Provider bias in the provision of contraceptives to adolescent girls and young women in South West Nigeria

Introduction

Interactions with providers can have an important influence on use of contraceptives and method choice (Harper et al. 2010), including among adolescents (Minnis et al. 2014). In many contexts in Sub-Saharan Africa (SSA), provider biases have been documented regarding provision of contraceptives to adolescent girls and young women (AGYW). Providers report imposing restrictions on certain methods based on age, marital status, or parity, counter to established medical guidelines, or refusing to provide services altogether (Nalwadda et al. 2011; Sidze et al. 2014; Tumlinson et al. 2015). Providers may also scold or question AGYW seeking contraception, or express opinions in support of abstinence (Wood and Jewkes 2006). Even if they ultimately provide services, judgmental or unwelcoming attitudes by healthcare professionals may discourage young people from seeking needed reproductive health services. Inhospitable services in clinical settings may also encourage AGYW to seek contraception from traditional or less skilled providers, such as drug shops, where quality of care is more uncertain (Mmari and Magnani 2003; Oye-Adeniran et al. 2005).

The majority of studies on provider bias in delivering contraception to AGYW in SSA are based on interviews with providers themselves, and, at times, users. Relatively less is known about how provider biases or non-evidence-based restrictions on provision of services actually play out during interactions with clients, and how this impacts broader quality of care for AGYW compared to older women. In this study, we use a matched sample of mystery client interactions and in-depth interviews with private sector providers in South West Nigeria to examine counseling quality and barriers to AGYW use of contraceptives.

Methods

Our analysis is based on a comparison between mystery client (simulated patient) surveys and vignettes administered as part of in-depth interviews on the same sample of family planning providers. A purposive sample of 60 private providers in the South West region offering family planning services was selected from the clients of a contraceptive social marketing organization. The sample was evenly distributed across four categories of clinical and non-clinical providers: pharmacies, patent and proprietary medicine vendors (drug shops), clinics/hospitals, and community-based health workers (CHEWs).

Fieldwork took place in two steps. First, two mystery client interactions were conducted, about a week apart, at each provider. The interactions were conducted by different actors following the same standard script: (1) A sexually active, unmarried adolescent girl aged 18 with no children, seeking a contraceptive method for pregnancy prevention (“Young”), and (2) a married woman aged 28 with two children, seeking a contraceptive method for birth spacing (“Old”). The actor then debriefed with an interviewer following a standardized survey. Providers were not informed of the visit ahead of time. The aim of sending both young and old profile actors to the same providers was to assess differences in counseling quality and method recommendations based on client profile. Paired (young-old) interactions were successfully conducted at 55 of the 60 selected providers.

Subsequently, a different field team was sent to conduct in-depth interviews with each of the 55 providers at which paired interactions were obtained. In addition to a series of questions about the provider’s family planning services, each provider was posed two vignettes corresponding to the characteristics of the mystery clients:

1. “Let’s say a woman has come to see you. She is alone and appears to be about 28 years old. The woman tells you that she is married and lives with her husband. She just had her second child one year ago and would not like to have another child so soon. She has never used family planning before.”
2. “Now let’s say a young girl has come to see you. She is alone and appears to be about 18 years old. She tells you that she has a boyfriend and would like to prevent pregnancy because she is still in school. She has never used family planning before.”

In-depth interviews were completed with 51 of the selected providers, yielding a matched sample of provider’s vignette responses to their interactions with the mystery client actors. Vignette responses were coded in Dedoose using a structured coding scheme that corresponded to the areas of counseling quality (e.g. interpersonal relations, choice of method) captured in the mystery client survey. Mystery client survey data was analyzed descriptively; additional multivariate analysis will be conducted for the final paper.

Results

We focus on three aspects of counseling quality – interpersonal relations, information to client, and choice of method – that could be assessed and compared through the two data collection methods. Vignettes were not designed to test provider technical competence. The majority of mystery clients from both profiles felt well-treated by the provider, although the younger profile consistently reported lower levels of satisfaction (Figure 1). Younger profile actors were more likely to feel “treated differently” by age. Note that in the survey question, being treated differently was not given a positive or negative connotation; the actor was instructed to respond in terms of whether or not the particular characteristic seemed to affect the provider’s interaction with her.

Providers were more likely to ask older profile actors relevant aspects of their histories, including if they had ever used contraceptives and if they were pregnant. Age profile was not associated with the likelihood of discussing side effects, but younger profile actors more often reported providers using side effects as a reason to dissuade them from using contraceptives.

