

Research Brief: Findings from formative research with first-time parents in two states of Nigeria

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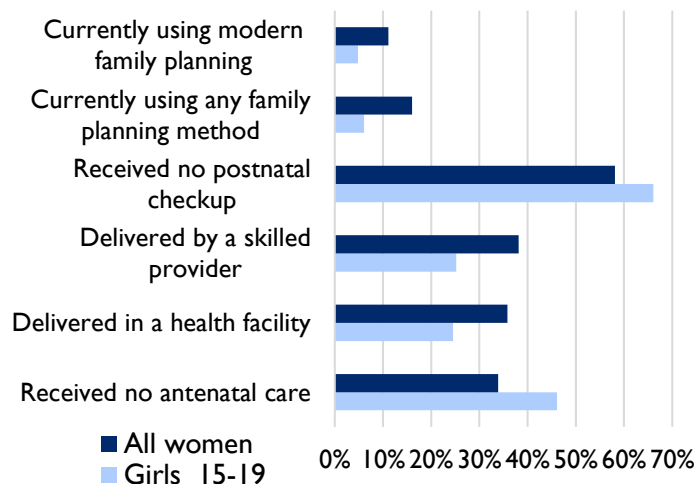
Background

Nigeria's population is young, with adolescents (aged 10-19 years) comprising about one-fifth of the total population (National Population Commission and ICF International 2014). Teen pregnancy is common; 41.3% of girls have begun childbearing by the age of 19 (National Population Commission and ICF International 2014). With a median birth interval of 26.3 months among adolescents (National Population Commission and ICF International 2014), many adolescent parents will soon become pregnant again with a second or third child. Use of key SRH services is lower among adolescent mothers than among all women (see Figure 1), making adolescent mothers and their children especially vulnerable to adverse outcomes. For example, 46% of mothers under 20 received no ANC, compared to 34% of all women. Fewer than 25% of adolescent mothers delivered in a health facility, compared to 36% of all women (National Population Commission and ICF International 2014).

Further, adolescents tend to have lower knowledge and use of contraceptives than older women. Although 9.8% of all married women use a modern method of contraception, only 1.2% of married adolescent girls do (National Population Commission and ICF International 2014).

Globally, adolescent pregnancy is associated with adverse health, educational, and economic outcomes for girls and their children. Women under 20 are twice as likely as older women to die during pregnancy or childbirth, and girls under 15 years are five times more likely to die during pregnancy or childbirth (World Health Organization 2011). Adolescent girls who become pregnant while in school are likely to curtail their education earlier than they would if they had not become pregnant, leading to long-term loss of economic opportunities (United Nations 1989). Children of adolescent mothers have a 34% higher risk of death in the neonatal period, and a 26% higher risk of death by age five (Bicego and Ahmad 1996; Moriarty et al. 2013). Further, about 250 of 1,000 adolescent pregnancies in Nigeria end in unsafe abortion; adolescents have 60% of the estimated annual 600,000 induced abortions (Isonguyo and Adindu 2013).

Figure 1. Use of sexual and reproductive health (SRH) services is lower among adolescents than



Source of data: National Population Commission and ICF International 2014

There is a clear need for interventions to connect pregnant and parenting young people to health services to increase their uptake of maternal and newborn care (MNC) and ANC services and promote healthy timing of a subsequent pregnancy. Yet in Nigeria and globally, few models/practices for reaching FTPs exist; most programs focus on delaying marriage or first pregnancy and do not target those who have already started their reproductive lives (Greene et al. 2014). Further, the few existing programs aim to increase use of family planning (FP) among FTPs, but there is also a need for programs that meet the broad SRH needs of FTPs, including ANC, MNC, and postnatal services beyond FP.

Formative Research

MCSP plans to implement an activity in Kogi and Ebonyi states in Nigeria to address the needs of pregnant and parenting adolescents, with the ultimate objective of increasing use of ANC, safe delivery, and PFP services to delay a subsequent pregnancy. To inform planning for this intervention, MCSP conducted formative research to understand the SRH needs of adolescent mothers in Ebonyi and Kogi states and the service gaps in the current system.

