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Factors Influencing Use of Health Services by First-Time Young Parents: Findings from Formative Research in Six States in Nigeria

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MCSP is a global USAID initiative to introduce and support high-impact health interventions in 25 priority countries to help prevent child and maternal deaths. MCSP supports programming in maternal, newborn, and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment. MCSP will tackle these issues through approaches that also focus on household and community mobilization, gender integration, and digital health, among others.

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Abbreviations

ANC	antenatal care
DHS	Demographic and Health Survey
ENC	essential newborn care
FGD	focus group discussion
FP	family planning
FTAF	first-time adolescent father
FTAM	first-time adolescent mother
FTYP	first-time/young parent
GBV	gender-based violence
IDI	in-depth interview
IEC	information, education, and communication
MCSP	Maternal and Child Survival Program
MNCH	maternal, newborn, and child health
PPFP	postpartum family planning
SRH	sexual and reproductive health
TBA	traditional birth attendant
TFR	total fertility rate

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Executive Summary

Study Design and Methods

This qualitative, cross-sectional, descriptive study used focus group discussions (FGDs) and in-depth interviews (IDIs) to investigate the dynamics related to sexual and reproductive health (SRH) care use patterns among first-time/young parents (FTYPs) in Nigeria. The aim of the study was to provide an understanding of the dynamics around the use of SRH care use among adolescents who just became mothers or were about to become mothers. The specific research questions included:

1. What are the patterns of current SRH service utilization among FTYPs, and how do young mothers perceive the need for maternal, newborn, and child health (MNCH) and postpartum family planning (PPFP) services?
2. What are the factors that influence FTYPs' access to and use of maternal health care, PPFP, and essential newborn care (ENC)?
 - Who positively and/or negatively influences MNCH and PPFP care-seeking behavior among FTYPs?
 - What are the demand-/supply-side facilitators and barriers?
 - What are the key factors that influence the use of MNCH and PPFP services?
3. What are the feasible, culturally appropriate programmatic change/intervention strategies that would most likely influence FTYPs to seek MNCH and PPFP services?

The study design enabled a comparison of similarities and differences among young mothers aged 15–17 and 18–19, their partners, and older female kin living in six states, one from each of the six zones of Nigeria, and in urban/rural settings. The adolescent sample was also drawn from those who were using health care at the time of the study and those who did not to allow for comparisons between the two groups.

Key Findings

To answer the study research questions, results are presented in two major sections: factors that act as facilitators of and factors that act as barriers to the utilization of MNCH, ENC, family planning (FP), and PPFP. Considering the various factors influencing health care use as either facilitators of or barriers to care simplifies how programs should be designed to influence change.

Facilitating Factors

Factors that facilitate use of health care include:

1. **Respectful staff and high quality of care (experienced or perceived)**
2. **Perceived need for care and beneficial health habits**
3. **Gender equality and empowerment**
4. **Support from people who influence first-time adolescent mothers (FTAMs)**
5. **Social capital**

Since perception of the need for care positively influences care use, it is classified as a facilitator of care in the results. A lack of perception of need, characterized by comments stating that there is no need for care during pregnancy, childbirth, or for FP, is classified as a barrier to care use. The third research question pertained to programmatic changes that will influence care use in this population.

Respectful Staff and High Quality of Care

Across states, the most commonly mentioned health system-related factors that influenced care use were personal satisfaction with care experience, a good reputation for high-quality care, and the relative benefits of a health facility versus an alternative treatment facility, especially for delivery. When stating that facilities were safer for delivery, comparisons were most commonly made with care provided by traditional birth attendants (TBAs), but other practitioners, such as herbalists and pastors, were occasionally mentioned. The positive way staff behaved with clients was not mentioned as something notable (with a few exceptions) because this was considered part of the good treatment they received.

Perceived Need for Care and Beneficial Health Habits

The decision to use care of any type is predicated on the perception of need for that care. In the case of preventive care during pregnancy, childhood, and for FP, communities and families need to understand the benefit of formal health care, even when they are not ill. For FTAMs in Nigeria, their partners and older female relatives must perceive the need for care. Otherwise, FTAMs will not receive it in the vast majority of cases due to their dependence on these people and lack of agency to advocate for their own preferences. This especially applies to maternal and newborn care; there were many descriptions of women who secretly obtained contraception, especially in the form of injections, but in other cases, women were dependent on people close to them for FP care as well.

Gender Equality and Empowerment

The majority of comments around gender pertained to the inequitable gender norms and roles that limit FTAMs' autonomy and enforce their dependence on partners, in-laws, and parents. Gender equality and empowerment have direct and indirect effects on the use of SRH care.

Support from People Who Influence FTAMs

Mothers, mothers-in-law, and male partners are heavily influential over FTAMs' health practices, including care seeking. Just as any person close to an FTAM may pose a barrier to care use, he or she may also be the force that facilitates use. The data show that partners, older female relatives, parents, and in-laws all act as barriers in some cases, but they can also facilitate care use. When people close to FTAMs understand the benefits of care, they are likely to help FTAMs seek care. These effects were observed in all states and in all groups. Clearly, it is important to include people close to FTAMs in interventions to increase care use, since FTAMs are often dependent on them and defer to their preferences.

Social Capital

Social capital is a form of social and economic power that an individual or group can leverage through social networks. Almost universally, FTAMs demonstrated little, if any, social capital. Part of this may be due to the fact that the study tools were not designed to measure social capital. However, there was enough evidence to indicate that FTAMs with social capital, even if it is an association with a group that has nothing to do with health, will use services more often if they desire them because of the social support and power that this confers on these young individuals.

Because the overall consensus among participants in all states is that pregnancy should happen within the context of marriage and that women should have completed their education and initiated their working life, girls who become pregnant in their adolescent years, especially those who become pregnant outside of marriage, are particularly vulnerable and lacking social capital.

