

Empowering Adolescent Girls as Peer Advocates for Family Planning

Designing and Testing a Peer Referral and Clinic Welcome Program in Uganda

Social norms, stigma, and limited agency in decisions about sex and contraception inhibit access to family planning (FP) services among adolescent girls in Uganda. A program that welcomes girls to consider FP and empowers them as advocates within their peer groups significantly increased uptake of FP services.

Background

Unplanned pregnancy can dramatically impact an adolescent's health and economic future. About 11% of all births worldwide are to adolescent girls; pregnancy and childbirth complications are the leading cause of death for girls aged 15-19.¹ Surveys in Sub-Saharan Africa find that nearly all adolescent girls who have ever been pregnant are out of school, with pregnancy cited as the most common reason for dropout.²

In 2016, 25% of adolescent girls aged 15-19 in Uganda had begun childbearing, yet nearly half of those births were reported as mistimed or unwanted—a higher proportion than among older women.³ Adolescents also have the highest abortion rate among recently sexually active women in Uganda,⁴ exposing them to risks associated with unsafe methods of abortion. Of the 2.5 million adolescent girls aged 15-19 in Uganda, 26% are sexually active and do not want a child for at least two years.⁵ However, only 39% of those girls use modern contraception, leaving six in 10 with an unmet need for family planning (FP) services.

To address the challenge of unmet need for FP, particular attention is needed to ensure that adolescents have meaningful access to youth-friendly counselling and services to support their informed choice. ideas42 partnered with MSI Reproductive Choices and Marie Stopes Uganda (MSUG) to explore the behavioral dimensions of adolescent girls' access to FP services and to design and rigorously test a novel intervention targeting the behavioral challenges that contribute to unmet need and inhibit adolescent uptake in Uganda.

Highlights

- ▶ Interventions aimed at adolescents may be especially critical when negative stereotypes and social stigma around contraception and sex inhibit uptake of family planning methods.
- ▶ A well-received peer referral and clinic welcome program in Uganda significantly increased adolescent uptake by 45%, even during the COVID-19 pandemic.

¹ WHO. *Adolescents: Health Risks and Solutions*. World Health Organization; 2018. Accessed October 23, 2020. <https://www.who.int/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions>

² Birungi H, Undie C-C, MacKenzie I, Katahoire A, Obare F, Machawira P. *Education Sector Response to Early and Unintended Pregnancy: A Review of Country Experiences in Sub-Saharan Africa*. Population Council; 2015. doi:10.31899/rh4.1047

³ Uganda Bureau of Statistics (UBOS), ICF. *Uganda Demographic and Health Survey 2016*. UBOS and ICF; 2018. Accessed October 23, 2020. <https://dhsprogram.com/pubs/pdf/FR333/FR333.pdf>

⁴ Sully EA, Atuyambe L, Bukonya J, Whitehead HS, Blades N, Bankole A. Estimating abortion incidence among adolescents and differences in postabortion care by age: a cross-sectional study of postabortion care patients in Uganda. *Contraception*. 2018;98(6):510-516. doi:10.1016/j.contraception.2018.07.135

⁵ *Adding It Up: Investing in Contraception and Maternal and Newborn Health for Adolescents in Uganda, 2018*. Guttmacher Institute; 2018. Accessed November 5, 2020. <https://www.guttmacher.org/sites/default/files/factsheet/adding-it-up-contraception-mnh-adolescents-uganda.pdf>

Context and Challenge

MSUG provides approximately 60% of all contraceptive services in Uganda through a range of channels designed to address needs of different underserved populations. One channel is the BlueStar Network of 151 private social franchise clinics, which deliver services in urban and peri-urban communities. MSUG builds service provider capacity through training, equipping, and supporting these franchised private sector clinics, which are required to meet sexual and reproductive health service quality standards. MSUG also supports community-based mobilizers to raise awareness and generate referrals for clinic services.