Research questions included:

1. What are the current SRH-seeking behaviors of pregnant adolescents and adolescent mothers, and how do they perceive their SRH needs as related to maternal health care, PFP, gender, and essential newborn care?
2. What are the key factors that affect the access to and use of SRH services from both public and private providers by adolescent mothers, pregnant adolescents, and their partners (demand- and supply-side barriers and facilitators/enablers)?
3. Which maternal, newborn, child health, and PFP promotion strategies are feasible and acceptable to adolescent mothers?

This brief represents the findings of an analysis of a subset of data collection questions and transcripts; full findings will be detailed in a comprehensive study report from the two MCSP-supported states (Ebonyi and Kogi) and four additional non-program-supported states (Bauchi, Cross Rivers State, Ondo, and Sokoto).

Methodology

MCSP conducted a qualitative, cross-sectional, descriptive study using FGDs and IDIs. Information about the attitudes and intentions of adolescents' older relatives (e.g., mothers-in-law) also provided an understanding of their influence over recently delivered adolescents. Ethical approvals were received from the Johns Hopkins University Institutional Review Board, the National Health Research Ethics Committee in Nigeria, and ethics committees for each respective state.

Data Collection Methods

Three groups of study participants were sampled:

- **Group 1:** Adolescent mothers and pregnant adolescents participated in either an FGD or IDI, depending on availability, held on different days.
- **Group 2:** Male partners of adolescent mothers and pregnant adolescents participated in FGDs.
- **Group 3:** Older influential female relatives (mother, mother-in-law, elder aunt, or guardian) participated in FGDs.

FGDs for first-time mothers and fathers explored perceptions of young couples that use SRH services and the support that young couples receive from their family and others throughout pregnancy and birth and for birth spacing. The discussion guides use a participatory method of asking participants to respond to a vignette

about a young couple. The IDIs with young mothers used a participatory influence mapping process to identify the individuals who were influential during their pregnancy and experience as a new parent.

Sample

The study was conducted in Kogi and Ebonyi states, where MCSP is currently implementing programs in collaboration with the Federal and State Ministries of Health and other partners. In each state, the catchment areas of the two health facilities in which MCSP works, representing urban and rural areas, were purposively sampled. These four pilot health facilities offer ANC, MNC, PFP, and postnatal care services; two of the four sites offer secondary-tier services (e.g., maternity services and permanent FP methods), and the remaining two sites offer primary-tier services. The study team enrolled a total of 305 study participants, as shown in Table 1.



Recruitment and Enrollment

All participants were recruited through snowball sampling and a voucher system. MCSP partnered with members of youth groups, community health extension workers, and health workers in the study areas, and provided vouchers to invite acquaintances or clients to participate in the study. Vouchers included information about how to contact the study team (by phone and in person) and volunteer for the study.

Male partners and older women were recruited to participate in the study when they gave consent for a younger adolescent to participate. They received an appointment for a later time and date. Additionally, once data collection was completed for the adolescent girls, they were asked to refer their male partner and/or an older female relative or non-relative whom they trust, respect, and look to for advice. The girls received appointment cards to give to the individuals they were to recruit. For all groups, a screening form was used to assess eligibility; the same consent process applied for both FGDs and IDIs.

Data Analysis

FGDs were recorded, transcribed, and translated from local languages (Ibo, Yoruba, and Igala) to written English, and a study team member took notes. Interviews were recorded, transcribed, and translated into English. Notes and transcripts were coded and analyzed in Atlas-ti 8.0 software.

To develop an intervention, the team conducted a discrete analysis to explore a subset of research questions identified as most relevant for programmatic purposes:

Table 1: Sample size		Total*
Focus group discussions (FGDs)		
Adolescent mothers/pregnant adolescents aged 15–17		4
Adolescent mothers/pregnant adolescents aged 18–19		4
Partners of pregnant adolescents/adolescent mothers		8
Parent/mother/older female relatives/guardian of pregnant or recently delivered girls aged 15–19		8
Total number of FGDs		24
Number of persons participating in FGDs		257
In-depth interviews (IDI)		
Pregnant adolescents/adolescent mothers aged 15–17		
Users of health services		12
Non-users of health services		12
Pregnant adolescents/adolescent mothers aged 18–19		
Users of health services		12
Non-users of health services		12
Total number of interviewees		48
Combined total number of participants		305
*Divided evenly by urban/rural in Kogi and Ebonyi.		

