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Author(s): Maia Sieverding, Eric Schatzkin, Jennifer Shen and Jenny Liu

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Bias in Contraceptive Provision to Young Women Among Private Health Care Providers in South West Nigeria

By Maia Sieverding,
Eric Schatzkin,
Jennifer Shen and
Jenny Liu

Maia Sieverding is assistant professor of public health practice, Department of Health Promotion and Community Health, Faculty of Health Sciences, American University of Beirut, Lebanon. Eric Schatzkin is research analyst, and Jenny Liu is assistant professor of health economics—both with the Institute for Health and Aging, Department of Social and Behavioral Science, School of Nursing, University of California, San Francisco, USA. Jennifer Shen is health policy postdoctoral fellow, Institute for Health Policy Studies, School of Medicine, University of California, San Francisco.

CONTEXT: Health care providers' biases regarding the provision of contraceptives to adolescent and young adult women may restrict women's access to contraceptive methods.

METHODS: Two mystery client visits were made to each of 52 private-sector health care facilities and individual providers in South West Nigeria in June 2016. In one visit, the mystery client portrayed an unmarried, nulliparous adolescent, and in the other, the client portrayed a married adult woman with two children. During subsequent in-depth interviews, providers were read vignettes describing hypothetical clients with these same profiles, and were asked how they would interact with each. Descriptive analyses of mystery client interactions were combined with thematic analyses of the interview data.

RESULTS: In greater proportions of married-profile visits than of unmarried-profile visits, mystery clients reported that providers had asked about past contraceptive use and method preference; the opposite was true in regard to providers' using side effects to dissuade clients from practicing contraception. In in-depth interviews, providers expressed concerns about fertility loss among unmarried women who used hormonal contraceptives. Providers more commonly recommended condoms, emergency contraception and the pill for unmarried clients, and longer-acting methods for married clients. The restriction of methods was typically explained by providers of various backgrounds in terms of protecting younger, unmarried clients from damaging their fertility.

CONCLUSIONS: Provider bias in the provision of contraceptives to adolescent and young adult women in South West Nigeria may affect quality of care and method choice. Interventions to reduce provider bias should go beyond technical training to address the underlying sociocultural beliefs that lead providers to impose restrictions that are not based on evidence.

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Health care providers can have an important influence on adolescent and young adult women's contraceptive uptake and method choice.¹ In addition to such well-recognized features of high-quality contraceptive counseling as informed choice of methods, communication of complete information and positive provider-client interactions,² counseling that targets young women's specific needs offers an opportunity to improve this population's broader sexual and reproductive health outcomes.¹ However, in many contexts, including a number of Sub-Saharan African countries, young women who want contraceptives may encounter discouraging attitudes and practices from providers,^{3–6} which may limit their ability or willingness to seek care.

Among the many barriers that women face in obtaining contraceptive services, biases among providers can shape the patient-provider interaction and, ultimately, the contraceptive method chosen. Provider bias was initially understood primarily in terms of providers' discouraging the use of specific contraceptive methods among certain populations (e.g., unmarried or nulliparous women), largely on the basis of erroneous medical rationales.⁷ However, a more-nuanced, multidimensional

understanding of provider bias has been adopted by some practitioners and is implicit in peer-reviewed literature on the topic. In this expanded conception, provider bias may stem from factors beyond technical knowledge.⁸ In some Sub-Saharan African contexts, provider bias in contraceptive services has been shown to stem from providers' inadequate technical skills or lack of confidence in their skills.^{4,5} Biases may also result from personal beliefs.^{4,9–11} These beliefs may be related to the appropriateness of a certain method for a given population (e.g., perceiving the IUD to be appropriate only for multiparous women⁹) or the general provision of contraceptives for a given population (e.g., believing that contraceptive use among unmarried women promotes promiscuity^{10,12}). These biases may lead to young women having their access to contraceptives restricted for reasons not supported by evidence and to their being denied methods because of their age, marital status or parity.^{3,5,6,10,12–17}

Although a robust body of literature from Sub-Saharan Africa describes restrictions providers place on the contraceptive methods offered to young women, this evidence is largely based on provider self-reports (usually via surveys) and lacks the multidimensional understanding of provider

bias needed to effectively improve sexual and reproductive health services for adolescent and young adult women. Little evidence exists about how providers impose non-evidence-based method restrictions on young women in their actual clinical practice or on how these restrictions differ from those imposed on older women. In addition, relatively little is known about how provider bias may affect other dimensions of quality of care—such as provider-client interactions—that can substantially affect young women's contraceptive care-seeking behavior.

In Nigeria, where this study took place, previous research based on cross-sectional surveys indicates that many providers self-report negative attitudes toward providing contraceptives to young women.^{3,10,18} According to a study of public- and private-sector providers in six Nigerian cities, high proportions reported restricting access to certain methods on the basis of client's age (e.g., younger than 15), marital status or, less commonly, parity; however, the study did not directly explore providers' reasons for imposing these restrictions or their behaviors when confronted with a young female client.³

In this study, we conducted mystery client visits and in-depth interviews with private-sector providers in South West Nigeria to assess how and why they may treat young women seeking contraceptives differently than older, married clients. Through this comparative approach, we aimed to examine how differential care may affect aspects of counseling quality beyond method choice and to inform programmatic efforts to develop services more friendly to young women.

Study Context

Contraceptive prevalence in Nigeria is low: only 15% among married women in 2013, compared with 26% for Sub-Saharan Africa overall.¹⁹ Modern contraceptive prevalence among young married women and sexually active unmarried women is even lower (5% among 15–19-year-olds, and 13% among 20–24-year-olds). In 2013, unmet need for contraception was 13% among women aged 15–19 and 17% among women aged 20–24.²⁰ South West Nigeria is the region of the country with the highest contraceptive prevalence (38%) and lowest unmet need among sexually active unmarried women (13%). Nationally, 60% of modern contraceptive users in 2013 obtained their method from private-sector sources, including drug shops and pharmacies; the private sector is a more common source of oral contraceptives, emergency contraception and condoms than of such longer-acting methods as injectables.^{20,21} Users pay out of pocket for contraceptive products and services from private-sector providers. Price data from the South West is not available; however, national median private-sector prices for contraceptive products in 2015 were \$0.06 for a male condom, \$0.40 for a pack of oral contraceptive pills, \$1.00 for emergency contraception, \$1.50 for an injectable, and \$5.00 for an IUD.²²

This study was carried out in the context of monitoring and evaluating the introduction of a subcutaneous

version of the injectable contraceptive depot medroxyprogesterone acetate in South West Nigeria via social marketing. The method was designed to allow for self-injection, which has generated broad interest because of its potential to encourage contraceptive use among groups that often face barriers to access, including young women.²³ Because self-injection of the injectable had not yet been approved in Nigeria at the time of the study, the product was administered by providers. Even once self-injection is approved, the injectable will likely require a prescription and at least one initial interaction with a provider will be necessary to purchase it. Thus, understanding providers' views on offering contraceptives—particularly the injectable—to young women and how they interact with clients fitting this profile were main points of interest for the evaluation of the subcutaneous injectable introduction.