About two thirds of social franchise clinics participate in the “RISE” program, funded by the UK Foreign, Commonwealth, & Development Office. Among other benefits, RISE allows clinics—generally in lower-income areas of the country—to offer and be reimbursed for subsidized vouchers that reduce or eliminate fees to clients. Vouchers are distributed in the community through mobilizers and allow the bearer to receive FP counselling and services for a short-term or long-acting reversible contraceptive of their choice. Youth vouchers are distributed for free to girls and young women under 25, and paid vouchers are sold to women of all ages for 2,000 Ugandan shillings (USD \$0.55)—a significant discount on the full price of services. The RISE program addresses cost barriers to FP access, a key, known barrier to access for adolescents.

Through interviews with adolescents, community-based mobilizers, and providers, we identified behavioral barriers to FP uptake among Ugandan adolescents, which persist even when services are available and affordable. This diagnosis work suggested that social norms and stigma related to adolescent sexual activity and contraceptive use lead adolescents to perceive the process of visiting a clinic as unpleasant and highly visible to their families and communities. Adolescent girls rarely take an active role in decisions about sex and contraception and are rarely prompted to consider FP. Because conversations about the topic are uncommon, girls may underestimate their peers’ use of or interest in FP, and as a result struggle to envision it as an option for girls like them.

We also learned that community-based mobilizers working with MSUG sought to actively engage adolescents, often by working through satisfied FP users to generate referrals to MSUG clinics. For example, mobilizers sometimes, after receiving consent, offered potential clients the phone numbers of past clients to answer questions and encourage them to visit a clinic. Conversations with mobilizers and clients revealed that only a relatively small number of adolescent clients played this role, and most did not have close relationships with the prospective clients they referred. Prior research from a range of settings shows that peer education initiatives where recipients are approached as more passive recipients or beneficiaries of such a program, rather than true peers, have limited success.⁶ Through our diagnosis activities, we learned that a *friend’s* personal endorsement was uniquely valuable in encouraging girls to visit a clinic and learn more about FP. This finding suggests an opportunity to re-envision peer referral to both broaden its potential reach and strengthen its effectiveness in linking girls to FP services.

⁶ Chandra-Mouli V, Lane C, Wong S. What does not work in adolescent sexual and reproductive health: a review of evidence on interventions commonly accepted as best practices. *Global Health: Science and Practice*. 2015 Sep 10;3(3):333-40. <https://www.ghsjournal.org/content/3/3/333>

Intervention Design

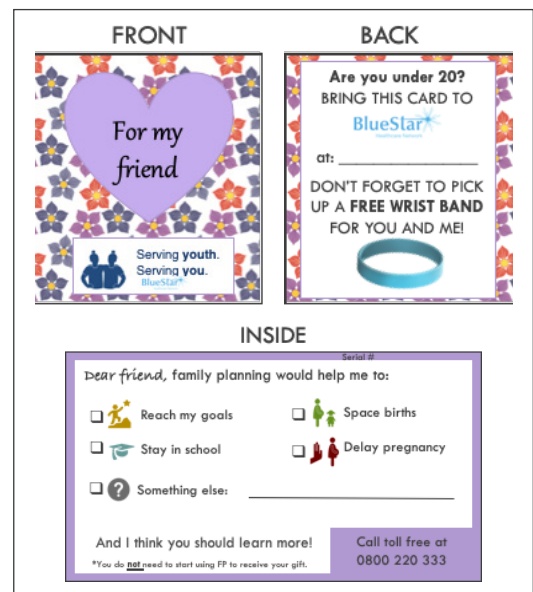
Working with MSI and MSUG Marketing and Behavior Change, Evidence, and Clinical teams, we designed an intervention based on a set of objectives informed by the diagnosis:

1. Create a moment for girls to consider whether to use FP.
2. Help girls envision FP as consistent with a positive self-image.
3. Build (or strengthen) an intention to use FP.
4. Offer a reason to visit the clinic now, rather than procrastinate.
5. Communicate that girls are welcome at BlueStar clinics.
6. Reinforce providers' commitment to welcome girls and treat them well.

The ultimate aim was to reduce adolescents' unmet need for modern contraceptives by increasing uptake of FP services at social franchise clinics. We refined the intervention through an iterative co-design and user-testing process with providers, mobilizers, and clients, as well as MSUG and MSI staff.