Barriers to Health Service Use

Barriers to health service use include:

1. **Lack of preparedness for pregnancy and parenthood**
2. **Financial burden of care**
3. **Poor attitudes of staff, low quality of care (experienced or perceived), and stock-outs**
4. **Ambivalent views on the healthy timing and spacing of pregnancies**
5. **Negative views on FP methods and side effects**
6. **Low perceived need for care and harmful health habits**
7. **Stigma and shame around adolescent pregnancy and parenthood**
8. **Religious barriers**
9. **Gender inequality, the powerlessness of FTAMs, and dependency on partners, parents, parents-in-law, and other family**

Lack of Preparedness for Pregnancy and Parenthood

More young FTAMs (15–17) than older ones (18–19) expressed that they were unprepared for becoming parents. Marriage was an important mediator of how people reacted to adolescent parenthood: Among unmarried FTYPs, pregnancy provoked a certain level of distress in FTYPs and their relatives. Reactions in these cases ranged from young people being so highly stigmatized in the community that they were put out of their homes by parents, to stress and worry around what will happen; almost no one was happy. When FTAMs are married, there is some stress around them being so young, but respondents were mainly happy. Married FTAMs may experience difficulty with such an early pregnancy, but they have the support of their family and from community norms on demonstrated fertility; having a baby soon after marriage is important for married couples in Nigeria.

Financial Burden of Care

The cost of obtaining maternal health care was one of the most important barriers identified by FTAMs, first-time adolescent fathers (FTAFs), and older women across all states, regardless of urban or rural residence. Finances were not mentioned in reference to ENC, FP, or PFP. Although services are supposed to be free in Nigeria, costs incurred for obtaining maternal health care included transport to services, hospital fees, maternity kits to bring with them to the hospital, and drugs and other supplies.

For FTYPs who may not have started working or who were just beginning a job, the costs of care were prohibitive. The financial burden was exacerbated by the fact that almost all FTAMs are dependent on their partners and/or other family members for facilitating and paying for their care during pregnancy and delivery. In general, husbands are expected to be the primary caretakers of their wives, but since they were also very young, they often did not have the financial resources needed to pay for formal health service-related costs. The people on whom FTYPs were dependent also often lacked the money to cover the cost of care. Most respondents mentioned that they preferred to use TBAs over formal health care due to financial constraints of the couple or family. TBAs take less money, and they often take goods in kind for payment, such as cola nuts and soap. Since TBAs live in the community, there is no transport cost involved with using them.

Poor Attitudes of Staff, Low Quality of Care, and Stock-Outs

Health system-related barriers were almost always mentioned in reference to maternal health care, though stock-outs were sometimes mentioned in connection to FP services. The most common health system barrier mentioned was staff attitudes. Staff at health facilities, including doctors, nurses, and others, were described as rude, mean, and disrespectful to patients in general and adolescents in particular. Across states, FTAMs stated that they felt staff treated them differently than they did older women (those over 20 years old). Staff attitudes

induced shame and embarrassment related to patients' young age. FTAMs, especially those aged 15–17, also stated that they were not taken seriously at health facilities. This treatment of young patients was reported based on FTAMs' own experience, by witnessing what happened to their relatives, and through word of mouth about what happened to other people they knew.

Ambivalent Views on the Healthy Timing and Spacing of Pregnancies

Views around what constitutes a healthy timing and spacing of pregnancy were directly related to the perception of need for the use of FP. Most of the data in this area were connected to FP/PPFP, unlike the other themes, which related mainly to MNCH/ENC. Many respondents across states said something about spacing, but the time periods varied from 2 to 5 years. Some respondents stated that the timing of pregnancies is up to God.

Negative Views on FP Methods and Side Effects

Despite generally positive views about pregnancy spacing, views about and experiences with contraceptive methods were often negative and strongly influenced patients' decision to use them. Poor quality of care that included stock-outs and staff inattention were mentioned as factors that prevented women from using services and men from being motivated to get their partners to services. Most comments about contraceptive methods referred to short-acting methods (primarily pills and injectables). There were a few comments about implants, but no references to intrauterine devices were made. Injectables were by far the most commonly mentioned methods in any context. Participants discussed side effects they experienced that contributed to discontinuation and myths related to side effects that inhibited contraceptive uptake.

Low Perceived Need for Care and Harmful Health Habits

Both low perception of the need for health care and detrimental habits based on tradition rather than medical guidance result in potential harm to the mother or child. Both areas are critical to address in order to improve care uptake and health outcomes for mothers and babies.

Low perceived need was commonly expressed by all types of respondents by indicating a preference for using TBAs or that pregnancy and childbirth do not require intervention. There was little variation across states. Harmful health care habits also fell into fairly uniform responses. Around breastfeeding, giving water in addition to breastfeeding, and not giving the baby colostrum were mentioned everywhere. Taking various drugs and undefined substances during pregnancy was another common practice. The third main theme was around cord care after birth. There were many substances—toothpaste and Vaseline being the most common—that were applied to the cord.

The FTAM herself can act as her own barrier to care. Her perception of need or beliefs about something can create a barrier to care use for her. Some expressed fear of having a cesarean section without having given her consent or other fears, whereas TBAs are more familiar to FTAMs and their families and will not perform an intervention without a patient's consent.

Stigma and Shame around Adolescent Pregnancy and Parenthood

Across states, FTAMs commented that antenatal care (ANC) attendance involves being made fun of by staff and others at the clinic because the women are so young and already pregnant, regardless of marital status, but unmarried FTAMs suffered the most stigma. The expectation of being shamed is as a formidable deterrent to FTAMs seeking care. Most people in all respondent groups across states indicated that there is a difference between the way FTAMs, particularly the youngest and unmarried, are treated compared with older mothers.

Religious Barriers

Religious beliefs were most commonly mentioned as drivers of health behaviors in Sokoto and Ondo. Frequently, trust in God was cited as a reason for not using health services, particularly for delivery. In other examples, participants expressed fatalistic beliefs about the number and timing of children being determined by God.

Gender Inequality, the Powerlessness of FTAMs, and Dependency on Partners, Parents, Parents-in-Law, and Other Family

FTAMs have little power because of their age and sex. They are beholden to husbands, parents, and in-laws, and they have low status in society. Across states, gender roles pertain to a husband's duty to care for his wife and children. Among users, this means getting them to the facility, paying for care, and seeing that they get everything that they need (maternity kits, drugs, etc.). Among nonusers, it is getting her herbs and taking her to a TBA. Whatever kind of care is deemed appropriate, the husband is involved and has the primary decision-making power.

Programmatic Recommendations

The two most important barriers to care across states and all groups interviewed were the financial burden and the quality of health care. Finances posed a fundamental block to accessing care, as availability of money was part of the initial decision-making process. The many items and services that need to be paid for before delivery added up to a burden that could not be carried by many FTAMs and their families. When financial difficulties are combined with a bad experience at a health facility where people are treated with disrespect or where there are regular stock-outs of supplies and drugs, a formidable barrier to care exists.