METHODS

For our analysis, we used data collected through mystery client (simulated patient) visits and in-depth interviews because of the methods' different advantages for understanding provider attitudes and behavior. Mystery client interactions can provide insight into actual provider behavior and quality of care in a manner that is more objective and less prone to social desirability bias than interviews.²⁴ In research on contraceptive services, mystery clients have been used to assess provider compliance with counseling guidelines, as in a study in Nigeria,²⁵ and to explore other dimensions of quality of care, including respectful treatment by providers²⁶ and such medical barriers to service as menstrual requirements.^{26,27}

However, mystery clients cannot provide depth of insight into why providers behave as they do. To better understand providers' behavior, we asked them in in-depth interviews to describe how they would behave in specific scenarios. Vignette-based interviews have been shown to be useful and cost-effective tools to assess provider decision making in various areas of health care.^{28,29} Although vignettes can be used to assess clinical quality, in this study, we followed literature using vignettes to assess provider bias toward certain types of clients.^{30,31} We used the vignettes to dissect provider attitudes toward young women seeking contraceptive services, and particularly to understand why they may treat young, unmarried women differently than older, married women similarly seeking services.

The study received ethical approvals from the Committee on Human Subjects Research at the University of California San Francisco and the National Health Research Ethics Committee, Ministry of Health, in Nigeria.

Selection of Providers

No overall register of private health care facilities was available in the study states, so for our sampling frame, we used the 205 private-sector health care facilities and individual providers (henceforth referred to as "providers") who

purchased the injectable from a social marketing organization in seven South West states in Nigeria (Ekiti, Kwara, Lagos, Ogun, Ondo, Osun and Oyo) and were enrolled in the broader monitoring and evaluation study. All enrolled providers were asked to record the number of injectable clients during the data collection period (March–May 2016); we excluded from the mystery client and in-depth interview activities 76 providers who did not provide data on their number of clients during this period, as well as two found to be public facilities.

Of the remaining 127 providers, 25 were clinics, maternity homes or hospitals (henceforth referred to as “clinics”); 20 were pharmacies; 25 were drug shops, known in Nigeria as patent and proprietary medicine vendors (PPMVs); and 57 were licensed community health workers (CHWs) who had been trained by the social marketing organization to proactively engage women in community-based settings, counsel them on method choice and provide contraceptive products. Whereas CHWs are individuals, drug shops and pharmacies may have one or several shop attendants, in addition to an owner-operator; the staff size of clinics can vary widely.

In addition, the provider types differ in their legal scopes of practice. Clinical providers (i.e., doctors, nurses and midwives) may offer all contraceptive methods, including long-acting methods that require insertion. Pharmacies may stock injectables, but are not permitted to administer them or other long-acting methods.³² PPMVs may only sell barrier methods and resupply oral contraceptive pills to women who already have a prescription. Although they are not permitted to stock or administer injectables in the shop, PPMV providers who hold a professional health degree that allows the administration of injections (e.g., a CHW) may do so outside of the premises. CHWs may provide short-acting methods and administer the injectable;³² however, the CHWs in this study were supplied only with the subcutaneous injectable. CHWs provided only contraceptive services,* whereas other provider types included in the study provided a wide range of services.

Our target sample was 15 of each provider type, for a total of 60. And because quality of care may be related to provider experience with contraceptives, we initially intended to further stratify the sample by subcutaneous injectable client volume. Few providers other than CHWs submitted their register data on time, however, and client volume was low or zero for many. Therefore, for pharmacies, PPMVs and clinics, we selected the 15 with the highest injectable client volume; this included some of each type that had few or no subcutaneous injectable clients. For CHWs, we stratified by subcutaneous injectable client volume—high (≥ 30), medium (10–29), low (1–9) and none—and then purposively selected CHWs to

obtain a mix of those with high, medium and low numbers of clients.

Mystery Client Visits

In June 2016, we conducted two mystery client visits to each provider: In one visit, a simulated patient portrayed a sexually active, unmarried woman aged 18 with no children who was enrolled in school and wanted to prevent pregnancy. In the other, an actor portrayed a married woman aged 28 with two children who was living with her husband and wanted to space her next birth. Both of the women portrayed were seeking a contraceptive method for the first time. The two visits were conducted on randomly chosen days at least one week apart, with different actors and a standardized script for each patient profile. Eight actors conducted visits (four for each profile), and all actors completed a four-day training and pretesting to ensure optimal standardization in behavior and reporting.

For visits, actors wore age-appropriate attire typical of middle-income women in the study area. Upon reaching the provider, they expressed interest in acquiring a contraceptive method and requested help, and then let the provider lead the interaction. If the provider did not discuss the subcutaneous injectable by the end of the conversation, actors specifically asked about the method before leaving. They did not purchase any products, and no exams were conducted. Providers were not informed of the mystery client visit ahead of time to avoid their modifying their behavior; the ethical review boards that reviewed the study waived the informed consent requirement for the mystery client visits on the grounds that it would have compromised the study and that the activity posed minimal risk for participants.

To avoid creating suspicion that could bias the results, actors were instructed not to request a specific provider or probe extensively about providers' identities. We can be reasonably sure that both mystery client actors visited the same individual provider for all CHWs and for most smaller clinics, pharmacies and PPMVs; however, actors of different profiles may have been attended to by different providers at larger facilities that employed multiple contraceptive health workers. We do not have data on staff size to determine at which facilities this may have occurred; thus, we focused our analysis on aggregate differences in how the two profiles were treated rather than on differences within individual providers. Pairs of mystery client visits were successfully conducted with 55 of the 60 selected providers. Following each visit, the actor involved completed a short, standardized survey administered by a survey manager that asked about her perceptions of how she was treated, which contraceptive methods the provider recommended or discouraged the use of, and whether she was given information on how to use the recommended methods and their potential side effects. To facilitate more accurate recall, the survey manager administered the surveys to the actors as soon as possible after the visit, out of sight of the provider.

