)**

Insight Synthesis	Technical strategy
 <p><b>The Methods</b> Consistent use of these methods prevents unplanned pregnancy</p>	<p><b>Contraception as a threat to dreams</b></p> <p>Contraception was viewed as dangerous by many adolescent girls—either because it was incorrectly understood as a risk to fertility or because it was deemed a signifier of sexual activity in girls’ social circles and, as such, threatened girls’ social standing and stability.</p> <p>This threat, felt keenly by girls, is deeply entrenched in community norms and perpetuated by girls’ influencers, particularly mothers.</p> <p>Evidence suggests that effective interventions must work with parents and community leaders controlling norms that dictate girls’ decision-making.<sup>10</sup> This is particularly true for unmarried girls, who may face additional barriers to act on fertility intentions, as compared to married girls.<sup>26</sup></p> <p>9ja Girls disassociates participation in the program with sexual activity by framing the conversation around contraception in the larger context of achieving goals. This provides a contextually appropriate way for girls—and their influencers—to engage with contraceptive programming.</p> <p>9ja Girls providers share comprehensive, accurate information with girls so that they can learn that modern methods are safe, reversible, and pose no threat to fertility. Girls are invited to see and touch methods and ask questions in an interactive format.</p> <p>Since provision of accurate information to girls does little to shift the enabling environment in which contraception is viewed and communicated as a threat, 9ja Girls works directly with community leaders, as well as mothers, to introduce the program and secure community support for participation before girls are invited to attend.</p>
	<p><b>Isolation and mistrust, and a complex relationship with mothers</b></p> <p>Girls’ experience of isolation is pervasive. This is compounded by the prevalent threat of violence in girls’ lives, whether in intimate relationships or otherwise. Girls feel alone in their experiences, particularly when seeking or disclosing sensitive information to secure the social or clinical support they need.</p> <p>Adolescents have a heightened need to be accorded status and respect but have few support channels that demonstrate this respect.<sup>25</sup> Though girls need people to trust, they see their options as scarce. While their relationships with their mothers remain important, girls’ experience of their mothers’ judgement and reprimands makes this relationship fraught. For girls, provider behaviors often mimic that of their mothers and, additionally, lack respect and confidentiality, rendering most health service delivery channels untrustworthy.</p> <p>9ja Girls creates a safe space for adolescent girls that combats this sense of isolation. As much a social experience as a clinical one, 9ja Girls messages support girls’ positive self-concept and acknowledge the violence girls may face while reinforcing girls’ right to bodily autonomy and integrity, for example through the 9ja Girls Mantra.<sup>33</sup> 9ja Girls providers and mobilizers appeal to girls’ need for a trusted confidant, highlighting that girls can access confidential, accurate SRH information from a friendly, non-judgmental provider. The program works directly with a cadre of young providers and mobilizers and trains them on the importance of serving adolescents with respect and maintaining confidentiality. 9ja Girls affirms girls’ aspirations and offers critical reproductive health information via a network of community mobilizers and providers. By embedding these actors in the public health system, the program helps girls build trust with providers and the system.</p>

### In the case of suspected or disclosed GBV 9ja Girls providers are trained to identify and refer girls for specialized counselling and support

**Figure 2. 9ja Girl Client Journey**

9ja Girls is designed to offer girls in southern Nigeria a transformed client experience at public health facilities that supports their journey to contraceptive use.



**STEP 1**

**Mobilization**

"I'm intrigued"

A girl hears about 9ja Girls through a female mobilizer, her mother, or a peer. She feels curious and agrees to attend an LLH class or counselling session, because it feels relevant and she feels supported by her community.

**STEP 2**

**Aspirational engagement**

"I'm inspired and motivated"

She can drop into an LLH class if she wishes (or if she prefers, she goes directly for a walk-in appointment). She outlines her goals using the Life Map and learns vocational skills. She feels inspired, listened to, and supported to make a plan for her future.

**STEP 3**

**Contraceptive counselling & service delivery**

"I feel respected and safe"

She feels invited to share her vision for the future with the service provider and is supported to see contraception as relevant and valuable to achieving her plan. Private opt-out moments or walk-in appointments make her feel safe and comfortable. She trusts and understands what she is hearing and is provided her method of choice, for free, on the spot.

**STEP 4**

**Follow up**

"I feel supported"

She feels comfortable returning to the health center whenever she has questions, experiences side effects or needs more contraceptive services. She receives follow-up calls from providers and feels supported to access services. She continues to see contraception as relevant to her goals.

**Looking beyond girls.**

Given girls' limited autonomy and reliance on gatekeepers for approval and access, 9ja Girls also works across girls' networks to build an enabling environment for the program.

**Collaboration with local and state governments**

Local governments work with SFH to select facilities, recruit and train providers and mobilizers, and conduct supportive supervision.

**Involving the community and moms**

9ja Girls' monthly mothers' sessions help moms understand that improved SRH is one of many tools that can help their daughters to achieve their goals. The sessions are designed to support girls and mothers to improve their relationships and communication skills – equipping moms to discuss health and life choices with their daughters.

**Mobilizers extend the reach of service sites**

Young community mobilizers recruit girls door-to-door and in community spaces, moms refer their daughters, and peers tell their friends about 9ja Girls.

**Strengthening public health facilities**

9ja Girls embeds youth-friendly health providers in government-run facilities to support the delivery of quality adolescent programming. SFH offers coaching and technical guidance to these embedded providers, as well as the facility providers to build their capacity long-term.

## 9ja Girls: User Journey

### Mobilization

"I'm intrigued"

Girls typically learn about 9ja Girls through community mobilizers who refer them to events and service delivery within existing government-run primary healthcare centers (PHCs). Mobilizers receive training and coaching to refine their skills in delivering 9ja Girls' messaging and targeting it based on girls' individual interests—highlighting that 9ja Girls supports girls to achieve their self-defined aspirations through goal-setting, vocational skills training, and private, adolescent-friendly SRH information and services.