The Refer-a-Friend Program

The first part of our behavioral intervention is a program that invites girls aged 15-19 who use contraceptives or have received FP counseling to give a “Refer-a-Friend” (RAF) card to a friend who is not currently using contraceptives. The card creates an opportunity to discuss FP and share information and advice, and prompts the recipient to visit a BlueStar clinic to learn more. Empowering a girl who has previously benefited from FP use or counseling as an advice-giver may also solidify her own intentions to use FP in the future.⁷ Prompting advice and referrals by close, trusted peers increases the chances that recipients will take the recommendation to heart and act on it.⁸ The peer referral program capitalizes on both of these mechanisms: peer endorsements help to encourage those who might otherwise feel uncomfortable speaking to a mobilizer or provider to seek services, and, when a girl endorses FP to a friend, it builds her confidence and solidifies her intention to use or continue using FP.



The “Refer-a-Friend” Card

⁷ Eskreis-Winkler, Milkman, Gromet, and Duckworth. 2019. “A large-scale field experiment shows giving advice improves academic outcomes for the advisor.” *Proceedings of the National Academy of Sciences of the United States of America* 116 (30): 14808-14810. Doi: 10.1073/pnas.1908779116 (December 22, 2020).

⁸ Zhao, Min, and Jinhong Xie. 2011. “Effects of Social and Temporal Distance on Consumers Responses to Peer Recommendations.” *Journal of Marketing Research* 48(3): 486–96. doi: 10.1509/jmkr.48.3.486 (September 16, 2019).

The content of the RAF cards illustrates a range of reasons adolescents may choose FP, signaling the connection between FP use and tangible goals and values that girls already hold. When a girl redeems a RAF card, she has an opportunity to directly access accurate information and guidance about her FP options.

The RAF program design also offers an immediate motivation for girls to engage in conversations about contraception, as well as visit clinics. When a girl visits a clinic and redeems a RAF card, she receives two friendship wristbands—one for her to keep, and one for the friend who referred her. These wristbands serve as a small token to motivate girls to make referrals and follow through on visiting the clinic. If the girl accepts contraceptive counseling or services after redeeming her RAF card, she receives a new card to give to another friend, becoming an advice-giver herself. In addition to providing an incentive to distribute and redeem RAF cards, the friendship wristbands signal that BlueStar clinics are a place where adolescents belong and that learning about and considering FP is acceptable for adolescents.

Girls are not required to accept FP counseling or to take up an FP method to receive the friendship wristbands.

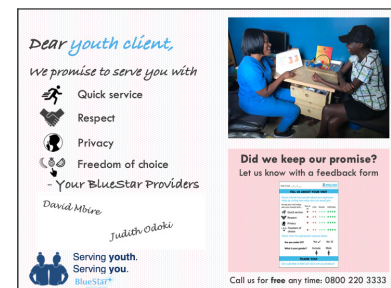
Clinic Environment Materials

We also designed materials for the clinic that reinforce a welcoming environment for girls. When a girl arrives at the clinic, she sees a poster stating a commitment to serve youth that is signed by the service providers who work in that clinic. She is also greeted by a provider wearing a name tag, which includes the same program logo as the RAF cards, the friendship wristbands, and the welcome poster. These materials assure girls that they are welcome and belong at the clinic. They also communicate that girls can expect high quality and welcoming treatment from providers. Together, these signals boost girls' confidence and generate a sense of commitment from providers to prioritize youth and deliver a high standard of care.

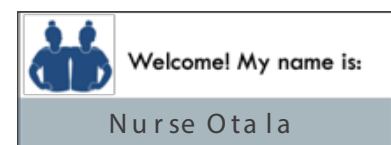
Girls who choose to receive FP counseling see a second poster in the counseling room, displaying redeemed RAF cards. This conveys that they are not alone in considering FP and reinforces the reasons for using FP that are consistent with a positive identity.



Friendship Wristbands



Poster Signed by Service Providers



Service Provider Name Tag



Poster with Redeemed RAF Cards

Youth-Friendly Services Training

In addition to the RAF program and the clinic environment materials, providers from a subset of clinics received a three-day training on provision of youth-friendly services (YFS), designed by MSI for the Uganda context and facilitated by a qualified member of MSUG's Youth Team.