*For providers other than CHWs, the social marketing organization engaged with them primarily through visits conducted by sales representatives who introduced providers to the organization and products. Sales representatives were responsible for developing their own sales visit routes based on local knowledge, under the supervision of a manager.

In-Depth Interviews

In August and early September 2016, a second field team conducted semi-structured, in-depth interviews with providers who completed both mystery client visits. In facilities with multiple providers or other staff, interviewers were instructed to interview the person who was most knowledgeable about the subcutaneous injectable and not to request a specific provider; thus, at those facilities, the provider who responded to the interview may have been different from the person or persons who attended to mystery clients. After briefly asking about the scope of family planning services offered by the provider, interviewers presented the following two vignettes corresponding to the unmarried and married mystery client profiles:

“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.”

“Now 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.”

After each vignette, interviewers asked providers what they would want to know about the woman to help her, what they would tell her about contraception and which method they thought was best for her. In-depth interviews were completed with 52 providers who had also completed two mystery client visits (Table 1); three CHWs could not be located for an interview.

Analysis

We adopted a mixed-methods analytical approach centered on two areas of counseling quality for which we had mystery client and in-depth interview data: provider-client interactions with a focus on information asked of and given to the client, and provider recommendations about method choice. Because we were unable to confirm mystery client visits and interviews were completed by the same individual provider, we focused our analysis on aggregate differences in how providers treated or said they would treat unmarried and married women across

providers, rather than on differences in individual providers’ behavior toward the two profiles or consistency in their responses across data collection methods.

We conducted descriptive analyses of mystery client survey data using STATA. For provider-client interactions, we analyzed responses related to questions asked and information given by the provider during the visit, and those that indicated whether the actor felt she was treated differently by the provider on the basis of her profile characteristics, including marital status and age. We also analyzed responses pertaining to the contraceptive methods recommended by the provider to the unmarried and married profiles.

For the in-depth interviews, we coded vignette responses using Dedoose. We developed an initial, structured list of codes corresponding to the areas of counseling quality (e.g., information asked about client, information provided to client, method recommended) captured in the mystery client data. To this initial list, we added codes that emerged from content domains found in the vignette responses. These domains were often on topics not easily evaluated in the mystery client interactions, such as the factors providers considered when making method recommendations. We used a parallel coding system in which all codes were used for both the married and the unmarried profile vignettes, allowing us better standards of comparison, even if certain codes were never used for one vignette or the other (e.g., as discussed below, condoms were never recommended as a contraceptive method for the married profile vignette). We assessed themes on providers’ self-reported behavior toward the unmarried and married profiles, and compared qualitative findings to quantitative responses measured by the mystery client survey.

RESULTS

Client Satisfaction and Perception of Bias

Mystery clients of both profiles reported being treated respectfully by the provider in the vast majority of visits (98% for married clients and 93% for unmarried clients; Figure 1). Unmarried mystery clients reported being asked about their age in 18% of visits and feeling that they had been treated differently because of their age in 16% of visits; for visits by married clients, those proportions were 5% for each. 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 the particular characteristic seemed to affect the provider’s interaction with her.

Information Requested from Clients

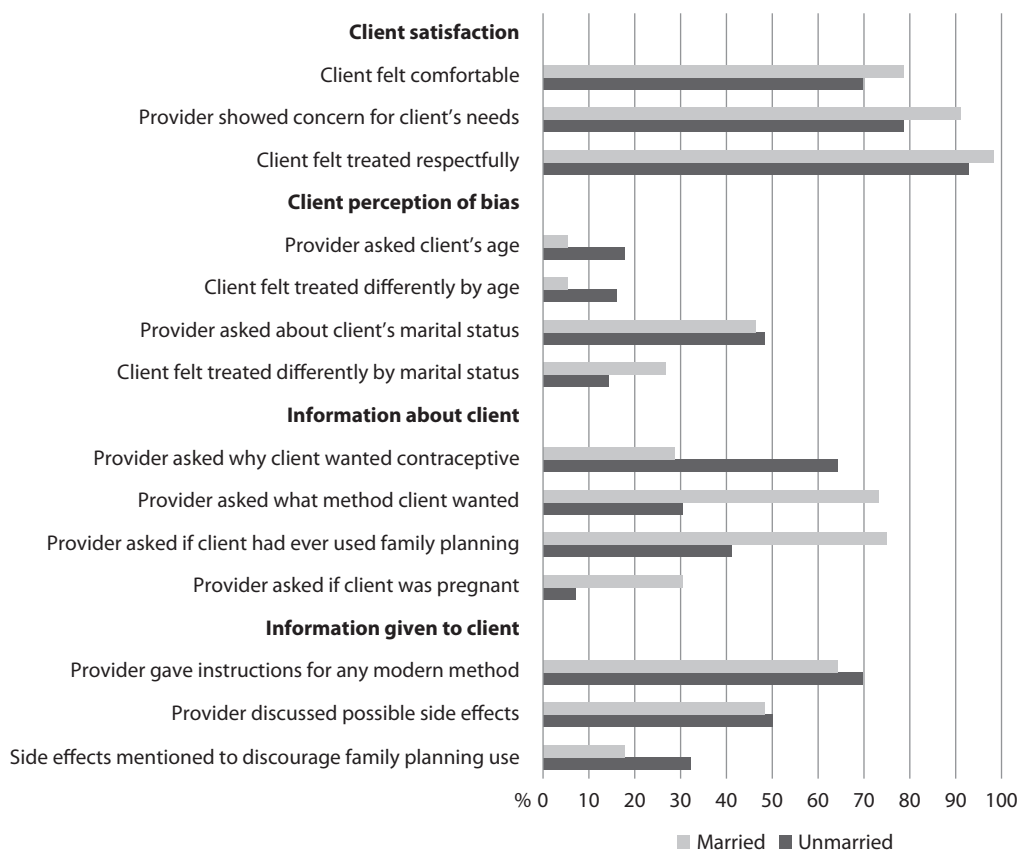
In greater proportions of married-profile visits than of unmarried-profile visits, clients reported that providers had asked about their histories, such as if they had ever used contraceptives (75% vs. 41%, respectively) and if they were pregnant (30% vs. 7%). In addition, married clients were asked what method they wanted in 73% of visits, whereas

TABLE 1. Sample of private-sector health care providers who participated in mystery client visits and in-depth interviews, by type, Nigeria, 2016

State	All	Pharmacy	PPMV	Clinic	CHW
Ekiti	7	1	3	1	2
Kwara	6	1	3	2	0
Lagos	21	9	5	4	3
Ogun	3	1	0	1	1
Ondo	3	0	2	1	0
Osun	4	1	0	3	0
Oyo	8	0	1	3	4
Total	52	13	14	15	10

Notes: PPMV=patent and proprietary medicine vendors. CHW=community health worker.