Overall, there are several areas in which successful interventions can transform social norms and address systems barriers that limit service use among FTYPs. Important state differences must be reflected in specific programmatic responses within the general areas defined by the data. The sharpest differences are between the northern and southern regions. Most of the barriers identified can be addressed by ensuring that facilitating factors are expanded and appropriately targeted to FTAMs.

Reduce Financial Burden of Care

Develop vouchers or special funding streams for FTAMs to be used for ANC, delivery, ENC, and FP/PPFP. The existing voucher program for transport in Cross River and the free services there were well tailored for people's needs and could be a model for scale at the national level. Support for movements for universal health coverage and other health financing, including voucher schemes, in Nigeria and elsewhere could contribute significantly to reducing the financial burden of care for all, including FTYPs.

Address Social and Gender Norms that Stigmatize Adolescent Pregnancy and that Limit FTAMs' Decision-Making Power

While ensuring that influencers of FTYPs' health-related behaviors have accurate information is critical, programs must address the underlying gender and social norms that stigmatize young and adolescent mothers, and limit their ability to make decisions about home health care practices and health service seeking. Norms that fuel stigma, shame, and gender inequality, including FTAMs' powerlessness to make decisions over their own care, need to be addressed at the community and family levels to influence the uptake of care among FTAMs.

Ensure Caring Staff Behavior and High Quality of Care

To support FTYPs' continued use of ANC, facility-based delivery, and uptake of PPFP, all facility interactions must be positive. Support efforts to mainstream adolescent-responsive services through all service areas and across all facility staff, including clinicians and support staff, rather than investing in separate services for adolescents. To address health workers' negative treatment of young mothers, particularly those

who are not married, programs must identify the social norms that shape their behavior and those who influence their norms.

Prepare Adolescents for Pregnancy and Postpartum FP Using Age, Life Stage, and Other Segmentation Approaches

The importance of tailoring program response to the age and life stage of adolescents and youth is well understood; the unique needs of FTYPs are the focus of this research. Findings from this study further reinforce this point and shed light on the importance of efforts before and after pregnancy.

Because many FTYPs are unprepared for pregnancy and parenthood, they lack information to counter advice from family about potentially unhealthy practices. Invest in school- and community-based “life planning” programs that encourage adolescents to plan their future, and inform them about the healthy timing and spacing of pregnancy (including the first pregnancy) and the role of contraception in achieving life goals. Identify and expand existing programs to include training on physiological and emotional changes to be expected, good baby care, healthy timing and spacing of pregnancy, contraceptive options, and the importance of health care during all reproductive life stages.

A group-based approach has been shown to be important for providing social support for FTAMs, who may be stigmatized and socially isolated. Activities with pregnant and parenting adolescents should provide also information about physiological and emotional changes to be expected, good baby care, healthy timing and spacing of pregnancy, contraceptive options, and the importance of health care during all stages. Programs should consider including a component of financial literacy and/or savings and loans to help FTYPs prepare financially for pregnancy and parenthood.

When present, involve male partners in activities and highlight the positive role of fathers during pregnancy, delivery, and postpartum. However, recognize that program approaches may need to be tailored according to FTAMs’ marital status, as inviting male partners/husbands to participate in group discussions may further isolate the FTAMs who are not partnered.

Social capital will also contribute to the empowerment of FTAMs and decrease their dependency on partners and others by creating a supportive, trusted network of people they can rely on in times of need. During the design phase of projects to reach FTYPs, consider mapping local systems and platforms that can facilitate efforts to build FTYPs’ social capital.

Consider the Holistic Needs of FTYPs

FTYPs, particularly FTAMs, in Nigeria have limited use of health services and use unhealthy practices because they lack influence over their own decisions and because of cost barriers. Much of FTAMs’ powerlessness stems from lack of education and financial resources. Connecting FTAMs with education and livelihood opportunities could help mitigate cost barriers and provide FTAMs with leverage to negotiate decision-making with partners and family. Education and work were the two pivotal elements identified as driving girls’ empowerment in Nigeria.

Improve Understanding of the Role of FP and Choice of Available Methods

Build on social norms that strongly support the ideal of pregnancy spacing for the health of mother and baby, and the harmony of the entire family. Include accurate information about available FP choices and their side effects in community programs reaching FTYPs and influential family members. Encourage satisfied users to share testimonials about their experience with FP methods to counter pervasive rumors about side effects.

Background: Adolescent Sexual and Reproductive Health in Nigeria

In Nigeria, the total fertility rate (TFR; the average number of children that women are expected to bear in their lifetime) in 2013 was 5.5 children, one of the highest in the region. Within the country, the TFR was highest in the northern zones, ranging from 6.3–6.7, and lowest in the southern zones, ranging from 4.3–4.7. The Nigerian population is young. Adolescents (aged 10–19 years) comprised about one-fifth of the total population. Almost one-fifth (17%) of women aged 15–24 had initiated sex by age 15. Adolescent pregnancy is high, with 23% of women aged 15–19 having had at least one child. Levels of adolescent pregnancy reflect the country's fertility rates, ranging from 36% of adolescents in the north having begun childbearing before the age of 19, compared with 8% in the south. Across the country, 32% of adolescents living in rural areas were mothers, compared with 10% of those in urban areas.¹

In Nigeria, use of key SRH services is lower among adolescent mothers than among all mothers, making adolescent mothers and their children especially vulnerable to adverse outcomes. With a median birth interval of 26.3 months, many adolescent mothers soon become pregnant again with a second or third child. Adolescents also tend to have lower knowledge and use of modern contraceptives than older women in a country with already very low rates of utilization. For example, among all married women, 9.8% use a modern method of contraception, and only 1.2% of married adolescent girls do. Among mothers under 20 years old, 46% received no ANC, compared with 34% of all women, and less than 25% of adolescent mothers delivered in a health facility, compared with 36% of all mothers.²

Pregnancy during adolescence is associated with adverse health, educational, and economic outcomes for young women and girls. The health consequences of early pregnancy and childbirth are well documented in lower- and middle-income countries. Women under 20 years old are twice as likely to die during pregnancy and childbirth compared with women over 20, while girls below age 15 are five times more likely to die as a result of similar causes.³

Education has been noted as a critical factor influencing good maternal and child health outcomes for decades. In a study using four waves of nationally representative data in Nigeria, women's education was associated with older age at marriage, higher demand for FP, decreased child mortality, and decreased adolescent fertility.⁴ Adolescent girls who become pregnant while in school have a high probability of curtailing their education earlier than they would if they had not become pregnant. Children of adolescent mothers have a 34% higher risk of death in the neonatal period and a 26% higher risk of death by age 5. Tailoring health care services to the needs of adolescents is important to ensuring access and leads to improved health outcomes.⁵

Nigerian adolescents in particular face major barriers to accessing contraceptives, including gender inequality, discrimination against unmarried clients and youth by service providers, a lack of sex education in schools, and strong religious pressure, leading to high fertility and poor health outcomes for women.