As members of the community in which they work, and as employees of SFH Nigeria, mobilizers establish rapport with girls through a series of short, engaging questions that help them identify what service offering may be most appropriate. Depending on the responses and each girl's interest, she may be referred to LLH classes or directly to the clinic for a walk-in appointment.

Mobilizers follow up with girls via phone to remind them of upcoming events. For girls who miss events, mobilizers follow up in person to understand and support them to overcome challenges to attending. This focused attention on complete referrals to events is supported by a pay-for-performance mechanism for mobilizers, with payment per referral redeemed.<sup>§§§</sup>

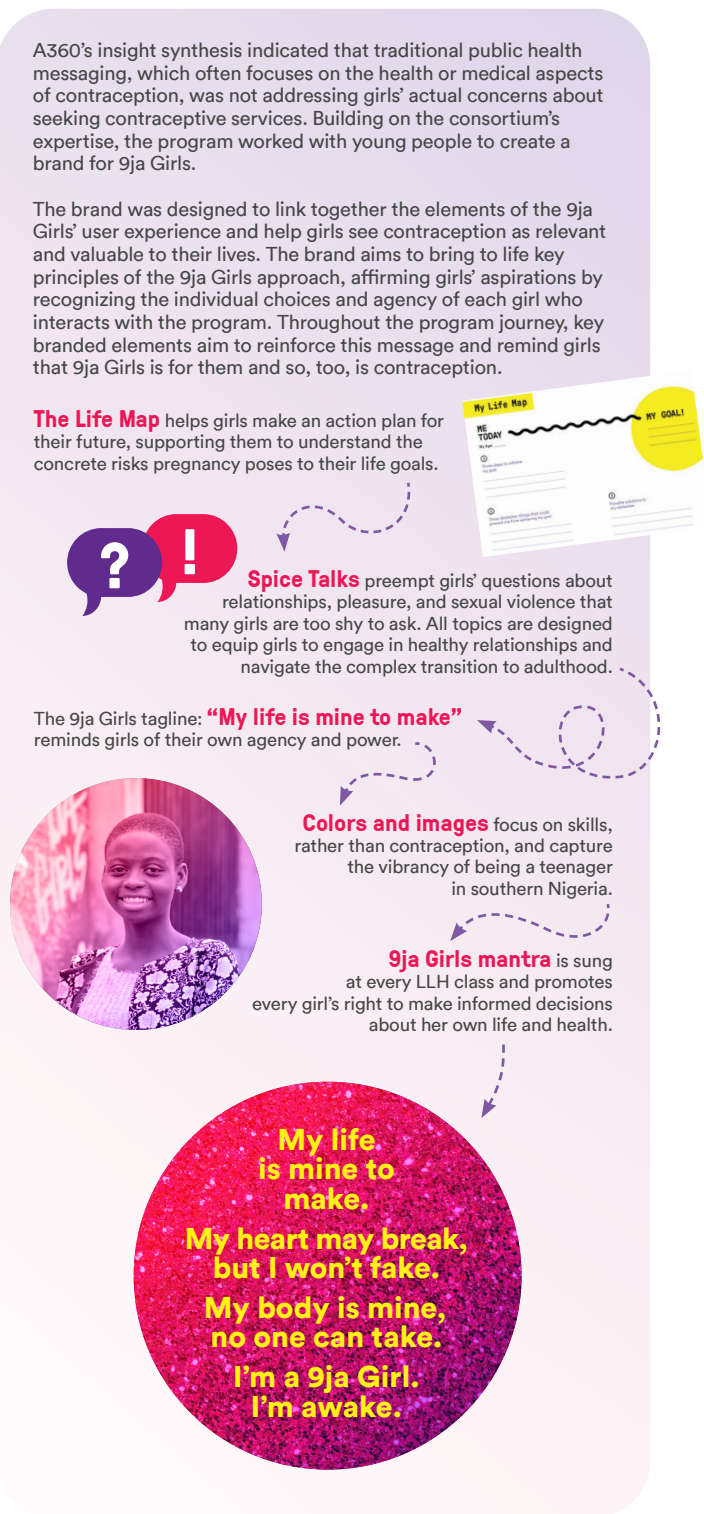
Understanding that girls' needs and preferences vary, mobilization approaches maintain flexibility—while many girls learn of 9ja Girls through paid mobilizers, others hear about the program through community leaders, mothers, peers, or other community-based influencers.

### Aspirational engagement

"I'm inspired and motivated"

During LLH classes, girls are led by 9ja Girls young providers\*\*\*\* through a series of interconnected activities intended to help them see the relevance of contraception in their own lives in a safe, social setting. To protect girls' privacy, each attendee is invited to create a "9ja Girl Name". Girls then participate in "Spice Talks," in which providers lead interactive sessions to acknowledge and foster dialogue about the challenges girls can face navigating relationships, self-worth, sex, reproductive health, and contraception. "Spice Talk" discussion guides are designed to support providers in demonstrating empathy and creating a safe space for honest discussion and learning. As part of these discussions, girls complete their *Life Map*, a paper-based tool designed to help girls consider concretely their goals for their future, and the steps necessary to achieve those goals. "Spice Talks" are then followed by introduction and discussion of contraceptive methods, where providers work to normalize girls' reproductive health information seeking by encouraging questions and dialogue—particularly as relates to effectiveness, return to fertility, and side effects. In addition, providers support girls to consider the goals defined

Figure 3. Developing a girl-powered brand



§§§ Mobilizers receive payment for attendance referrals redeemed only. No payment is linked to contraceptive uptake, in line with principles of informed contraceptive choice and to prevent perverse incentives that could lead to coercion to use contraception.