Providers’ responses to the vignettes similarly suggested different approaches to counseling for married versus younger, unmarried clients. When asked what they would ask such a client, for the married women, providers generally focused on whether she wanted to have more children and when, whether she had her husband’s permission to use family planning, and, at times, past contraceptive use or contraindications for certain methods.

I will like to know the specific year she want to have another baby because to some people six month is not enough … I will like to know all her medical conditions before treating her. – Pharmacy, Ekiti state
With younger users, providers were more focused on why the hypothetical client wanted to use contraception and her relationship with her partner.

*I will want to know her family background that is she from a good home, are the parents together, is she well taking care of, why is she having boyfriend* – Clinic, Osun state

*Well the motive matters. I won’t like to encourage some things… I don’t discourage people to be on safe side because family planning could be of help. [But] I would have to sit her down and ask her [to] talk to me, what her reasons are.* – Hospital, Lagos state

Many providers mentioned HIV or other STI risk in relation to their interest in knowing more about the younger client’s reasons for family planning. Although some said that they would give the client contraceptives regardless, few mentioned other aspects of her medical history.

**Provider discussion and recommendations about method choice**

As shown in Figure 1, younger profile actors were more likely to be asked why they wanted contraception, but older profile actors were more than twice as likely than the younger profile actor to be asked what method she wanted (73.2% vs. 30.4%). The mystery client interactions revealed that the large majority of providers mentioned different methods to the young and old profile actors. In aggregate, this resulted in systematic differences in which methods the simulated clients were most likely to be told about and recommended to use. For example, 17.9% of younger profile actors were recommended to use EC, but no older profile actors (Figure 2). Younger profile actors were also more likely to be recommended condoms, the pill and abstinence. Conversely, older profile actors were more likely to be recommended injectables, IUDs, and implants. Although the majority of providers did not recommend against particular methods (64.3% and 55.4% for the older and younger profile actors, respectively), younger profile actors were more likely to be discouraged from all methods except condoms.

In the in-depth interviews, providers were similarly more likely to express opinions about which methods were not appropriate for unmarried or young women. For the older client, providers’ discussion of method choice focused on aspects related to the length of spacing desired and side effects. For the younger client, many providers said that hormonal methods were not suitable, an opinion that was primarily based on the perception that such methods, and particularly injectables, would delay fertility when she married and wanted to get pregnant.

*...family planning is not for a young girl that is not married that has never given birth before because it has side effects....[if] we advise her to go for injectables, or insertion [implant] or take pills, when she is ready to marry and she wants to give birth, the drug will still be effective in her and it can prevent her from getting pregnant* – Drug shop, Kwara state

Some providers also expressed the opinion that taking hormonal contraceptives would encourage the girl to be promiscuous because she would then always be protected against pregnancy. Accordingly, most recommended that the young client use condoms or EC.
From my own religion point of view I will first advise her to abstain from sex. I don’t give unmarried lady a family planning method, I consider it giving them an opportunity to be able to practice sex when is not suppose to…the only advice I can give her if there is any at all is to have the Postinor [brand of EC] – Pharmacy, Ekiti state

There was, however, a smaller group of providers who were willing to provide a range of methods to the younger client. This was particularly true among CHEWs, all of whom had received training that included contraceptive counseling for adolescent or unmarried users.

Discussion

Our preliminary findings support the broader literature that providers treat AGYW differently when providing family planning counseling, and may impose restrictions on their access to certain contraceptive methods. Actual counseling quality measured via mystery client actors varied systematically for younger, unmarried versus older, married profiles of clients. Providers verified these differences in their responses to the vignettes posed during in-depth interviews, providing reasons for why differential treatment of AGYW seeking contraception is warranted. Further, there is some suggestive evidence that specific training on counseling for AGYW may help to reduce such biases and create more equitable counseling and method choice for all women. Analysis of interview transcripts is ongoing, and further analyses by provider type will be conducted for both the interview and mystery client data.

Several limitations should be noted. Mystery clients visited providers before interviews were conducted to avoid the development of any priors about clients of different profiles due to the vignettes. Because some facilities experience very low family planning client volume, it is possible that providers could have become suspicious and this may have affected interview responses. However, such instances did not come to our attention during the study period. Our sample of providers is not random, and may be biased towards more open attitudes to family planning provision for AGYW due to their contact with the social marketing organization. The findings from our study will have broader implications for improving the youth-friendliness of family planning program in SSA.

References