¹ National Population Commission (NPC) [Nigeria] and ICF International. 2014. *Nigeria Demographic and Health Survey 2013*. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.

² NPC [Nigeria] and ICF International. 2014. *Nigeria Demographic and Health Survey 2013*. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.

³ World Health Organization (WHO). 2011. *WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Health Outcomes among Adolescents in Developing Countries*. Geneva: WHO.

⁴ Westoff CF, Ejemi CL. 2016. *Trends in Reproductive Behavior in Nigeria, 2003–2013*. Rockville, Maryland, USA: ICF International.

⁵ Moriarty Daley A, Sadler LS, Dawn Reynolds H. 2013. Tailoring clinical services to address the unique needs of adolescents from the pregnancy test to parenthood. *Curr Probl Pediatr Adolesc Health Care*. 43(4):71–95. doi: 10.1016/j.cppeds.2013.01.001.

Research shows that Nigerian men often control household assets and decision-making, and often do not understand the lifesaving benefits of healthy timing and spacing of pregnancies, the importance of ANC, or delivering in a facility. They are thus reluctant to give their female partners permission and money to access facilities. About one-third of urban Nigerian women in union (married or cohabiting) do not have access to income on their own. Women who have access to money of their own are significantly more likely to use modern FP methods than women who do not. The same study also reported that women who have access to their own money are significantly more likely to have had a skilled attendant present at their last birth or to give birth in a facility.⁶

⁶ Corroon M, Speizer IS, Fotso JC, et al. 2014. The role of gender empowerment on reproductive health outcomes in urban Nigeria. *Maternal Child Health J.* 18(1):307–15. doi: 10.1007/s10995-013-1266-1.

Methodology

Using qualitative methods, this formative research explored the context of these issues in detail among younger (aged 15–17) and older (aged 18–19) adolescent girls who were first-time parents, their partners, and their older female relatives. The purposive sample of participants was drawn from urban and rural areas in six states, one from each of the six geopolitical zones in Nigeria. The aim of the research was to inform interventions to improve MNCH outcomes among FTYPs by demonstrating how to increase the uptake of MNCH and PPFP service utilization among them. The study design and methods are described in the next session. Results focusing on the factors that explain the patterns of SRH care use among adolescents follow. Finally, programmatic recommendations based on the findings of this research are presented.

This formative research was conducted with the goal of improving the uptake of SRH services, and thereby maternal and child health outcomes, among FTYPs. The study was conducted among adolescents aged 15–19 who were either currently pregnant or had recently given birth to their first or second child in six states located in the six geopolitical zones of Nigeria: Bauchi in the North East, Cross River in South South, Ebonyi in South East, Kogi in North Central, Ondo in South West, and Sokoto in North West. The research was carried out to inform the design of effective, feasible, and culturally acceptable interventions that will lead to more FTAMs using SRH services during the pregnancy, birth, and postpartum periods in these areas of Nigeria.

Study Aims and Research Questions

Specific Aims

- Describe current patterns of SRH services-seeking behavior and the perceptions of the need for SRH care among FTYPs.
- Identify the factors affecting access to and use of SRH services among FTYPs, including demand- and supply-side facilitators and barriers.
- Recommend effective, feasible, and culturally acceptable MNCH and PPFP promotion strategies.

Research Questions

1. What are the patterns of current SRH service utilization among FTYPs? How do these young mothers perceive the need for MNCH and PPFP services?
2. What are the factors that influence FTYPs' access to and use of maternal health care, PPFP, and ENC?
 - Who positively and/or negatively influences MNCH and PPFP care-seeking behavior among FTYPs?
 - What are the demand-/supply-side facilitators and barriers?
 - What are the key factors that influence the use of MNCH and PPFP services?
3. What are the feasible, culturally appropriate programmatic change/intervention strategies that would most likely influence FTYPs to seek MNCH and PPFP services?

Study Design and Sampling

This was a qualitative, cross-sectional, descriptive study using data from FGDs and IDIs. The sampling allowed for comparisons between young mothers aged 15–17 and those 18–19, their partners, and their older female kin living in the six geopolitical zones of Nigeria and in urban/rural settings. Information was obtained about attitudes and beliefs connected to early parenting, timing and spacing of pregnancy, social pressures about childbearing, patterns of infant care, and factors relating to family size. Information was collected from adolescents' older relatives (e.g., mothers-in-law) and partners on attitudes and beliefs to provide an understanding of their influence on adolescents who just became mothers or were about to become mothers. The adolescent sample was also divided by those who used health care services and those who did not to allow comparisons between the two groups.