\*\*\*\* Young Providers are healthcare providers and counselors who are committed to providing adolescent girls with non-judgmental counseling and services, and who are nested in public sector facilities. Trained and paid by SFH Nigeria, these providers tend to be younger and offer dedicated contraceptive services to young people during and between 9ja Girls events.

in their *Life Map*, and the relevance of contraception as a tool to prevent unintended pregnancies, and stay on track to achieve goals. Throughout discussions girls are invited to submit anonymous written questions into a box, which the provider answers at the end of the session.

Contraceptive and life planning dialogue sessions are followed by vocational skills classes, in which local small businesswomen offer skills development trainings to support girls in learning a basic trade. All activities focus on skills that girls can use immediately to earn additional income. By combining this element with the broader LLH class curriculum, 9ja Girls presents girls with multiple opportunities to consider the connections between future aspirations and unplanned pregnancy.

### Contraceptive counselling and service delivery "I feel respected and safe"

Following LLH sessions, girls are offered an "opt-out" counselling session, a step designed to ensure minimal experience of stigma as girls transition from programming to clinical counseling and services. During "opt-out" moments—which take place during vocational skills trainings—providers approach each girl at the day's event to invite her for a confidential conversation.

For many girls, engagement with mobilizers' curated messages about confidential, one-on-one SRH counselling is sufficient to make the decision to go directly to a 9ja Girls provider for contraceptive counseling and services. These girls bypass the LLH classes and visit the PHC for a scheduled appointment with a provider. Providers begin with girls' goals and reframe contraceptive use in the context of girls' wider aspirations. For these girls, the invitation to seek services from a mobilizer combined with the support and tailored counseling offered by the young provider can be sufficient for her to decide to adopt a contraceptive method on the first visit.

Regardless of whether girls reach 9ja Girls providers through LLH classes or directly through walk-in visits, providers aim to deliver a tailored and conversational experience that begins with a girl's goals for her life, discusses the utility of contraception to help her stay on track toward her goals, and transitions to contraceptive information and services. All counseling sessions are designed based on the *Counseling for Choice*<sup>\*\*\*\*</sup> approach, supporting 9ja Girls providers to deliver key SRH and contraceptive information using evidence-based approaches to foster informed

choice. Job aids support providers to deliver counseling in stages, fostering girls' comprehension of key SRH information, and identify the most effective methods that suit her needs and preferences based on her priorities.

For instance, rather than leading with efficacy, this approach supports providers to lead with questions about girls' perception of the consequences of pregnancy right now, their desired timing for a next pregnancy, the need to keep contraceptive use secret, and tolerance for changes in menstrual bleeding. In this way, providers are better able to present the essential information her client requires to make an informed choice about a method, while mitigating risk of loss of comprehension and confidence that can occur if the client feels overwhelmed with information.

9ja Girls service delivery is co-located with the LLH activities. When girls choose to adopt a contraceptive method, services and commodities are provided on-site, on-demand, and at no cost.<sup>\*\*\*\*</sup>

### Follow-up "I feel supported"

Future-oriented messaging incorporated throughout girls' interactions with 9ja Girls prompts girls to see contraception as relevant to their goals. Girls are told at the time of counselling about method side-effects and complications and which side-effects warrant a return visit to the facility. Providers invite girls to share a phone number to receive follow-up support after her initial adoption of a method. Providers then follow a protocol for proactive follow up of clients—calling two to three days after girls initially adopt a method, followed by a month or two post-adoption, depending on the method. For short-term methods, girls receive a reminder call a few days before her due date for renewal. For long-acting methods (LARCs), providers check in at six-months to discuss the girl's level of confidence and experience with her method of choice, with an emphasis on side effects.

The provider also invites questions to assess each girl's need for subsequent follow-up support. For girls who are not actively experiencing issues with side effects and voice confidence in their method, providers shift their follow-up approach to allow girls to initiate as needed. Through these calls, providers continue their relationship with girls and work to build their confidence to continue with their method of choice.



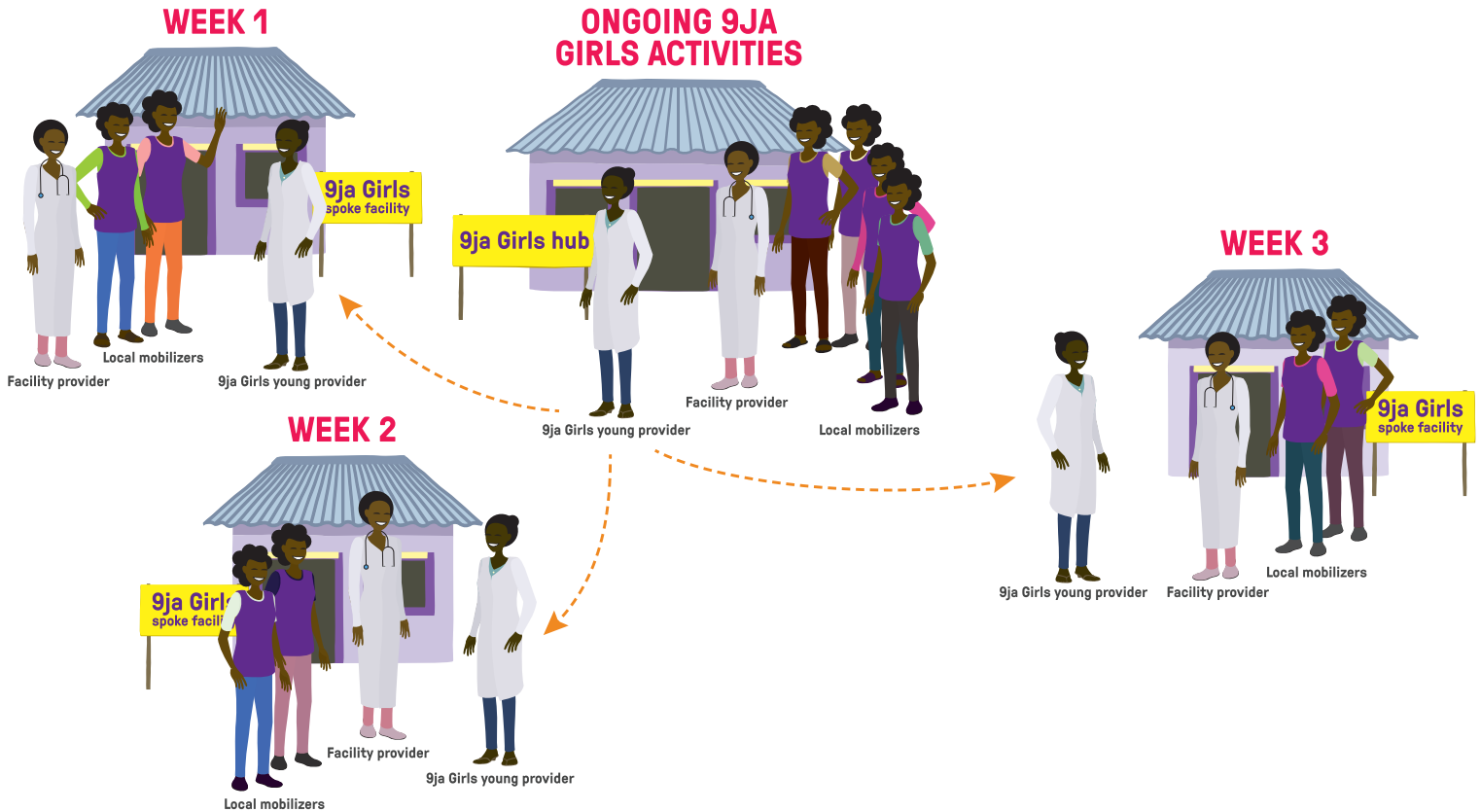
**"I see girls holistically.  
I understand who they are,  
and I do it without judgment."  
Peace  
9ja Girls Youth-Friendly Provider**