FIGURE 1. Characteristics of provider-client interactions, by mystery client profile



unmarried clients were asked their method preference in only 30% of visits. In contrast, unmarried clients were asked why they wanted a contraceptive in 64% of visits, whereas married clients were asked in only 29% of visits.

Providers' responses to the vignettes were consistent with the mystery client results in that more providers said that they would want information on the health status and contraceptive needs of the married client than of the unmarried client. Many providers said that they would want information about the married client's general health status—such as her pregnancy status, recent menstrual cycles, and weight and blood pressure—to inform method recommendation and screen for contraindications of certain methods; however, very few providers said that they would want this kind of information for the unmarried client. Similarly, many providers said that they would want information on the married client's past contraceptive use to help make a specific method recommendation—either more strongly considering methods that she had liked or tolerated well, or eliminating methods with which she had had a negative experience. For example, a provider at a pharmacy in Lagos said:

“I would ask certain questions from her. Has she used pill in the past? How does she react to pill? Some people take pill and [have adverse reactions]. Some people, it doesn't really work for them.”

Many providers also said they would want to know about desired birthspacing and total family size for the

married client to make a method recommendation. A pharmacist in Ekiti remarked:

“I will like to know when she wants to have another baby....I will like to know the number of children they will like to have in the family, so that I will be able to pick whether to use [a] two-months, three-months or monthly [method].”

In regard to the unmarried client, no providers mentioned the issues of the desired time frame for postponing pregnancy or current pregnancy status, and very few said that they would want to know about her past contraceptive use.

Another frequently mentioned question for the married client was whether she had permission from her husband to obtain a contraceptive.† Many providers indicated that they wanted such information to avoid situations harmful to their business. CHWs and providers at pharmacies and PPMVs were particularly likely to mention husband permission in the context of avoiding potential encounters with men upset that their wife was practicing contraception, along with a related desire to avoid creating intrafamilial conflict. Some providers who wanted to know about husband permission also indicated that they might not give contraceptives to a married woman without her husband's approval. For example, a PPMV in Ekiti said:

“I will tell her that I hope she is not just here in order to insult me or blame me if your husband should [find] out

†This topic was not included in the mystery client debriefing survey, so we are unable to compare it with the mystery client results.

that you are using contraception. I hope your husband will not come here to embarrass me.”

In contrast, the topic of partner permission came up only once in regard to unmarried clients. Instead, consistent with the mystery client results, providers focused on the nature of the unmarried client’s relationship and why she wanted a contraceptive. Many mentioned wanting to know about her frequency of sex and number of sexual partners, as well as details about how involved she was with her partner, including if she lived with him, if she planned to marry him and the extent to which he offered financial support. For example, a provider at a clinic in Oyo remarked:

“I will want to know, how often [do they have sex]? Do they live together? Is the partner a casual boyfriend? If he is a casual partner, then I will let her know about emergency contraceptives and condoms.”

Another clinical provider in Osun said:

“I will want to know her family background. If she is from a good home. Are the parents together? Is she well taken care of? And I would want to know why she has a boyfriend? Maybe that boy is the one assisting her in school, helping [to support] her.”

CHWs and clinical providers were somewhat more likely than providers at retail outlets to say they would want this kind of information from an unmarried client.

Information Given to Clients

In half of both unmarried- and married-profile visits (50% and 48%, respectively), mystery clients reported that the provider had discussed possible side effects of contraceptive methods (Figure 1); however, in 32% of unmarried-profile visits and 18% of married-profile visits, clients reported thinking that the provider mentioned side effects to dissuade contraceptive use. In in-depth interviews, many providers mentioned side effects when prompted about what information they would give to clients regarding contraceptives; however, the type of information providers said they would give differed by client profile. Providers of all types said they would inform the married client about expected side effects, including possible changes in menstruation and weight, and a few also mentioned delayed return to fertility. For example, a pharmacist in Lagos said:

“I will tell her about side effects, like the irregularity in menstruation, that some people will add weight and some people may lose weight. And I will also tell her that when she wants to get pregnant, once she stops taking it, it may take four or five months before she can actually get pregnant.”

For the unmarried client, a few providers said that they would warn about possible menstruation- and weight-related side effects; however, providers often focused on perceived fertility-related side effects of contraceptives—primarily hormonal methods, including the injectable. Many expressed concern that contraceptives might cause

not only delayed return to fertility, but infertility as well. A pharmacist in Lagos remarked:

“[Contraceptives] may not be good for [an unmarried client]’s health. It might cause harm to her. She may be taking it and may not know that it may affect her womb.... So instead of taking contraceptives, she could be using condoms.”

In addition, many providers said in in-depth interviews that they would tell clients about the benefits of contraceptives, but again, the type of information differed by client profile. Providers said they would inform married clients about the effectiveness of contraception, the health benefits of birthspacing and the freedom from worry about unplanned pregnancy. For example, a provider at a clinic in Oyo remarked:

“I will tell [the married client] that family planning is to help women space their children, not just to avoid being pregnant. I will counsel her that if she is able to space her children well, she should think of the benefits to her work and to her health.”

For the unmarried client, providers often said that they would explain the primary benefit of contraception as the prevention of abortion. Occasionally, providers indicated that they would tell unmarried clients that contraception was a way to retain agency and autonomy, but primarily in specific contexts, such as continuation of education. For example, a provider at a clinic in Oyo said:

“Family planning, that will help her to prevent pregnancy, because once you have an unwanted pregnancy... it might push [younger client] to go and get an abortion, which could endanger her life or damage her womb.”