When a new adolescent client receives a warm welcome and excellent service, she may be more likely to take up a method, to return for other services later, and to refer her own friends. While our diagnosis research did not suggest that providers commonly mistreat or turn away youth clients, the YFS training intended to build providers' skills, intentions, and confidence to meet the needs of youth clients, translating an increase in adolescent visits to sustained increases in contraceptive uptake.

Pilot Test Findings

We assessed the intervention's impact on adolescent FP uptake using a randomized controlled field trial (RCT). In total, 126 BlueStar clinics were stratified based on RISE voucher status and adolescent patient volume and then randomly assigned to a control group (offering standard services), a Core group (implementing the RAF program and clinic materials), or a Core+ group (implementing the RAF program, clinic materials, and YFS training).⁹ Clinics implemented the intervention for six full months in 2020, interrupted mid-way for three months due to COVID-19 precautions.

Using MSUG administrative data, we measured the impact of the intervention on 1) the number of adolescents aged 15-19 receiving FP services and 2) the proportion of total FP clients who are adolescents. Both outcomes were measured monthly at the clinic level.

We observed statistically significant¹⁰ positive impacts of the intervention on both outcomes compared to baseline and relative to control clinics. The monthly number of **adolescent clients increased on average by 45%** (5.4 more per clinic, on average). The monthly **adolescent proportion of clients increased on average by 5.3 percentage points**. This suggests that nearly 2,000 adolescents became new FP users as a result of the intervention during the six months of implementation. See Figure 1 below for a visual representation of these findings within a typical BlueStar clinic.

The effects were marginally stronger with the more intensive Core+ package: a 62% relative increase in monthly clients (7.4 more per clinic) compared to a 26% increase (3.2 adolescents per clinic) when the intervention was implemented without the YFS training. The average increase in adolescent proportion of clients (5.4 and 5.3 percentage points, respectively) was more consistent between intervention groups.

While the intervention was effective in both voucher and non-voucher clinics, those with youth vouchers for free FP services performed marginally better in increasing adolescent clients than intervention clinics

⁹ BlueStar clinics active for six months and meeting service quality standards prior to randomization were eligible for inclusion; the resulting 126 clinics were divided into 11 strata based on their voucher status (paid and youth, paid only, or none) and quartile mean adolescent FP visits, and randomized into treatment (N=66) and control (N=60) groups. The treatment group was subsequently randomized into "Core" (N=31) and "Core+" (N=35) arms. Ten clinics dropped out of the BlueStar network after randomization, leaving a final evaluation sample of 116 clinics.

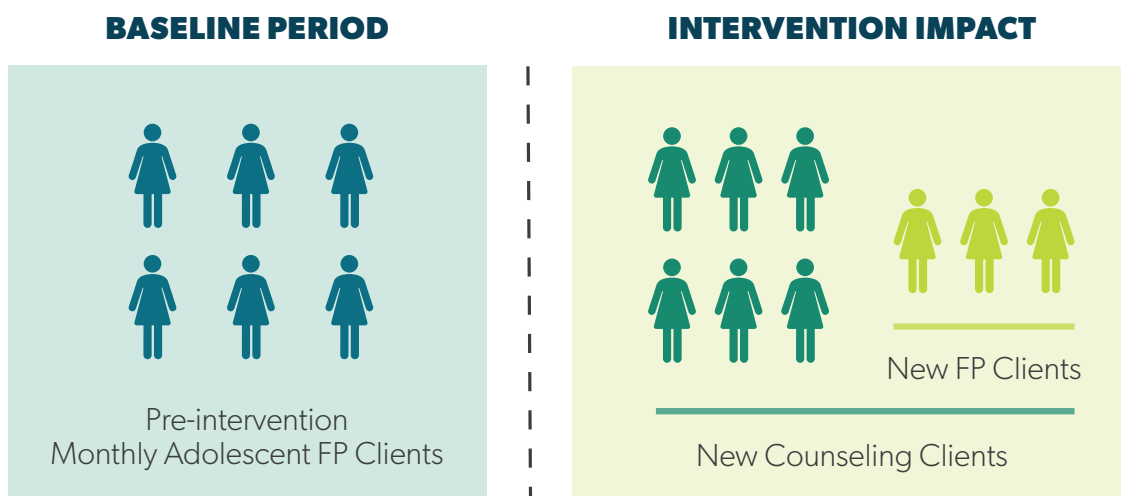
¹⁰ All findings statistically significant ($p < .01$) except for the increase in monthly clients due to Core treatment alone.