<sup>\*\*\*\*</sup> Counseling for Choice (C4C) is a PSI initiative that contributes to a positive narrative around the choices family planning clients have. C4C pulls from existing counseling best practices and is intended to maximize client satisfaction and reduce method discontinuation among girls and women in need of contraception. C4C is currently piloting its main tool – the Choice Book – in several countries, with an official study being conducted in Malawi. Results will be available in 2020. Details on the protocol can be found here: [paa2019.populationassociation.org/uploads/193064](http://paa2019.populationassociation.org/uploads/193064)

<sup>\*\*\*\*</sup> With the exception of permanent methods and abortion, all contraceptive methods are provided on-site at 9ja Girls facilities.

**Figure 4. 9ja Girls Hub and Spoke Model**

Hosted in Primary Healthcare Centers (PHCs), 9ja Girls operates full time at Hub facilities, which host weekly LLH classes and have a nested, young provider to offer quality contraceptive services. Each “hub” facility supports several “spoke” facilities to host outreach events once or twice a month on a rotating basis. SFH provides family planning technical support and hires mobilizers to refer girls for 9ja Girls events and counselling. This approach is designed to improve coverage of 9ja Girls services and build capacity among local PHCs to offer high-quality adolescent contraceptive services.



### Implementation Strategy

9ja Girls currently operates in seven states and covers 92 health facilities using a “hub and spoke” model (see Figure 3). This model, introduced in late 2018, allows 9ja Girls to serve a diverse mix of girls while building capacity among government-run facilities. Both hub and spoke facilities are government-managed primary care facilities run by the local administration. Hubs tend to be in densely populated urban areas, consistently see 9ja Girl walk-in clients, and host LLH classes every Saturday thanks to nested, SFH-paid providers and full-time mobilizers.

The spoke facilities are supported by SFH to host outreach events once or twice a month on a rotating basis. These facilities are chosen based on data that suggest a relatively higher unmet need for family planning in the catchment area, as well as interest of the facility to receive technical support from SFH. Spoke facilities tend not to have full time family planning providers and are often in less densely populated areas than the corresponding hub. Girls attending spoke events are mobilized in advance of an event, and aspirational program offerings are more limited than at the hub facilities, with an abridged version of LLH that does not include vocational training. SFH staff offer guidance and coaching to spoke facility providers and strengthen their ability to provide youth-friendly services, as well as

support with data collection and consumable procurement to ensure consistent, free services for adolescent girls.

Seeking to cultivate a sense of joint ownership for 9ja Girls, SFH has collaborated with federal and state officials since the inquiry phase. Once program implementation began, state governments were invited to participate or lead in 9ja Girls recruitment, site selection, training, supportive supervision, and data collection and analysis. Before beginning work at health facilities, SFH collaborates with local government officials to introduce 9ja Girls to the community. SFH meets with influential community leaders identified by government administrators to explain the aspirational programming approach and seek approval to begin training providers and mobilizing adolescent girls. Starting in 2019, A360 increased partnership with state governments to institutionalize 9ja Girls approaches, with the goal of achieving long-term sustainability of programming. The SFH team completed an analysis of the core components of 9ja Girls, their understood importance to contraceptive uptake among adolescents aged 15-19, and the likelihood that state governments could replicate the components using existing systems, infrastructure, and staffing. SFH works closely with several state governments, notably Ogun, Oyo, and Osun, to pilot government-led implementation of 9ja Girls.

## Implementation Experience

At the end of 2017, with the core intervention components defined, 9ja Girls shifted into a period of adaptive implementation, an approach to implementation that focuses on continuous program quality improvement by identifying and rapidly responding to learning.<sup>27</sup> In A360, adaptations were primarily informed by data to understand performance, girls' client experience, clinical and programmatic quality, and cost-effectiveness. Based on this focus, from 2018-2020 A360 undertook iterative improvements aimed at refining 9ja Girls in pursuit of cost-effectiveness (achieving contraceptive adoption rates at efficient cost), balanced with changes to the model to enable participating PHCs to better respond to girls' needs over time. This resulted in the 9ja Girls 'Hub and Spoke' model (see Fig. 4 for detail), as well as two dominant themes of ongoing adaptation: 1) empathy-based service delivery, and 2) responses to bias.