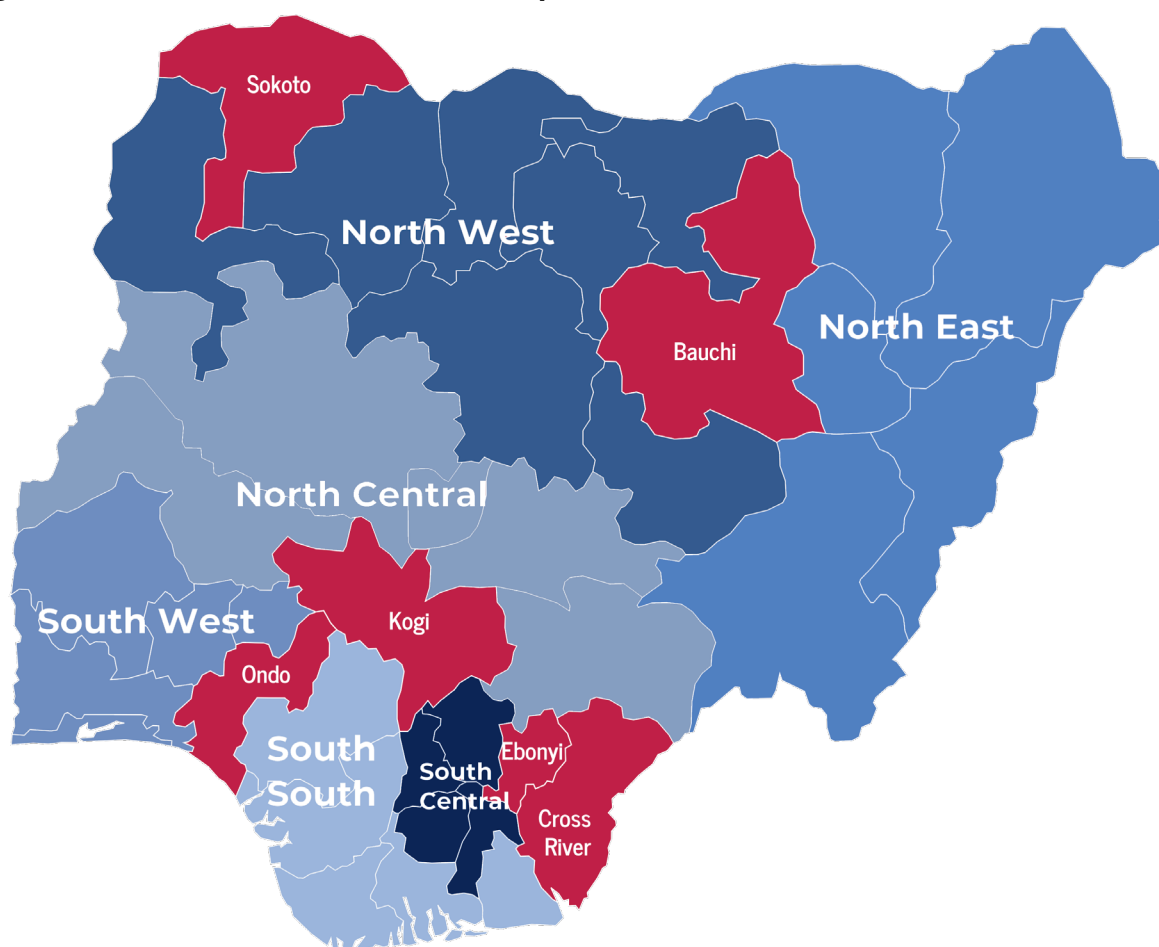
Study Setting

The study took place in six states, representing each of the six geopolitical zones in Nigeria:

Table I. Study sites and languages

State	Zone	Rural Site	Urban Site	Language
Bauchi	North East	Itas Gadau	Bauchi	Hausa
Cross River	South South	Obudu	Calabar	Ibibio and Bete (rural)
Ebonyi	South East	Afikpo	Abakaliki	Igbo
Kogi	North Central	Egbe	Lokoja	Yoruba and Igala
Ondo	South West	Ikare	Ore	Yoruba
Sokoto	North West	Tangaza	Sokoto	Hausa

Figure I. States and zones from which respondents were selected



Demographic data show significant variations in fertility and key health indicators across these states (see Table 2). Use of key health services, including contraception, ANC, and facility-based delivery services, is generally lower in the two northern, majority Muslim states of Bauchi and Sokoto.

Table 2. Key demographic and health indicators by state

	Total Fertility Rate¹	Current Modern Contraceptive Prevalence Rate (married women 15–49)²	Received Antenatal Care from a Skilled Provider²	Delivered in a Health Facility²
Bauchi	5.4	2.1%	69.3%	19.3%
Cross River	4.7	14.4%	79.4%	39.0%
Ebonyi	5.9	5.6%	83.8%	60.8%
Kogi	4.4	8.5%	96.7%	80.2%
Ondo	4.7	20.4%	84.3%	56.0%
Sokoto	4.1	0.7%	30.1%	5.3%

¹ National Malaria Elimination Programme (NMEP), National Population Commission (NPC), National Bureau of Statistics, ICF International. 2016. Nigeria Malaria Indicator Survey 2015. Abuja, Nigeria, and Rockville, Maryland, USA: NMEP, NPC, and ICF International.

² NPC [Nigeria] and ICF International. 2014. Nigeria Demographic and Health Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.

Recruitment

In each state, two health facility catchment areas were purposively selected—one each from urban and rural areas. Participants were recruited as follows:

- **Group 1:** Adolescent girls (15–19 years old) who were pregnant or had given birth in the last 12 months
- **Group 2:** Spouses or male partners of adolescent girl participants, recruited with their permission for a separate discussion group
- **Group 3:** Mothers or other older female relatives of adolescent girl participants, recruited with their permission for another separate discussion group

Participants were recruited through respondent-driven sampling and a voucher system. MCSP partnered with youth group members, community health workers, and facility-based health providers, who were given vouchers to invite their acquaintances or clients to participate in the study, along with information on the eligibility criteria for participants. The health care workers involved in recruitment explained that study participation was voluntary and had no impact on their ability to access health services. Youth groups received training on how to recruit volunteers in a noncoercive way. Participants were sought from a variety of backgrounds, in and out of school, and from a variety of neighborhoods and socioeconomic settings.

Each study participant was given vouchers to invite their acquaintances. Those found eligible were invited to participate in an FGD or IDI. Study participants also provided names and telephone numbers of other potential participants to the study team. Once data collection was completed for adolescent girls, they were asked to refer their male partner and/or a senior woman relative or nonrelative whom they trust, respect, and look to for advice.

Respondents

Table 3 summarizes the number of IDIs and FGDs conducted by state, rural/urban area, and participant type (adolescent mother, fathers, older women). In total, 72 FGDs were conducted, including 24 with adolescent mothers, 24 with fathers, and 24 with older women; 140 IDIs were conducted with adolescent mothers, including users and nonusers of health facilities. The sample was nearly equally divided among rural and urban participants.