- Who influences adolescent mothers (positively or negatively) during pregnancy, childbirth, and the postpartum period, and how?
- What are other key factors that affect access to and use of SRH services from both public and private providers by adolescent mothers, pregnant adolescents, and their partners (supply- and demand-side barriers and facilitators/enablers)?
- Which changes or interventions could make young parents more likely to seek SRH services?

The research team developed a codebook and conducted content analysis for a total of 28 transcripts. The formative research will be replicated in the four additional states of Nigeria in 2017, with data from the six total states analyzed together, resulting in a comprehensive six-state study report.

Findings

Key influencers: Fathers

The baby's father was reported to influence various stages of pregnancy in multiple ways, such as providing (or withholding) money or material resources, doing domestic work, and carrying water. The father could be an active participant, if not the main decision-maker, in the choice of delivery place. In a few instances, participants mentioned the role of the father in providing emotional support. However, the provision of financial and logistical support was the predominant responsibility assumed by the father.

It is the responsibility of the husband to provide the money and again for the husband to be around. And his responsibility is to take the wife to the hospital and to be around when the wife will give birth to the baby. Then if the nurses want to send you on an errand, they can tell you to go and get this thing for your baby.

FGD with male partners, Ebonyi

The roles reported by young fathers and young mothers were different. Although young fathers in the FGDs often reported that they supported their partners with household tasks, young mothers reported that their partners' roles were often limited to financial and logistical support, when able, and influence in the decision about where to deliver and the use of PPF.¹ Other young mothers reported that their partners had abandoned them early in their pregnancy and were no longer involved.

We were on good terms, but as soon as he impregnated me ... he left me and ran away.

IDI with SRH service user, age group 15–17, Ebonyi

One participant explained that the young father's obligations to provide financially for his family could prevent him from assuming a significant role in parenting.

If the father has work at hand, he will not stay at home to help his wife because it is food that the child will eat and even the wife too will eat. The father is supposed to get up and look for a job. People will just be mocking him in the community, saying that the father has no job so the child will know him very well.

FGD with male partners, Kogi

The vignette in the FGDs featured a scenario in which the young couple did not agree on the number of children to have. This scenario, in particular, resulted in different responses from participants on the influence of the spouse/child's father, ranging from the husband convincing (and in limited situations, forcing) his preference on his wife, to mutual discussion/listening, or to the husband fully deferring to his wife.

Mothers and mothers-in-law

Mothers of adolescent girls described giving advice and guidance to their daughters pre-pregnancy about how to care for the home, and also advised them to avoid having sexual relationships to prevent pregnancy before they had finished their schooling and found a good husband. Mothers did not report providing information about family planning to their daughters before pregnancy occurred.

¹ The study design does not allow for systematic comparison of the roles reported between a matched sample of young mothers and their partners. Selection bias may be a key driver of this divergence, as young fathers who were available and willing to be involved in the formative research may differ from non-participants.

I tell them that once you start seeing your menses, you are now a woman, that any time you meet a man, you can get pregnant, and in having sexual intercourse with a man, you can get infections. I tell them that if they get pregnant, they will stop schooling and they will change and cause problems for themselves.

FGD with influential family members, Ebonyi

The adolescent mother's parents, specifically her mother, were also mentioned as significant influencers in various stages of pregnancy. Specific areas of support mentioned by study participants included providing advice before marriage, providing advice during pregnancy and guiding health decisions, doing domestic chores (e.g., washing clothes, fetching water), feeding the new mother, and providing a place for delivery.

When they deliver, I stay in their house for three months, bathing the child, cleaning the house for her so she can rest and so that she can enjoy having a mother around. I go to the market and buy things for them.

FGD with influential family members, Ebonyi

Mothers-in-law were also listed as a key resource for care during and after pregnancy, particularly if the girl's mother did not live nearby.