### Enabling empathetic service delivery

At the time of this publication's writing, the 9ja Girls service delivery model embeds young providers into existing PHC facilities to provide consistent, youth-friendly, and empathetic services for girls. But when A360's original design period ended, the 9ja Girls intervention had been designed with a service delivery model based on integration of a new and highly branded experience into existing stand-alone, youth friendly, and girl-only spaces. These spaces were introduced to offer girls what they said they wanted: a space just for girls, where services were available any time, without judgement, and with highest levels of discretion and confidentiality.

Given the information available at the time—both regarding the evidence on the value of safe spaces for girls, the ineffectiveness of stand-alone youth centers, and live prototyping findings that demonstrated girls' strong desire for these separate spaces—there was intense debate among the consortium about this design decision.<sup>28,29</sup> Thus, at the start of its adaptive implementation period in 2018, A360 prioritized rapid testing of the stand-alone safe spaces. Though desirable to girls, a combination of factors—the upfront start-up costs, challenges maintaining infrastructure, and low client flow resulting from the narrow focus on adolescent contraceptive provision—meant the stand-alone spaces were not cost-effective, nor scale-able.

This rapid testing and inquiry revealed actionable learning. Rather than the service delivery space, it was the attentiveness and commitment of the young providers to girls that girls consistently reported as transformative in their client experience. Young providers believed in the mission of the project and were highly motivated to reach adolescent girls with contraception, with reports of some providers working extended hours in the evening so girls could access services after school. In response, the SFH-led 9ja Girls team eliminated the stand-alone spaces and integrated adolescent contraceptive service provision within the broader PHC operations. Young providers became a nested model, reflecting a close partnership between SFH, PHC, and health system leaders in participating states. Despite

feedback in the inquiry phase that girls would not feel comfortable seeking contraceptive services in public clinics, in practice this proved less important than the attitude of the provider and the quality of the counseling experience.

### Understanding and addressing bias

In 2018, external Participatory Action Research (PAR)<sup>§§§§</sup> findings identified that despite enthusiasm and commitment from providers, positive attitudes alone were not enough to ensure provision of fully unbiased services.

At the individual level, many providers experienced a cognitive dissonance around adolescent contraceptive use—a gap between their desire to serve adolescent girls, versus what they do in practice—that led them to limit girls' choice of and access to methods.

For example, the PAR found that some service providers integrated discussions around abstinence and 'self-control'—promoting a message that abstinence is best—during LLH classes and counseling sessions. To address these issues, A360 added to its existing initial intensive trainings—introducing a supportive supervisory system that emphasizes provider coaching and mentorship around implicit bias and commitment to empathetic service. Executed by SFH Quality Focal Persons, supportive supervision occurs through routine quality assurance visits. All visits are conducted using a standardized checklist to assess quality. An electronic scoring system supports quality focal persons to tailor and target their coaching efforts to the areas of greatest need for each individual provider.

At a systemic level, biases were driven through structural issues posing challenges to the provision of a full range of contraceptive options, particularly stock-outs of consumables and commodities. In response, A360 strengthened its partnership with state governments to address commodity and infrastructure challenges. The Quality Focal Persons liaise with Family Planning Managers in the government to assess stock levels and advocate for the availability of all methods for adolescent clients. SFH partners with state governments to accurately project commodity needs for adolescent clients by sharing timely, accurate data on commodity use at the facility-level. The program also addresses immediate challenges by arranging transfer of commodities from PHCs with low demand to those with high demand to alleviate localized stockouts. Complimented by refined counselling approaches, such as the integration of *Counseling for Choice*, 9ja Girls' adaptive implementation experience is one that has remained focused on quality services for adolescents that ease the pathway to contraceptive uptake and continuation.

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§§§§ PARs are part of the Adolescents 360 Process Evaluation, an independent evaluation to distill lessons and support A360 in understanding contextual enablers and barriers to implementation, and to guide adaptive management for continuous program quality improvement. The Process Evaluation is led by Itad. Process evaluation and PAR findings are online and can be accessed at: [www.itad.com/project/evaluation-of-adolescents-360](http://www.itad.com/project/evaluation-of-adolescents-360)

## Performance

### Modern Contraception Use

In two and half years of implementation, the 9ja Girls intervention has demonstrated its ability to support local health systems to reach adolescent girls with resonant, accessible contraceptive services. Since January 2018, the program has supported public health facilities to reach more than **153,000 GIRLS**— this represents **13%** of the total population of unmarried adolescent girls across the regions where 9ja Girls operates. On average, **74%** of eligible girls\*\*\*\*\* reached through the intervention chose to take up a modern contraceptive method (see Figure 5). Girls who adopted methods through 9ja Girls selected LARCs at significantly higher rates than national averages: modeling shows **72%** LARC users reached for 9ja Girls compared to only 1% as reported by Multiple Indicator Cluster Surveys (MICS). This modeled method mix provides a more accurate comparison to national survey data, which represents a snapshot of contraceptive users at a point in time rather than continuous service data (see Figures 6 and 7).

In addition to contraceptive uptake, the 9ja Girls process evaluation findings affirm that the aspirational approach is building girls' self-efficacy and skills, and offers a quality, supportive SRH experience. Girls attending LLH classes report that they are more informed about their menstrual cycles, feel more motivated to focus on their goals, and are better equipped to navigate relationships with boys.

“Before this program I was a very shy person, shy to talk...But since the providers used to call us for confidential talk, I really feel free to talk to them, so with that, I have been able to gain confidence to talk to someone that is ready to listen to me.”

*Girl, Ogun, A360 Process Evaluation*

Government stakeholders also praise the program for its aspirational approach, appreciating the skill building element and link to life goals.

“Another good aspect of it, is the skill acquisition [that aims] to empower the girls, to take them off the street, by giving them the ability to fend for themselves...”