Another clinical provider in Lagos said:

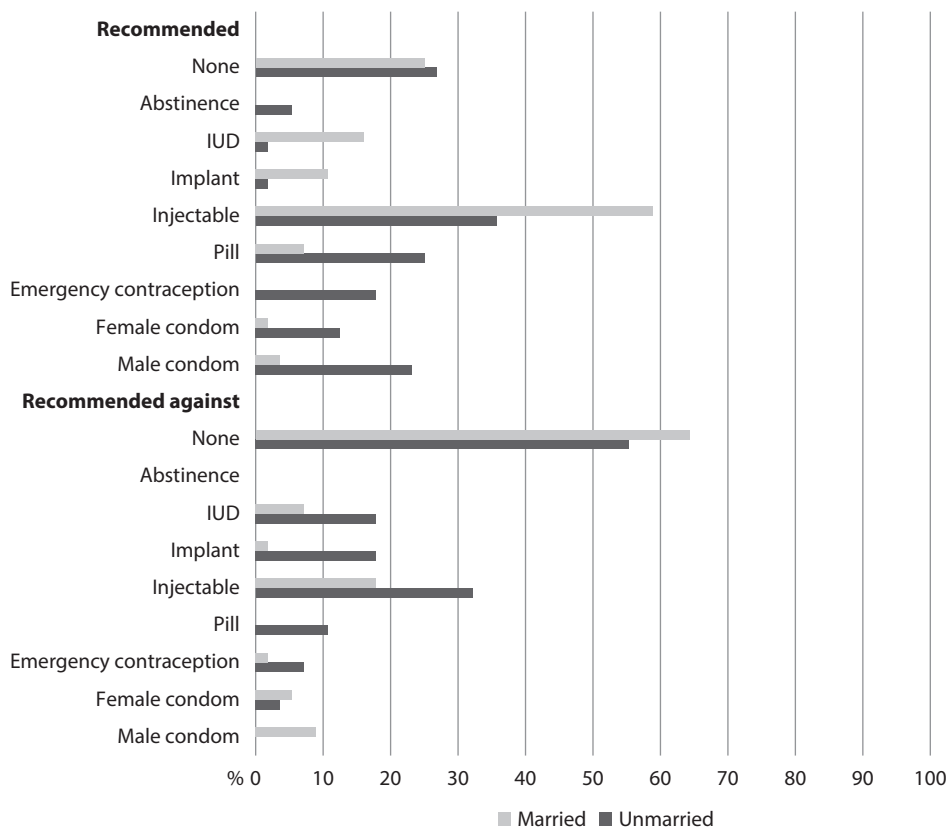
“Family planning can make [the unmarried client] live happily, enjoy her life and prevent unwanted pregnancy, while at the same time she can face her education.”

A small number of PPMVs also said they would mention prevention of STIs to unmarried clients as a secondary benefit of barrier method use.

Method Recommendations

In mystery client visits, providers selectively recommended contraceptive methods depending on whether women were married or unmarried. Barrier and other short-term methods were more often recommended to unmarried clients than to married ones. Unmarried clients reported that the male condom had been recommended in 23% of visits and the female condom in 13% of visits; among married clients, those proportions were 4% and 2%, respectively (Figure 2). In addition, in greater proportions of unmarried-profile visits than of married-profile ones, clients reported that the provider had recommended the pill (25% vs. 7%), emergency contraception (18% vs. 0%) and abstinence (5% vs. 0%). In contrast, in greater proportions of married-profile visits than of unmarried-profile visits, clients reported that the provider had recommended relatively long-acting methods, including the injectable (59% vs. 36%), the IUD (16% vs. 2%) and the implant (11% vs. 2%). In the majority

FIGURE 2. Providers' recommendations for and against certain methods, by mystery client profile



of married- and unmarried-profile visits (64% and 55%, respectively), clients reported that the provider had not discouraged the use of any particular method; however, in greater proportions of unmarried-profile visits than of married ones, clients reported having been discouraged from using any method except male condoms.

Overall, providers' method recommendations during in-depth interviews were consistent with the mystery client results. For the unmarried client, condoms were the method most commonly recommended by all provider types, except CHWs. Providers gave two main reasons for preferring condoms (both male and female). The first was dual protection against pregnancy and STIs, as described by a provider at a clinic in Oyo:

"I will tell her the importance of family planning because she is not safe by having unprotected sex. She is not safe from infection and she is not safe from pregnancy. And for that, family planning will take care of that. Most especially, condom will take care both."

The second main reason—which was common among clinics, pharmacies and PPMVs—was concern about hormonal methods causing delays in pregnancy or leading to infertility, as exemplified by a pharmacist in Kwara:

"Generally, introducing young girls to contraceptives who have not had any child before, I feel little bit reluctant to use it, because I have seen people that their fertility did not return after they stopped using the injectable....I would rather prefer her using condom, abstinence and emergency contraceptives."

In addition, some providers assumed that the unmarried woman in the vignette would be having infrequent sex, so it would be better if she used an on-demand method, such as condoms or emergency contraception. For example, a pharmacist in Lagos said:

"Of course she's still a student, [so] I don't expect her to be staying with a guy, so am not expecting them to be having sex all the time. [So] if she could convince the guy if he could use a condom...but if that is not working for her, another thing is to use [emergency contraception]."

A few providers also said that they would recommend that the unmarried woman use an on-demand method so as not to encourage her to have sex more often—something they believed that she might do if she used a longer-acting method. A pharmacist in Ekiti remarked:

"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 practicing sex when [they are] not supposed to, so I don't give it to them. The only advice I can give her if there is any at all is to have the [emergency contraception]."

Many providers who preferred a limited set of methods for the unmarried client also prefaced their method recommendations by saying that they would advise abstinence first, and would recommend a contraceptive method—usually condoms or emergency contraception—only if the client would not listen to them.

In contrast to most providers who viewed delayed fertility as a risk of injectable use for the unmarried client, some CHWs and PPMVs said that the injectable is a good method for the unmarried client because she would not wish to get pregnant soon. Some of these providers recommended the subcutaneous injectable specifically, because it is effective and can be taken discreetly. A PPMV in Oyo remarked:

“At that age, she might be feeling shy to tell a nurse to give her the injectable. But in this case, she will just go to buy the injectable [subcutaneous injectable brand] in a pharmacy or medicine store for her to inject herself without anybody knowing what she is doing.”

Finally, a very small number of primarily clinical providers said that they might recommend the IUD for the unmarried woman if she were in a monogamous relationship, because it is long-acting and nonhormonal. Very few providers recommended the pill—somewhat in contrast to the mystery client results—or the implant for the unmarried woman.

Providers' method recommendations for the married client were nearly opposite to those for the unmarried client. Similar to the mystery client results, the injectable was the method providers most commonly recommended for the married client, which is likely at least partly attributable to its being both the only longer-acting method offered by all study provider types and the method that CHWs were specifically trained to provide. Reasons for recommending the injectable included convenience, not needing to remember a daily pill and shorter protection duration. Some providers also said that they would recommend the subcutaneous injectable because it has a low dosage and clients reported experiencing fewer side effects. On the other hand, a small number of providers expressed concerns that the injectable would delay return to fertility and, therefore, recommended other long-acting methods for the married client. While providers of all types recommended the injectable for the married profile, some clinical providers also recommended the IUD; no providers mentioned condoms for the married client, and only a few mentioned emergency contraception or the pill.