Like me, when I was pregnant, and when I went to deliver, my mother-in-law took care of me very well. She did not even allow me to lack anything. And my husband too tried his best to make sure I did not lack anything.

FGD with adolescent mothers, Kogi

Mothers, as well as mothers-in-law and other female relatives, are particularly influential in the choice of the delivery place; some encourage the use of the services of a traditional birth attendant (TBA) based on their own experiences and preferences.

These young people who give birth in these traditional places, it's not mostly them personally who woke up one morning and said, "I want to give birth in this traditional center or this place." It's those older people who are around them. Since the young people don't know, then also it's like they don't have a choice. So, when those older people suggest, "Hey, this is where I gave birth and this place was so perfect with everything for me," the young people don't have a choice so, they have to enter that road.

FGD with influential family members, Ebonyi

The mother's village or home may be a refuge for an adolescent mother as she approaches delivery time and during the postpartum period. However, the role of parents is not always positive; in some cases, the pregnant adolescent's parents punish her for the pregnancy.

If she went to school before, her mother will not support her to go again. She will not have free movement again, because now all her ways are not pleasing to her mother. So whatever she does will be wrong to the mother. There will not be love again. But later her mother will know that if you use the right hand to discipline a child, you will use the left hand to draw closer and will realize her mistake at the end of the day.

FGD with influential family members, Kogi

Other key influencers

Fathers and fathers-in-law were seen as particularly important as role models and mentors for young fathers.

They talk sense to him: "You are now a man, like us, so [...] you have to start behaving like us now, you are welcome to the family and to the world of fathers so you have to change your attitude."

FGD with male partners, Ebonyi

In a few cases, asking for money from friends or the broader family was discussed as a strategy for paying for services when the young mother or couple did not have access to funds.

I had my baby here [at the hospital] but I did not have money to pay the hospital bill. No one came to my rescue but my grandmother, who went to borrow money from her meeting to rescue me.

IDI with service user, age group 15–17, Ebonyi

Facilitators of SRH Service Uptake

First-time mothers, fathers, and their influencers often spoke of the perceived value of using health services to ensure the health of the young mother and her child. The use of ANC services was cited as an important opportunity to ensure the good health and development of the baby. Health facilities were perceived as having better trained staff and specialists capable of managing emergencies, surgeries, and sick newborns, as well as better equipment, particularly for delivery services. Many young parents expressed low confidence in TBAs or local herbalists due to lack of poor birthing instruments or care of instruments, lack of knowledge about how to treat complications or emergency situations during childbirth, and lack of timely referral to hospitals in an obstetric emergency.

I cannot recommend that [use of TBAs' services] because the TBAs will not be able to address all the complications from the delivery process. It will be at the last minute that they will ask the family to take her to the hospital and the unexpected may happen.

FGD with influential family members, Kogi

Question: *Why do some prefer a health facility?* **Response:** *Because the staff are educated very well ... about women or delivery or the way that the child is inside the womb; they will be able to manage it so that the baby will come out peacefully without any error.*

FGD with male partners, Ebonyi

Despite recognition of the importance of SRH service use among many participants, cost barriers and family influence often inhibited the use of services by young parents, even when they were convinced of the value of these services.

Barriers to SRH Service Uptake

Many participants cited costs associated with health services as the primary barrier to service uptake. Although health services are free in Nigeria, incidental expenses (such as gloves, syringes, and transportation), can be prohibitive, particularly for delivery, and can vary based on the situation.

Many participants contrasted these expenses with the costs of using the services of TBAs, whose services are overall less expensive and who often allow families to pay their debts over time rather than immediately.

It is money that determines things, because if there is no money, there is nothing. That is why someone goes to the TBA.

FGD with male partners, Kogi

Another key barrier to service use is the treatment of young parents by health facility staff. Young mothers and their partners reported that providers were stern and unfriendly and insulted them or did not provide attentive services.

They don't really take care of the young pregnant adolescents there [at the hospital] ... When you tell them you come for antenatal services, some nurses will look at you like you are too young. They don't really attend to you. That is why some of the adolescent mothers don't really want to go to the hospital or even for antenatal because instead of encouraging and giving advice, they [facility staff] will insult and abandon them.