Table 3. Final analytic sample of in-depth interviews and focus group discussions

		No. of Focus Group Discussions Conducted				No. of In-Depth Interviews Conducted			
State		Mothers (15–17 yrs)	Mothers (18–19 yrs)	Fathers (15–24 yrs)	Older Women	Mothers (15–17 yrs)	Mothers (18–19 yrs)		
						Non-User	User	Non-User	User
Bauchi	Urban	1	1	2	2	3	3	3	3
	Rural	1	1	2	2	3	3	3	3
Cross River	Urban	1	1	2	2	3	3	3	3
	Rural	1	1	2	2	2	3	2	3
Ebonyi	Urban	1	1	2	2	3	3	3	3
	Rural	1	1	2	2	3	3	3	3
Kogi	Urban	1	1	2	2	3	3	3	3
	Rural	1	1	2	2	2	2	3	3
Ondo	Urban	1	1	2	2	3	3	3	3
	Rural	1	1	2	2	3	3	3	3
Sokoto	Urban	1	1	2	2	3	3	3	3
	Rural	1	1	2	2	3	3	3	3
TOTAL		12	12	24	24	34	35	35	36

Tools

Four tools were used: three FGD guides and one IDI guide. The tools used in this study, along with others, have been packaged into a toolkit now available from MCSP.⁷ The numbers of the tools listed below that were used for this study correspond to the numbers in the toolkit.

FGD Guides

- **Young mothers and pregnant women who were nonusers of services (FGD Tool 1) and young fathers and fathers-to-be (FGD Tool 2):** These FGD guides explored perceptions of young couples who did not use SRH services and the support that young couples receive from their family and others throughout pregnancy, birth, and around birth spacing. The guides used a participatory method of asking participants to respond to a vignette about a young couple. The story focused on a young pregnant woman named Onyinye (for southern state participants) or Aisha (for northern state participants) and her husband, Tunde (in the south) or Musa (in the north), as they navigated their first experiences with pregnancy, preparation for delivery, and new parenthood. The facilitator paused at key points in the story to ask participants how they thought Onyinye/Aisha, Tunde/Musa, and their families and friends would feel when learning about the pregnancy; how they would make decisions about seeking ANC; choosing the place of delivery, baby care, and PFP; and who would influence their decisions.

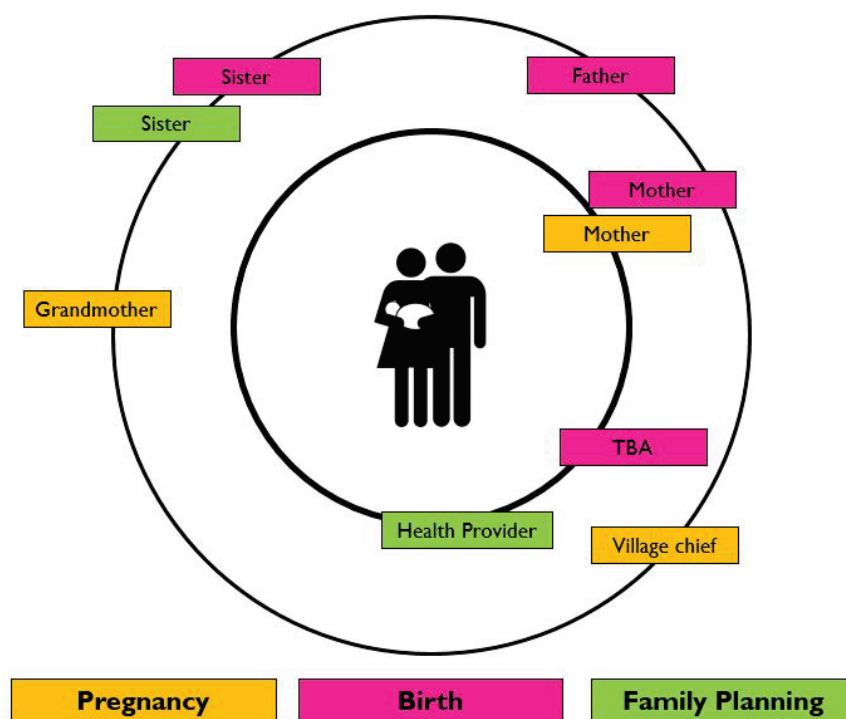
⁷ MCSP. 2018. *Factors Impacting Use of Health Services by First-Time/Young Parents: A Formative Research Toolkit*. Washington, DC: MCSP.

- **Parents and influential kin (FGD Tool 3):** FGDs identified the roles and responsibilities of the family in supporting young parents and the use of SRH services by young parents. The FGD guide used a participatory process to engage participants in discussion about the family members who support FTYPs and their specific roles.

IDI Guide

- **Young mothers and pregnant women (service users) (IDI Tool 1):** IDIs discussed household context (age of couple, number of children, household members, etc.); dynamics around pregnancy, birth, and FP use; and barriers to SRH service use among young mothers and mothers-to-be. The guides used a participatory influence mapping process to identify individuals who were influential during FTYPs' pregnancy and experience as new parents. Interviewers used a piece of paper with two concentric circles and a set of Post-it notes in three different colors to represent different SRH services. Participants were asked to identify individuals (e.g., aunt, friend) who were helpful or influential during their pregnancy and delivery. The facilitator helped the participant write the individual's name on a Post-it note; participants placed these labels on the paper, and the placement of the label in relation to the proximity to the center of the concentric circles corresponded to how helpful that person was to them. The process was repeated using Post-it notes of different colors for childbirth and FP services; see Figure 2 for an illustrative example of a completed influence map (these are only illustrative and do not represent an aggregation of study results).

Figure 2. Sample completed influence map from in-depth interviews with first-time/young parents



Data Collection

Data were collected by teams of 10 local data collectors in each state, with each team supervised by research coordinators engaged as consultants by MCSP. In Ebonyi and Kogi, data were collected between November and December 2016. In Ondo, data collection started in June 2017; in Bauchi and Sokoto, in July 2017; and in Cross River, in August 2017. Interviews were recorded, translated into English, and transcribed.

Analytic Strategy

Translated transcripts in Microsoft Word were imported into ATLAS.ti software (version 8.0). The initial codebook was developed by the analytic lead using deductive codes developed from the research aims and questions and the interview guides. Inductive codes were developed by the research and coding teams together during a 4-day analysis workshop in October 2017. The team came to consensus on the definitions and applications of the codes. The first two interviews were jointly coded by the five members of the coding team along with the other members of the research team. After the workshop, the five members of the coding team coded 10–15 interviews together before independently coding documents. Each coder was assigned one state to code, and Sokoto was split among all coders. Reliability checks were performed by a coding team member and the analytic lead.