Also, providers explained their method recommendations for the married client noticeably differently than for the unmarried client. Rather than focusing on the client's age or marital status, providers' main consideration for method choice for the married client was her desired duration for avoiding pregnancy. Providers also discussed a larger number of method options for the married client than for the unmarried client, including the injectable, the implant, the IUD and, sometimes, the pill. Moreover, providers discussed methods' relative advantages and disadvantages, such as their mode of administration or insertion and duration of efficacy.

The larger number of methods most providers considered for the married client corresponded with their stated interest in understanding her medical and family planning histories, as well as her spacing desires. This attention to individual factors that could affect the contraceptive needs of the married client was ultimately reflected in some

providers' view that she should choose a contraceptive method for herself, as exemplified by a CHW in Oyo:

“Since she [married profile] has already has two [children], I will tell her inform the husband if she wants to. But if she does not want to, I will introduce the kind of family planning that I have so that she can choose one for herself. I cannot choose for her.”

That method choice should be entirely up to the client was not mentioned by any of the providers when discussing the unmarried profile, although some providers mentioned that they would explain a range of available methods to the unmarried client.

DISCUSSION

Our findings demonstrate several ways in which private-sector providers in South West Nigeria treated young unmarried and older married contraceptive clients differently. Consistent with other studies from Sub-Saharan Africa,^{3,5,6,13} many providers supported restricting young unmarried women's use of certain contraceptive methods. In mystery client interactions and in-depth interviews, providers had the least restrictive attitudes toward providing young, unmarried, nulliparous clients with condoms and emergency contraception, and the most restrictive attitudes toward providing them with longer-acting methods; these findings corroborate those from a recent survey of public and private providers in Nigeria.³ In addition, we found that providers' behaviors and attitudes regarding contraceptive methods were more restrictive for young unmarried clients than for older married clients, for whom providers were willing to provide a wider range of contraceptives, including longer-acting methods.

Some of providers' restrictive attitudes toward unmarried clients may have resulted from their technical knowledge or lack thereof. For instance, the providers who in in-depth interviews recommended the IUD for the young unmarried client were mostly clinical providers—the only study cadre trained to insert the method. In contrast, PPMVs and CHWs were more likely than other provider types to recommend the injectable for the unmarried client; these providers have the most limited scope of practice, and CHWs were trained specifically to distribute and administer the subcutaneous injectable. In addition, it is important to consider that for-profit, private providers—such as the providers who made up our sample—may lose business if they recommend a method that they do not provide. This likely incentivizes lower-level cadres, for example, to be more open to providing unmarried women with the injectable. Similarly, clinical providers who can provide young women with the IUD and other longer-acting methods may be more inclined to do so because these products have a higher profit margin than short-term methods.

However, providers' responses to the vignettes suggest that many also had personal views about which methods were appropriate for unmarried clients. In particular, providers explained not giving hormonal contraceptives to unmarried women out of fear that such methods could

cause infertility; however, this was primarily for longer-acting hormonal methods, given that emergency contraception was commonly mentioned as a recommendation in in-depth interviews, and the pill was commonly mentioned during mystery client visits. Providers also demonstrated a degree of bias against the injectable in general, by expressing concerns over the method's impact on fertility for both married and unmarried women; other studies have similarly found high levels of provider bias against the method.^{3,12} Because the injectable has a higher price and likely a higher profit margin than shorter-acting methods, our findings suggest that personal beliefs may have weighed against profit motives in at least some of providers' decisions about method recommendation.

The sexual and health needs of unmarried young women can differ from those of older, married women. For example, providers' concern with dual protection and their recommendation of condoms is an important and legitimate aspect of contraceptive counseling for women at risk of an STI. Yet, the differences in how providers treated unmarried and married clients suggest that their personal biases also influenced quality of care beyond method choice. That providers in in-depth interviews said that they would ask the unmarried client about her relationship (i.e., why she had a boyfriend, number of partners) and would recommend that she practice abstinence suggests judgmental attitudes about the "type" of woman engaging in premarital sex. Providers' negative attitudes about premarital sex and their promotion of abstinence may make young women feel uncomfortable while seeking contraceptive services, or could discourage them from doing so at all.³³ At the same time, providers never raised concerns about dual protection for the married profile, even though it may be a valid concern if married women or their husbands have multiple partners. It is possible that lack of concern over dual protection for married women was related to the fact that in a higher proportion of visits by married clients than of those by unmarried clients, providers recommended against using condoms; however, further research is needed to interpret this finding. Likewise, some providers appeared to make assumptions about unmarried clients' contraceptive needs that could contribute to poorer technical quality of care: For example, providers were less likely to ask unmarried clients about their medical or contraceptive history, which could reduce the likelihood of identifying contraindications.

It is important to note, however, that providers often explained their restriction of methods in terms of a desire to protect unmarried clients from immoral behavior (e.g., premarital sex) or, more commonly, from methods they believed could damage fertility; they rationalized these restrictions on the basis of a mix of cultural and medical beliefs. A study of primarily public-sector providers conducted in Ghana in the mid-1990s found similar rationales for protecting unmarried clients through contraceptive service restrictions.¹² Furthermore, providers' reasons for denying young women certain methods did not appear to

vary by their clinical qualifications, which is consistent with results from a quantitative survey in Nigeria that found no relationship between in-service training and providers' likelihood of reporting that they would impose method restrictions.³ Together, these findings suggest that interventions to reduce provider bias in the provision of contraceptives to young women need to go beyond technical training to address some of the underlying sociocultural beliefs that lead providers to impose restrictions that are not based on the evidence. In addition to provider training on client-provider interaction and nonjudgmental approaches to adolescent clients, outreach to adolescents themselves and their communities is needed to build an environment that supports this population in seeking sexual and reproductive health services.^{34,35}

Limitations

Several limitations of our study should be noted. Mystery client visits were conducted before in-depth interviews to avoid providers' being exposed to the vignettes and developing expectations about seeing clients of different profiles that could bias the mystery client findings. Even so, providers at facilities with low family planning client volumes may have become suspicious during mystery client visits, which could have affected interview responses; however, to our knowledge, no such instances occurred during the study period. In addition, for facilities with multiple staff, we do not know if interviews were conducted with the same providers who participated in mystery client interactions. As a result, we could not compare providers' treatment of unmarried and married clients at an individual level; however, by conducting the data collection activities at the same facilities, we substantially reduced variation in the sample of providers for each activity.