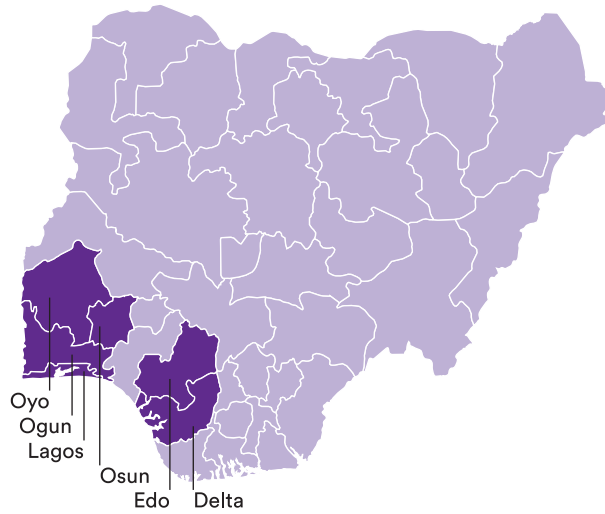
*Government Stakeholder, Ogun, A360 Process Evaluation*

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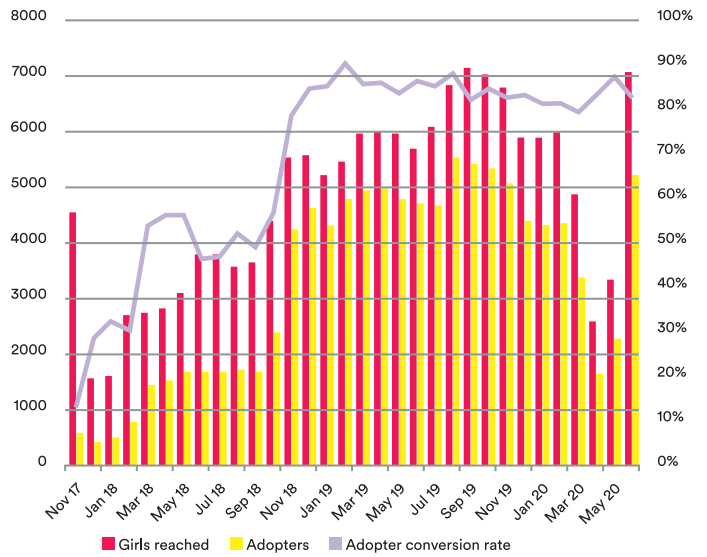
\*\*\*\*\* Eligible girls are those who are neither pregnant nor currently using a modern method of contraception at the time of counselling



**Figure 5. Map of 9ja Girls implementation states**



**Figure 6. 9ja Girls reach and adoption**



The average rate of voluntary contraceptive method adoption among girls aged 15-19 during this period was 74%. November 2017-January 2018 represent early testing of the 9ja Girls model. The increase in reach and adoption rates observed between October 2018 and January 2019 (73% increase) is attributed to the introduction of outreach events at spoke sites, and the shift to the Counseling for Choice protocol. The drop in the number of girls reached and girls adopting a method observed in April through May 2020 is the result of local lockdowns and reduced service delivery due to the COVID-19 pandemic.

**Figure 7. 9ja Girls method mix (services)**

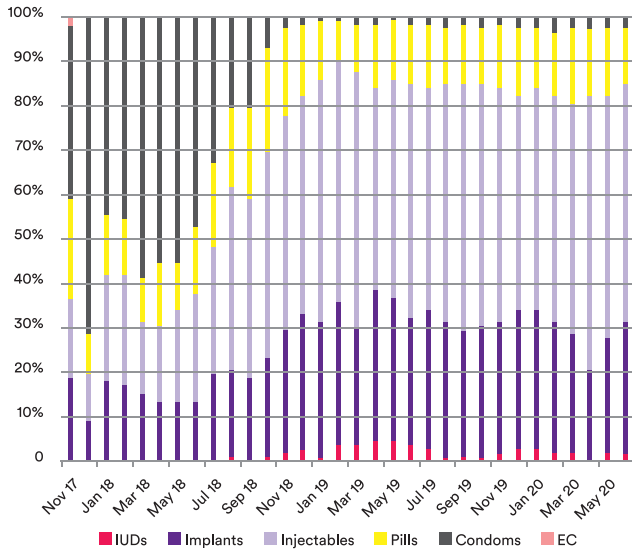
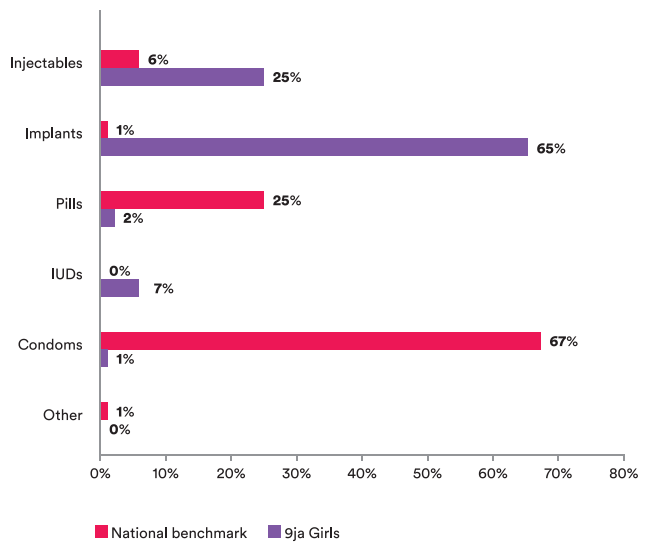


Chart reflects 9ja Girls method mix at service delivery sites. Over time, the overall proportion of adopters selecting condoms only declined, as adoption of injectables and IUDs rose, and adoption of implants remained constant. This shift over time to more effective methods is considered related to adaptations to strengthen counseling protocols and address systems- and individual-level bias.