Codes were grouped into seven thematic categories guided by both the research questions and those that emerged from the data. These thematic categories were:

- Attitudes and beliefs (about the healthy timing and spacing of pregnancy, the experience of first-time parenthood, stigma, and social norms)
- Barriers (related to finance, the health system, logistics around getting care, religion and culture, and those created by people)
- Facilitators (related to the health system, programs in the community, helpful people, perception of the need for care, and social capital)
- Gender (women's empowerment, gender-based violence [GBV], gender power, and gender roles)
- Health care habits (personal habits relating to caring for selves and children)
- Service use

The analytic process proceeded in two basic steps: Using the thematic groups, emerging topics were summarized related to each research question while analyzing content to compare the four different respondent groups across the six states. Memos were used to reflect on the thematic groups, summarize information about patterns and trends within the data, and differentiate patterns between groups of respondents. Illustrative quotes were selected to provide examples of evidence supporting the themes within and across groups and states.

Ethical Approval and Informed Consent

The study was approved by the Johns Hopkins University Institutional Review Board in the United States. In Nigeria, it was approved by the National Health Research Ethics Committee of Nigeria and the ethics committee in each of the six states.

A research assistant obtained oral consent after giving information about the study and explaining the content of the consent form in the language that the participant understood. An adolescent younger than 18 but married, pregnant, or with a baby is considered an “emancipated minor” in Nigeria.⁸ Potential participants were informed that they would be contacted and may be asked to participate in an FGD or IDI. In addition, potential participants were informed during the consenting process of their rights as participants, risks, and benefits. Obtaining consent was done in a setting that allowed for individual auditory and visual privacy.

Study Limitations

This was an ambitious qualitative study. Well over 200 interviews and FGDs were conducted to obtain maximum variation on the themes explored, representing the four groups across six states in urban and rural residences. There was variability in the quality of the interviews/FGDs and transcripts. Some of the interviews were very short, without in-depth probing. The interviews and FGDs were translated as they were transcribed. As a result, the meaning of the participants’ responses were left to the discretion of the transcriber/translator, with no checks. Some interview transcripts had responses and longer passages that were difficult or impossible to interpret because of the presentation in the English files.

Due to the way the user versus nonuser groups were selected, it was not possible to describe the patterns of care used in this population. If study subjects were randomly selected without regard to whether they used health services, it would have been possible to contextualize patterns of care utilization. Despite this limitation, the data offered rich descriptions of facilitators and barriers around utilizing SRH services, enabling analyses to focus on the remaining research questions. The perception of need was interpreted to be a facilitator, and the lack of perception was classified and presented as a barrier. Male partners or spouses were only interviewed if they were 24 years old or younger to ensure the perspectives of those becoming fathers for the first time were represented. The study therefore missed the dynamics around girls having an older partner or spouse. All but a few of the study participants were either married, partnered, or pregnant under the age of 18, but the study selection criteria prevented exploring the effects on service use for possible forced or coerced marriage.

Communities were selected randomly in consultation with a group of stakeholders convened at the state level, except in Cross River, where it was of convenience and with the idea of which community would gain state support for the study.

Finally, even though quality checks were employed on the coding process, due to the volume of interviews and the number of coders, there was variation in the quality of the coding. In particular, the construct of social capital was difficult to detect, and many instances were missed by several coders. There was also variation around some of the coding related to gender norms.

⁸ Federal Ministry of Health (FMoH). 2014. *Guidelines for Young Persons’ Participation in Research and Access to Sexual and Reproductive Health Services in Nigeria 2014*. Abuja, Nigeria: FMoH.

Results

To address the research questions of the study, the results are presented in two major sections: factors that act as facilitators of and those acting as barriers to the utilization of MNCH/ENC and FP/PPFP care. As explained in the study limitations, it was not possible to explain the patterns of current SRH service utilization. The study team knows that many of the women in the sample used services and some did not. Although results from the Demographic and Health Survey (DHS) demonstrate that the vast majority of adolescents in Nigeria do not use SRH services, this was not reflected in this study's sample because of the way participants were selected.

The first research question also asked what women's perceptions of their need for care were. Since perception of need positively influences care use, it is classified as a facilitator of care. A lack of perception of need, characterized by comments stating that there is no need for care during pregnancy, childbirth, or for FP, is classified as a barrier to care use. The third research question, pertaining to programmatic changes that will influence care use in this population, is addressed in the programmatic recommendations section.

A Note on Presentation Format

Illustrative quotes are shown within each section to demonstrate examples of emergent themes explaining the factors influencing care use. When there were notable differences between how respondents talked about a theme, whether by respondent group (FTAMs 15–17, FTAMs 18–19, FTAFs, or older women) or by state, they are noted in the analysis of each section. State differences are characterized in the theme column of the matrices presented in Appendix 1 that correspond to each section, but the sharpest differences are noted in the section analysis.

Quotes are presented in italics with the interviewer prompts (for context) in plain font within the text. In the matrices in Appendix 1, quotes are presented in plain font, with interviewer prompts in italics. Each quote in the text is labeled by respondent group, followed by urban or rural residence and state. In cases where quotes were taken from FGDs, when there was more than one response on the topic, these were presented together, with numbers separating the different responses, followed with a label detailing how many respondents' responses are included in the quote.

For example:

What motivates you to go (to the facility)?

1) The knowledge or the medical attention given by the health workers. 2) Their services and medical care and attention, like drugs, available drugs, available doctor (2 FTAFs, rural Ebonyi).

The interviewer prompt begins this quote with a question. The two responses are numbered in italics. Within the parentheses, the "2" indicates two different FTAFs from rural Ebonyi.

Facilitators of Care Utilization

Five theme areas comprise the facilitators section:

- **Health system-related facilitators** pertaining to maternal health care include respectful staff, high quality of care (experienced or perceived), and, in some states, female providers of maternity services. For FP, they pertain to care quality, such as availability of supplies.
- **Perceived need for care and beneficial health habits** refer to thinking that formal health care is beneficial for MNCH. Beneficial health habits are what people do that aligns with MNCH, such as exclusive breastfeeding and appropriate umbilical cord care.

- **Gender equality and empowerment** include factors that contribute to FTAMs' decision-making power around obtaining health care for themselves and their children.
- **People who influence FTAMs** to seek care for pregnancy and childbirth refer to partners and close relatives on whom FTAMs rely for decision-making around the use of care. When these people believe that MNCH/ENC and FP/PPFP are beneficial, they encourage FTAMs to seek care and provide money and other assistance needed to facilitate its use.
- **Social capital** refers to the social network resources available to FTAMs that they can leverage to accomplish what they need—which in this case is to access care.