In addition, our sample was not random, and consisted of mostly urban providers, because they were drawn from the sales records of a reproductive health social marketing organization. Also, the sample was made up exclusively of private-sector providers, and thus profit motives and scope of practice limitations for lower-level providers likely influenced method recommendations more than would be the case for public providers. Because no register of private health care facilities existed for the study states, it is not possible to determine how our sample differs from the overall population of facilities in these states; however, because providers in our sample had contact with a social marketing organization, they may have had more open attitudes about providing contraceptives to young women—particularly, the CHWs directly employed by that organization. The context of the in-depth interview data collection (i.e., part of a broader monitoring and evaluation for the introduction of the subcutaneous injectable) also may have influenced providers' discussions about method choice. This would likely have influenced providers to recommend the injectable instead of other methods, as would the fact that CHWs were specifically trained to sell and administer the subcutaneous injectable. Thus,

concerns about offering young women the injectable may be stronger among the general population of providers than among the providers in this study. Many of the providers in the study, however, did discuss methods other than the injectable with both married and unmarried clients.

Conclusions

Understanding the motivations behind providers' non-evidence-based restrictions on contraceptive services for young women is key to designing effective interventions to address them. Our findings build on recent discussions among practitioners in the contraceptive field and argue for broadening our understanding of what constitutes provider bias to include such factors as fear of doing harm and personal views on specific methods or populations that may lead to restrictions in contraceptive method offerings.⁸ It is also important to further expand research and interventions on provider bias toward outcomes beyond method choice, including aspects of technical and interpersonal quality of care that may affect access to contraceptives for different subpopulations. Interventions to address provider bias should go beyond clinical training to include topics such as fears of inadvertently doing clients harm and societal pressures that may make providers reluctant to offer the full array of contraceptives to young women.

REFERENCES

- Minnis AM et al., Provider counseling to young women seeking family planning services, *Perspectives on Sexual and Reproductive Health*, 2014, 46(4):223–231.
- Bruce J, Fundamental elements of the quality of care: a simple framework, *Studies in Family Planning*, 1990, 21(2):61–91.
- Schwandt HM, Speizer IS and Corroon M, Contraceptive service provider imposed restrictions to contraceptive access in urban Nigeria, *BMC Health Services Research*, 2017, 17(1):268.
- Paul M et al., Healthcare providers balancing norms and practice: challenges and opportunities in providing contraceptive counselling to young people in Uganda—a qualitative study, *Global Health Action*, 2016, 9:30283, doi:10.3402/gha.v9.30283.
- Nalwadda G et al., Constraints and prospects for contraceptive service provision to young people in Uganda: providers' perspectives, *BMC Health Services Research*, 2011, 11:220, doi: 10.1186/1472-6963-11-220.
- Tumlinson K, Okigbo CC and Speizer IS, Provider barriers to family planning access in urban Kenya, *Contraception*, 2015, 92(2):143–151.
- Shelton JD, Angle MA and Jacobstein RA, Medical barriers to access to family planning, *Lancet*, 1992, 340(8831):1334–1335.
- Carlough M and Jacobstein R, Five ways to address provider bias in family planning, *VITAL*, June 2, 2015, <https://www.intrahealth.org/vital/five-ways-address-provider-bias-family-planning>.
- Robinson N et al., Barriers to intrauterine device uptake in a rural setting in Ghana, *Health Care for Women International*, 2016, 37(2):197–215.
- Ahanonu EL, Attitudes of healthcare providers towards providing contraceptives for unmarried adolescents in Ibadan, Nigeria, *Journal of Family & Reproductive Health*, 2014, 8(1):33–40.
- Murphy MK et al., Interdependent barriers to providing adolescents with long-acting reversible contraception: qualitative insights from providers, *Journal of Pediatric and Adolescent Gynecology*, 2016, 29(5):436–442.
- Stanback J and Twum-Baah KA, Why do family planning providers restrict access to services? An examination in Ghana, *International Family Planning Perspectives*, 2001, 27(1):37–41.
- Sidze EM et al., Young women's access to and use of contraceptives: the role of providers' restrictions in urban Senegal, *International Perspectives on Sexual and Reproductive Health*, 2014, 40(4):176–183.
- Mané B et al., Emergency contraception in Senegal: challenges and opportunities, *European Journal of Contraception & Reproductive Health Care*, 2015, 20(1):64–73.
- Nyblade L et al., Perceived, anticipated and experienced stigma: exploring manifestations and implications for young people's sexual and reproductive health and access to care in North-Western Tanzania, *Culture, Health & Sexuality*, 2017, 19(10):1092–1107.
- Marlow HM et al., Postpartum family planning service provision in Durban, South Africa: client and provider perspectives, *Health Care for Women International*, 2014, 35(2):175–199.
- Godia PM et al., Sexual reproductive health service provision to young people in Kenya; health service providers' experiences, *BMC Health Services Research*, 2013, 13:476, <http://dx.doi.org/10.1186/1472-6963-13-476>.
- Adekunle AO et al., Adolescent contraception: survey of attitudes and practice of health professionals, *African Journal of Medicine and Medical Sciences*, 2000, 29(3–4):247–252.
- World Bank, Contraceptive prevalence, any methods (% of women ages 15–49), no date, <http://data.worldbank.org/indicator/SP.DYN.CONU.ZS?locations=NG-ZG>.
- National Population Commission and ICF International, *Nigeria Demographic and Health Survey 2013*, 2014, <https://dhsprogram.com/pubs/pdf/FR293/FR293.pdf>.
- Corroon M et al., Key role of drug shops and pharmacies for family planning in urban Nigeria and Kenya, *Global Health, Science and Practice*, 2016, 4(4):594–609.
- FPWatch Group, *FPwatch Study Reference Document: Nigeria, 2015*, Washington, DC: Population Services International, 2016, <http://www.actwatch.info/sites/default/files/content/publications/attachments/Nigeria%20FPwatch%202015%20Findings%20Full%20Report%20Final.pdf>.
- Williams RL, Hensel DJ and Fortenberry JD, Self-administration of subcutaneous depot medroxyprogesterone acetate by adolescent women, *Contraception*, 2013, 88(3):401–407.
- Fitzpatrick A and Tumlinson K, Strategies for optimal implementation of simulated clients for measuring quality of care in low- and middle-income countries, *Global Health, Science and Practice*, 2017, 5(1):108–114.
- Ugaz J et al., Impact of family planning and business trainings on private-sector health care providers in Nigeria, *International Perspectives on Sexual and Reproductive Health*, 2017, 43(2):51–65.
- Tumlinson K et al., Simulated clients reveal programmatic factors that may influence contraceptive use in Kisumu, Kenya, *Global Health, Science and Practice*, 2013, 1(3):407–416.
- Hardee K et al., Quality of care in family planning clinics in Jamaica. Do clients and providers agree? *West Indian Medical Journal*, 2001, 50(4):322–327.
- Veloski J et al., Clinical vignette-based surveys: a tool for assessing physician practice variation, *American Journal of Medical Quality*, 2005, 20(3):151–157.
- Dresselhaus TR et al., An evaluation of vignettes for predicting variation in the quality of preventive care, *Journal of General Internal Medicine*, 2004, 19(10):1013–1018.
- Haider AH et al., Association of unconscious race and social class bias with vignette-based clinical assessments by medical students, *Journal of the American Medical Association*, 2011, 306(9):942–951.
- Li L et al., Using case vignettes to measure HIV-related stigma among health professionals in China, *International Journal of Epidemiology*, 2007, 36(1):178–184.