**Figure 8. 9ja Girls method mix (users) against benchmark**



Data visualization comparing 9ja Girls modeled users reached by method mix (November 2017-June 2020), as compared to Nigeria Multiple Indicator Cluster Survey (2016-17). To make this comparison, 9ja Girls service-level monitoring data has been converted from services provided to users reached. Each service is multiplied by the total number of products provided (relevant for short-term methods such as EC, pills, and condoms where more than one cycle of coverage is provided at a given point of service) and multiplying the total products provided in each method category by a coefficient which represents the total time period of effectiveness. Where the national method mix among adolescents aged 15-19 in Nigeria demonstrates a high proportion of short acting methods, 9ja Girls shows a greater proportion of voluntary adopters selecting LARCs.



## Quality assurance

Evaluation results suggest the quality of contraceptive counselling is also high. Girls report perceptions of counseling as relevant to their lives, and feelings of safety, comfort, and support in interactions with providers. In client exit interviews, 9ja Girls providers exceeded national averages: where 2018 DHS data indicates that 83% of girls nationally were informed of multiple contraceptive methods by providers during contraceptive counseling, 96% of respondents to A360 Client Exit Interviews were similarly informed. Further, where 74% of girls nationally were informed of side effects—a key factor in discontinuation—81% of 9ja Girls respondents report having been informed.<sup>30</sup>

## 9ja Girls clients

Given the complexity of the factors that influence individual girls' lives, the program has not identified a single predictive indicator of how a girl will choose to engage with the options in 9ja Girls. There is more to learn about which girls seek LLH classes versus a walk-in appointment and how each pathway influences the decision to adopt modern contraception, including whether that method is a short-acting or long-acting reversible contraceptive. Multivariate analysis reveals that contraceptive adoption is higher among those who go directly to walk-in counseling, are older, and married with children. However, there is significant variation across states and, at this stage in the project's implementation, A360 evidence cannot yet reflect the long-term effects of LLH classes. Girls attending LLH classes are less likely to adopt a contraceptive method than those who go directly to walk-in counseling

(63% compared with 92%). However, girls who do adopt a method following an LLH class are more likely to choose a LARC than those who walk-in: IUD adoption is 4% for LLH classes compared to 2% for walk-in and implant adoption is 32% for LLH classes as compared to 23% for walk-in. Additionally, there are indications that the classes may be reaching a segment of girls who need support to perceive the value of contraception to their lives. Process evaluation findings suggest the classes may be raising awareness and building support for contraception among these girls and their influencers.

*"Since I was counselled, I know if anything should happen, I have a place to come...I know that if I don't want to get pregnant, I should come here [to the health facility] and I will be protected."*

*Girl, Ogun, A360 Process Evaluation*

As a learning project, A360's focus on continuous program improvement remains. Process evaluation findings suggest that, despite community outreach with local leaders and mothers, for some girls stigma continues to pose entrenched and insurmountable barriers. Furthermore, client exit interviews show that equity is an area for improvement: 9ja Girls does not consistently reach girls in the lowest wealth quintiles, neither for contraceptive services nor the livelihoods and LLH classes that may be of greatest use to this segment of girls. In both instances, A360 will work to understand these barriers and expand program capacity for more equitable reach and coverage.



## Lessons Learned and Recommendations

As A360 reflects on its design and implementation experience, lessons stemming from the project's commitment to learning and girl-centered programming offer useful insights for future ASRH programming for unmarried adolescents.



### Understanding the role of aspirational programming in contraceptive services and uptake

In 9ja Girls, aspirational programming helps girls and their community to see the relevance of contraception. However, there is more to learn about whether and at what level of intensity this type of programming influences the decisions adolescents make in the medium- to long-term. In southern Nigeria, 9ja Girls' vocational skills classes are widely praised by community members, mothers, and girls.

Yet, contraceptive adoption is highest among girls who bypass these classes and directly walk-in for services. Findings from A360's process evaluation suggest that this does not mean the classes are unnecessary, but rather that they may be most beneficial for girls who are not yet in need of contraception—those who, as a result of the classes, now have new skills, knowledge, and confidence to choose to use contraception in the future. If this is the case—and the classes influence girls' decision-making and engagement with the health system long-term—then the benefit of reaching girls at this earlier stage is evident. But without appropriate metrics and methodologies to assess and validate the value of livelihoods intervention components, this aspect of the technical strategy cannot be sufficiently understood.

In the future, cross-sectoral partnerships may offer an opportunity to build out robust and evidence-based vocational offerings for girls. By tracking success inclusive and beyond service uptake, such collaborations can help the project to improve understanding of the value of ASRH aspirational program models like 9ja Girls, which forge linkages between health and non-health sectors.



### Design and adaptive implementation strengthen teams and programming

Given the complexity of the problems facing development, lessons from A360's multi-disciplinary approach to design and implementation, coupled with youth-adult partnership, may be a valuable model for future programming. This approach yielded an intervention model that responded directly to girls' lived experiences and priorities. Evidence-based adaptive implementation for continuous improvement, pursued with youth and local health systems, enabled ongoing tweaks till rapid voluntary contraceptive adoption and community support became strong.

As SFH Nigeria staff leading 9ja Girls implementation have reflected, this multi-disciplinary approach was at times challenging. The approach insisted on ongoing inquiry and learning and forced the unlearning of many traditional ways of working, requiring active debate, trial and error, involvement of young people, and a mindset of continuous quality improvement.

While the resulting trial and error was at times a strain for staff who had previously focused primarily on clinical service delivery, SFH staff report that this continuous learning has led to a valuable culture shift. This shift has offered a new framework for addressing implementation obstacles and achieving results in adolescent health programming. As described in the adaptive implementation section, this approach has given the implementation team agency to seek and identify pathways to improved efficacy when it comes to the challenging work of meeting the contraceptive needs of adolescent girls.



### A delicate balance: designing for girls and scalability

As the first phase of A360 closes, the project is looking critically at what it will take to scale 9ja Girls through the government health systems. SFH and PSI are examining whether the right balance has been struck between responding to girls' expressed needs and designing with the government as the ultimate program owners.