with no voucher program. This may suggest that the intervention was more effective where vouchers were available to remove cost barriers to service uptake. However, because the availability of youth vouchers is not random, the differences might also reflect some other difference between voucher and non-voucher clinics.

With an RCT evaluation design, we were able to detect significant impacts of the intervention despite disruption in implementation and subsequent changes to the study context due to the pandemic. This positive impact is a testament to the program’s resilience and endurance. However, effect sizes were strongest during the initial months of implementation, suggesting that factors related to the pandemic may have weakened the impact of the intervention during and after COVID-19 restrictions were enacted.

Redeemed RAF cards also offer some insight into the program’s reach among girls who visited a clinic but did not take up a method. MSUG’s routine service reporting does not capture counseling services provided at BlueStar clinics. However, interviews with providers suggest that virtually all girls who redeemed a RAF card chose to receive free FP counseling. According to provider reports, a minimum of 5,477 RAF cards were redeemed during the study. Although this number is a conservative estimate, since RAF card redemptions were not consistently reported by providers, it suggests that for every adolescent girl who took up FP, another two girls received FP counseling to support their informed choice at a later time. It also suggests that adolescents who visited clinics to redeem RAF cards did not commonly feel pressured to take up a method.

FIGURE 1: Visual representation of impact in a small BlueStar clinic



Pre-intervention period is November 2018—January 2020. Intervention period is February—April and August—October 2020.

Implementation Insights

In addition to the impact evaluation, we performed a process evaluation which assessed whether the program was implemented and used as intended, how it was received, and any instances of misuse of materials or adverse events. Process data was collected through two rounds of interviews with providers, mobilizers, and adolescents; observations of girls' interactions with providers in clinics and with mobilizers in communities; and RAF card distribution and redemption reports.

➤ **Implementation Insight #1: Mobilizers, service providers, and adolescents see the value of this program and confirm it works as intended.**

Those involved in implementing and receiving the intervention were satisfied with their experience and its results. They thought the designs were attractive, the referral process was intuitive, and to clinic staff, the results were worth the extra work of delivering the program. In fact, when the COVID-19 pandemic led us to pause implementation in April 2020, providers urged us to reconsider; from their perspective, girls needed the program more than ever during the outbreak.

Furthermore, providers and mobilizers felt that this program allowed them to access harder-to-reach clients and improved their relationships with existing clients.

"It has helped us to reach areas we couldn't reach. Yes, if I get a chance of reaching in those areas, I can talk to those people but remember this satisfied user can easily connect with her friends. It has really helped because there are people within the community that are now getting the services."

–Community Mobilizer

"She told me she wanted to get family planning but didn't want to go to the main hospital and didn't know where else she could get the service. I told her about my visit here and the RAF card and she was so excited, so I gave her the card."

–Adolescent Client

"The program so far is working good because it has helped us to reach girls in the village who couldn't get access to family planning counseling and methods but with the help of fellow adolescents."

–Service Provider

"When we come to the facility, they welcome us with respect. The provider takes us to the counseling room and talks to us. After talking to us on issues concerning family planning, he will not force you to take a method, it's done willingly."

–Adolescent Client

"It's bringing us clients because when someone takes the RAF cards and gives it to someone, she gets morale to come and get a service. It is helping us so much."

–Service Provider

Girls who experienced the program felt welcome and respected, and appreciated being offered counseling even if they weren't ready to take up a method. Although we are not able to measure the longer-term effects this counseling may have on girls' uptake of FP, their positive experiences visiting clinics and learning about FP suggest that they may be likely to return when they are ready to use FP.