FGD with adolescent mothers, Kogi

Program Implications

Participants shared ideas about which interventions or changes to current programs could best support young parents, particularly regarding fostering linkages to the health system. In alignment with participants' reports of the main barriers to SRH service use, mitigation of service costs featured most strongly.

What made us not go to the hospital is because they want to collect their fees and I have no money to give them. What I want is for the hospital to reduce its charges.

IDI with non-user, age group 15–17, Kogi

Participants shared a desire for education about pregnancy and baby care, with a preference for education in a group setting.

They should be teaching us ... it's not only for teenagers who will [deliver] in the hospital, but also ... they should organize something for women who gave birth during a certain period of time to come together. Let them teach them because some people don't know ... about children, so when they bring them, they will tell you what to do to make your child move to each stage, and ... what to do to help your child stay healthy ... At least once in a while they should organize a come-together.

FGD with 18–19 year olds, Ebonyi

The recommendation for group education and discussion sessions aligned with another key theme emerging from the data: some young mothers, particularly those who have been abandoned by the baby's father, expressed a sense of isolation and judgment from their families and communities related to their status as a teenage mother.

When she goes to the hospital, you see people ... talking about ... this small girl who got pregnant. They [assume] ... that she is just suffering with no husband.

FGD with male partners, Kogi

Male partners referenced a desire for education to include an emphasis on couple communication and conflict resolution to promote marital harmony.

I would like ... for them to educate us and enlighten us more and more ... [and] that should be the end of these disagreements within relationships.

FGD with male partners, Ebonyi

Other young mothers expressed a desire to return to school to complete their education and ensure a better life for themselves and their children. Although Nigerian law allows pregnant or parenting girls to attend school, in practice, the shame they feel based on family or community reaction, as well as limited time and resources, inhibits young mothers from continuing their education.

What I like is that, this education, it is very important for me. I like ... to go to school, so if they can help me continue my school I would be happy.

Rural IDI with non-user age 18–19, Kogi

Recommendations

Program Design

- Apply a **socio-ecological approach** to engage key influencers of young parents, particularly mothers and mothers-in-law, in addition to engaging young mothers and fathers directly and building the capacity of the health system to provide services that are friendly and attractive to young people.

Use a **gender-synchronized approach** to engage both young mothers and young fathers, addressing gender norms, building capacity for couple communication, and encouraging positive male involvement in PPF and parenting. Keep in mind the cultural context of marriage; for example, couples may live in union without a formalized marriage.

- Consider that the family and social situations of young mothers may vary significantly; information and **services must be tailored for girls** whose partners are not involved as well as those living in union.
- Leverage ongoing efforts to engage health workers for change to **ensure that the perspectives and needs of FTPs are represented**, from strategy development to program design and implementation.

Program Activities

- Conduct **advocacy activities to reduce or remove cost barriers** to service access, particularly for adolescent clients.

- Include an aspect of **social support**, particularly for young single mothers; group discussion sessions with other young mothers and pregnant girls may be an ideal venue to provide information about pregnancy, birth planning, PFP to delay a subsequent pregnancy, and baby care, as well as encourage SRH health-seeking and foster service linkages.
- Incorporate a **financial planning component**, such as a savings and loan scheme, to support currently pregnant girls to save for delivery costs and parenting girls to save for the costs of PFP services and/or a subsequent pregnancy.
- Support an **enabling environment** for first-time parents; advocate for the removal of social and cost barriers so pregnant and parenting teens can continue their education.
- Ensure that **health services are friendly and welcoming** to young people through whole-site training that addresses provider attitudes and beliefs, followed by facilitative supervision.
- Explore approaches to support young parents to **mitigate the burden of expenses** for delivery and baby care during pregnancy, such as village savings and loan schemes in the context of MNH.

Program Content

- Ensure that individuals with significant influence over young parents, particularly mothers and mothers-in-law, have **accurate information** about safe delivery; postnatal care, including PFP for healthy timing and spacing of pregnancy; and newborn care.
- Use messaging to **emphasize the benefits of health service use**, particularly the reduction of risk, to mother and baby.
- **Challenge attitudes and social norms** that stigmatize pregnant adolescents and young mothers.

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