A360 led with a focused intent to understand girls' desires and aspirations and used the resulting insights to develop new ways of programming. This focus resulted in some missteps, as with the initial emphasis on stand-alone safe spaces, which responded to girls' desires, but ultimately was not a sustainable, quality approach for contraceptive services. A360 acknowledges that elements in the program's current form—for example, 9ja Girls mobilizers—may be difficult for the MOH to incorporate, as they require parallel systems or significant additional financial resources. And yet, in the initial investment period the mobilizers have played a critical role in bridging a key gap identified in design research: though services were available at clinics, adolescent girls were not using them.

Mobilizers have served as ambassadors of the health system, helping girls see the relevance of contraceptive counselling and assuring girls that they will find safe, confidential, and friendly services. Considering the future, A360 is now reflecting on whether it would have been possible to identify a similar mobilization or young provider cadre within the government system if, as literature supports, full partnership with government actors had begun at the initial design phase. Or if, by contrast, there may be utility in enabling a local NGO like SFH to introduce non-traditional roles and demonstrate their additional value to make the case for future work. In either case, such trade-off decisions—in this case between



**“My dream is to see all girls [achieve] their own potential. 9ja Girls is helping us ensure girls’ brighter futures ahead.”**  
**Dr. Akintayo**  
 Medical Officer of Health,  
 Nigeria’s Agege Local Government



**“9ja Girls has given my daughter more confidence to achieve her life dreams.”**  
**Mrs. Falohun**  
 Mother

innovation, effectiveness, and scalability—are ones that should be identified early and discussed with government partners transparently.

When innovation is jointly agreed to, implementers and governments can then design assessments together to understand the feasibility and cost-benefit implications of retaining effective novel approaches into standard health system practice.

### Next Steps

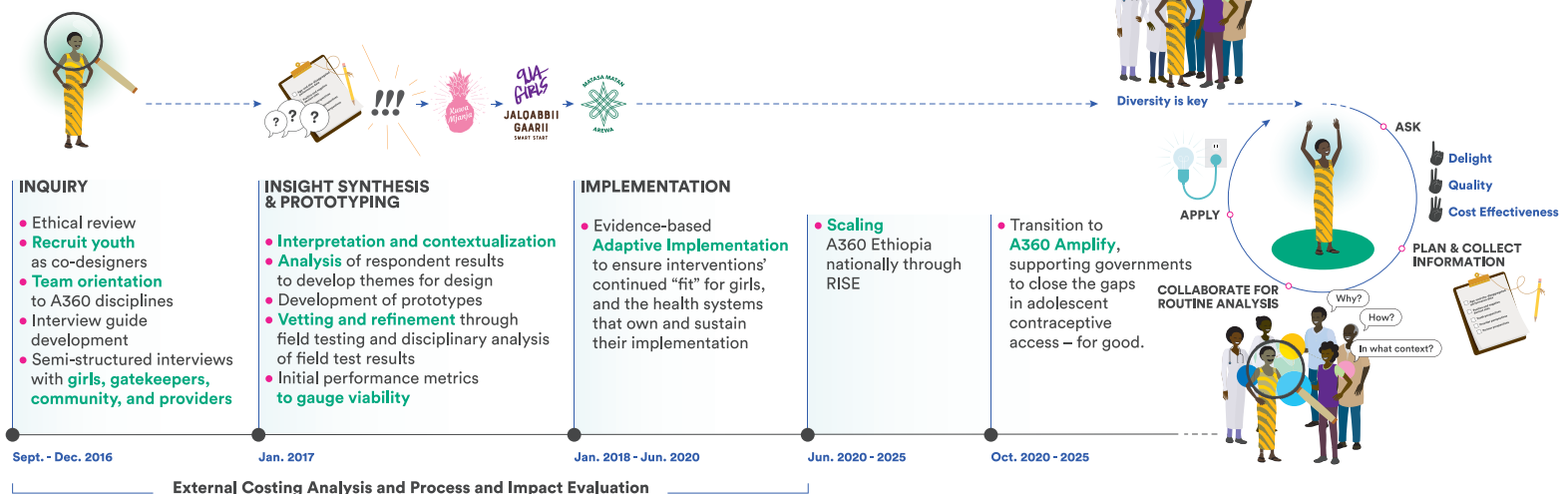
In its four and a half years of design and implementation, 9ja Girls has remained focused on supporting local health system actors to better reach and respond to the SRH needs of adolescent girls. By recognizing and supporting girls’ aspirations for their lives, health systems gain a pathway to improved coverage both in support

of girls’ access to modern contraception, and their expressed need for developmental support in pursuit of a stable future.

Over time, 9ja Girls has worked to advance this innovative health- and non-health sectoral approach to SRH in partnership with federal, state, and local governments and community leaders, and aims to continue building local implementation capacity to sustain this model into the future.

Additional funding has been secured to extend 9ja Girls through 2025 under A360 AMPLIFY. With this investment, 9ja Girls will further support state service delivery systems and expand programming to reach more girls, including those from lower socio-economic statuses and girls whose access to contraception is limited by stigma. 9ja Girls will build on lessons learned and strive for sustained, quality services for girls as the program partners with governments to take the model to large-scale.

**Figure 9. Scaling 4 country programs: A360’s transition to A360 Amplify**



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## Endnotes

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Adolescents 360 (A360) is a four-and-a-half year initiative co-funded by the Bill & Melinda Gates Foundation and the Children's Investment Fund Foundation (CIFF). The project is led by Population Services International (PSI) together with IDEO.org, University of California at Berkeley Center on the Developing Adolescent, and the Society for Family Health Nigeria. The project is being delivered in Ethiopia, Nigeria and Tanzania, in partnership with local governments, local organizations, and local technology and marketing firms. In Tanzania, A360 has built upon investments and talent from philanthropist and design thinker Pam Scott.

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