Although increased access to FP counseling can be considered a positive outcome even for girls who do not immediately take up a method, some providers noted that it created an additional burden. BlueStar clinic providers are compensated according to the number of FP services they provide and receive no compensation for free counseling. While a small number of providers requested additional compensation for this workload, other providers recognized it as an important way to generate additional clients in the future.

➤ **Implementation Insight #2: Mobilizers and providers offered firsthand perspective on ways to expand the program's reach and impact.**

Mobilizers and providers alike felt that the guidance on who they should offer RAF cards to—adolescent girls ages 15-19 who had either received FP counseling or taken up a method—was limiting, and that they should be allowed to offer cards to older women and boys. They viewed these groups as other potential FP advocates to adolescent girls who could refer their daughters, neighbors, family members, and girlfriends to broaden the reach and impact of the program. Mobilizers also found that the RAF cards were an effective tool for referring non-FP users straight to the clinic. Although we did not initially intend for the materials to be used in this way, direct referrals using RAF cards are likely to have contributed to some of the increases in visits to clinics for FP counseling and methods.

"I have not ever given out a card to a boy because they are not in the program; however, I would advise for them to be included in the program, reason being they have girlfriends or friends who they can refer for those services."

–Service Provider

"I wish this program was for up to 25; getting teenagers is really a complicated thing but getting girls from that age and 25 is simple."

–Community Mobilizer

➤ **Implementation Insight #3: Discretion and anonymity are critical to the program's success and participants' safety.**

When designing the materials for this program, we intentionally created the materials to be recognizable and attractive to adolescents, while also ensuring discretion, given that concerns over visibility and privacy were identified as a significant barrier to FP uptake during diagnosis. Girls reacted very positively to the wristbands and design materials and expressed relief knowing that their name or personal information would not be included on cards or posters. They were willing to participate in the RAF program because they felt assured that they would not receive unwanted attention or reveal themselves as FP users to anyone they did not want to. While very few instances of undesired attention

or conflict were reported, anticipating and mitigating any risks to girls should remain a priority. If the program is adapted to other settings, the safety and comfort of the girls participating warrants special attention and may require adjustment of the materials or additional training for providers and mobilizers.

“Those I have ever issued RAF cards to, they straight away go to see the information and say, ‘actually this one is more attractive, hey look at this purple heart, this is more eye catching.’ They look at the floral decorations on the card.”
 –Service Provider

“After receiving the method, [the service provider] asked me if [she] could pin my card on the poster that had very many other cards and I said yes. She told me not to get worried because they do not write our names there.”
 –Adolescent Client

Implications and Recommendations

The results of a robust, multi-faceted evaluation of the peer referral and clinic welcome program show that it was well-received, context-appropriate, and impactful.

The program successfully addresses non-cost barriers to FP uptake, and is effective both where services are free and where they are not. This is notable, because it is tempting to focus first on structural barriers like cost and assume that behavioral interventions are best used only after those barriers have been eliminated. Although providers in clinics without vouchers noted that some girls who wanted to take up a method after receiving counseling were often unable to afford one, there were still significant increases in method uptake within those clinics. While a behavioral intervention such as this one may be most effective when services are free, our results underscore its potential even where resource constraints make it impossible to offer free services.

We also found that the program was most effective when it included the YFS training component that built providers’ skills, knowledge, and intention to offer youth-friendly care. However, we found that the program was impactful even without the additional, more costly training component. Again, this suggests that a streamlined, relatively low-cost program that encourages referrals and welcomes girls to clinics can increase access to FP even when the resources are not available for more intensive provider training.

Finally, in addition to the immediate effects on FP uptake, it is likely the program will have future impact by increasing exposure to the clinic environment and FP counseling. Ultimately, this will allow girls who are not yet ready to take up a method to envision themselves accessing FP services in the future. Based on this program’s demonstrated success, MSUG is expanding it to all social franchise clinics as well as other service channels in Uganda. MSI is exploring program adaptation to other country settings.

The results of this work underscore that empowering girls as peer advocates and offering a welcoming clinic environment can meaningfully improve access to important health services.