32. Nigeria Federal Ministry of Health, *Task-shifting and Task-sharing Policy for Essential Health Care Services in Nigeria*, 2014, <http://afp.cg-dev2.com/sites/default/files/resources/Nigeria%20taskshifting%20policy-Aug2014%20REVISED%20CLEAN%20Approved%20October%202014.pdf>.

33. Wood K and Jewkes R, Blood blockages and scolding nurses: barriers to adolescent contraceptive use in South Africa, *Reproductive Health Matters*, 2006, 14(27):109–118.

34. Mmari KN and Magnani RJ, Does making clinic-based reproductive health services more youth-friendly increase service use by adolescents? Evidence from Lusaka, Zambia, *Journal of Adolescent Health*, 2003, 33(4):259–270.

35. Chandra-Mouli V, Lane C and 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, 3(3):333–340.

RESUMEN

Contexto: El sesgo de los proveedores de servicios de salud relativo a la provisión de anticonceptivos a mujeres adolescentes y adultas jóvenes puede restringir el acceso de las mujeres a los métodos anticonceptivos.

Métodos: En junio de 2016, se realizaron dos visitas de usuarias simuladas en cada uno de 52 centros de salud del sector privado y proveedores individuales en Nigeria sudoccidental. En una visita, la usuaria simulada representaba a una adolescente soltera y nulípara, y en la otra, la usuaria representaba a una mujer adulta casada y con dos hijos. Durante entrevistas a profundidad posteriores, se leyeron a los proveedores relatos describiendo usuarias hipotéticas con estos mismos perfiles, y se les preguntó cómo habrían interactuado con cada una de ellas. Los análisis descriptivos de las interacciones con usuarias simuladas se combinaron con los análisis temáticos de los datos de las entrevistas.

Resultados: Las usuarias simuladas reportaron que los proveedores habían preguntado en mayor proporción sobre el uso anterior de anticonceptivos y preferencia de método en las visitas con perfil de casada que en aquellas con perfil de soltera; lo opuesto ocurrió con respecto al hecho de que los proveedores se refirieron a los efectos secundarios para disuadir que las usuarias practicaran la anticoncepción. En las entrevistas en profundidad, los proveedores expresaron preocupaciones sobre la pérdida de fecundidad en las mujeres solteras que usaban anticonceptivos hormonales. Fue más común que los proveedores recomendaran condones, anticoncepción de emergencia y la píldora a las usuarias solteras, y métodos de más larga duración a las usuarias casadas. Típicamente, la restricción de métodos fue explicada por proveedores de diferentes antecedentes en términos de proteger a las usuarias más jóvenes y solteras frente a posibles daños a su fecundidad.

Conclusiones: El sesgo de los proveedores de servicios de salud en la provisión de anticonceptivos a mujeres adolescentes y adultas jóvenes en Nigeria sudoccidental puede afectar la calidad de la atención y la elección de métodos. Las intervenciones para reducir el sesgo de los proveedores deben ir más

allá de la capacitación técnica, para abordar las creencias socioculturales subyacentes que conducen a los proveedores a imponer restricciones que no están basadas en la evidencia.

RÉSUMÉ

Contexte: Les préjugés des prestataires de soins de santé concernant la fourniture de contraceptifs aux adolescentes et aux jeunes femmes peuvent restreindre l'accès des femmes aux méthodes.

Méthodes: Deux visites de « clientes mystère » ont été effectuées auprès de chacun des 52 établissements de soins du secteur privé et prestataires individuels dans le sud-ouest du Nigeria en juin 2016. L'une des 'clientes mystère s'est présentée comme étant une adolescente non mariée nullipare, et l'autre représentait une femme mariée mère de deux enfants. À l'occasion d'entretiens ultérieurs en profondeur, des scénarios décrivant des clientes hypothétiques répondant aux mêmes profils ont été lus aux prestataires, qui ont été interrogés sur leur interaction éventuelle avec chacune. Les analyses descriptives des interactions avec les clientes mystère ont été combinées avec les analyses thématiques des données obtenues lors des entretiens.

Résultats: En plus grandes proportions de visites à profil « mariée » que « non mariée », les clientes mystère ont déclaré que les prestataires les avaient interrogées sur leur pratique contraceptive passée et leur méthode préférée; les proportions étaient inverses concernant l'invocation par les prestataires des effets secondaires pour dissuader les clientes de pratiquer la contraception. Lors des entretiens en profondeur, les prestataires ont exprimé leurs inquiétudes concernant la perte de fécondité des femmes non mariées qui utilisaient la contraception hormonale. Ils recommandaient plus souvent le préservatif, la contraception d'urgence et la pilule pour les clientes non mariées, et les méthodes à plus longue durée pour celles mariées. La restriction des méthodes était généralement expliquée par les prestataires de différentes formations en termes de protection des clientes plus jeunes et non mariées contre un affaiblissement de leur fécondité.

Conclusions: Les préjugés des prestataires concernant la fourniture de contraceptifs aux adolescentes et aux jeunes femmes dans le sud-ouest du Nigeria peuvent affecter la qualité des soins et le choix de la méthode. Les interventions visant à contrer ces préjugés doivent aller au-delà de la formation technique, de manière à résoudre les croyances socioculturelles profondes qui conduisent les prestataires à imposer des restrictions sans fondement factuel.

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Author contact: ms299@aub.edu.lb