Health System-Related Factors: High Quality of Care and Respectful Staff

Across the states, the most commonly mentioned health system-related factors that influenced care use were personal satisfaction with care experience, a good reputation for high-quality care, and the relative benefits of a health facility versus an alternative treatment facility, especially for delivery. When stating that facilities were safer for delivery, comparisons were most commonly made with care provided by TBAs, but others, such as herbalists and pastors, were occasionally mentioned. Facility staff behaving in a positive way with clients was not mentioned as something notable (with a few exceptions) because this was considered to be just part of the good services received. Those who touched on it confirmed this, saying respectful behavior was part of a provider's job. In other words, caring behavior from staff is expected and not worth mentioning for people who were happy with their care; notably, however, this job responsibility is not always fulfilled. Another theme echoed across states was the educational aspect of care that FTAMs enjoyed pertaining to maternal and newborn care. According to respondents, high quality of care means effective treatment that is delivered in a respectful, kind way at a facility with adequate supplies. Some respondents noted long wait times and stock-outs related to FP services in particular, which diminished their opinion of the quality of the services provided or limited them from receiving a contraceptive method altogether. There were few differences among states or respondents in this area.

I was very happy for a safe delivery without any problem, and this was due to care and support [I received] from the hospital and other organizations. (FTAM 18–19, rural Bauchi)

Why did you seek care there?

They told me about how the health center cares for the baby and the mother also, and they didn't collect any money. (FTAM 15-17, urban Cross River)

What motivates you to go (to the facility)?

1) The knowledge or the medical attention given by the health workers. 2) Their services and medical care and attention, like drugs, available drugs, available doctor. (2 FTAFs, rural Ebonyi)

At the [clinic], they will educate you on what to do. They will run tests. So and they will educate the person on what to do, how to use it so that pregnancy does not occur. That is why we go. (Older woman, rural Ondo)

Perception of Need and Beneficial Health Care Habits

The decision to use care of any type is predicated on the perception of need for that care. In the case of preventive care during pregnancy, childhood, and for FP, people need to understand the benefit of formal health care, even when they are not ill. For FTAMs in Nigeria, partners and older female relatives must perceive the need for care or the FTAM will not receive it in the majority of cases because of her dependence on these people and lack of agency to advocate for her own preferences.

Health care habits refer to either detrimental or (in this case) beneficial behavior patterns associated with how FTAMs care for themselves and their babies. Beneficial habits mentioned were applying alcohol to umbilical cords, exclusive breastfeeding for at least 6 months (including feeding colostrum), exercising personal hygiene to avoid infection, and eating nutritious food.

In Bauchi, there were over twice as many instances in which the perception of need for MNCH/ENC was mentioned as compared with FP. In all states except Sokoto, comments about the need for MNCH/ENC were made across groups and residences, as were responses for not needing care at all. Regarding beneficial health care habits, comments similarly crossed groups and residences. In Sokoto, there were no comments about beneficial habits from older women, but they were mentioned by the rest of the groups.

Do you advise mothers to use the service of TBAs that are in the community?

1) Times have changed; those are things of the past. 2) Nobody would want to take traditional medications now. 3) We made use of traditional medicine then, but now things have changed. 4) Now everybody goes to the hospital. (4 older women, urban Bauchi)

Why do you think they (the people in the story scenario) will start using FP?

1) It will help them to reduce the (number of) children they will have. 2) The problem is not even birth alone because any family without planning, I don't see it as a good family. So they must [use FP] so that the family will stand very strong. (2 FTAFs, rural Ebonyi)

What would motivate you and your partner to come to the health facility?

1) To look after your health when pregnant. 2) I am of the opinion to come to hospital for checkups. (2 FTAMs 15–17, rural)

Gender Equality and Empowerment

The majority of comments around gender pertained to the inequitable norms and roles that limit FTAMs' autonomy, enforcing their dependence on partners, in-laws, and parents; these are presented under barriers (below). Gender equality and empowerment have direct and indirect effects on the use of SRH care.

Comments referring to gender empowerment were observed only in Ebonyi, Kogi, and Ondo, and were mostly related to education and work. Girls who could continue attending school throughout adolescence and those who were able to secure work after finishing school were described as having a degree of independence, something the girls in the study stated they had missed, since they were already mothers. In all states, gender equality referred to cooperative decision-making among couples about using MNCH care, planning families, and using contraceptives.

There was no mention of gender empowerment in Bauchi, Cross River, and Sokoto. In Bauchi, there were fewer comments that referred to cooperative decision-making around FP and MNCH than in other states, but it was mentioned by every respondent type. In Cross River, most FTAMs and FTAFs reported making FP decisions together. Sokoto was similar to Bauchi, where all respondent types talked about cooperative decision-making but only a few comments were made there, as compared with the other states, where most people talked about it.

Male partners taking responsibility for their wives' care was a universally expressed theme across all states and respondents. This responsibility included facilitating care, whether traditional or at a health facility, and ensuring her wellness at home. In some places, it was expressed as helping her at home. This included helping their pregnant and newly delivered wives by doing "her" chores (cooking and carrying water were mentioned the most). This means that women who do not have partners present are greatly limited, since the person who is supposed to shoulder the responsibility for their care is absent.

I have a wife, and we discussed [using FP] together. (FTAF, rural Bauchi)

My own idea is that when you finish your university and finish your service, and you have a better job, at least when the father of your baby is not responsible in any way (meaning he is not involved), you can still head the family. (FTAM 15–17, rural Ebonyi)

Like in my own community, like in our own house. If my wife just delivered, there are so many chores that she will stop doing. I need to at least make her happy...reduce her stress. I need to give her a helping hand to make sure that I am always there for her, so it happens a lot [doing women's chores]. (FTAF, urban Kogi)

Speaking of the advice her elder brother has given her: He would say when I have delivered my baby [after a few months] and the West African Examination Council exam (exams that follow completion of high school) is near, I should register for the exam and make sure I pass. If I decide that I want to learn any trade, I should learn, and I should not rely on any man. That men tend to deceive people. (FTAM 18–19, rural Ondo)

People Who Influence FTYPs to Use Care

Just as someone close to an FTAM may pose a barrier to her care use, he or she may also be the force that facilitates her use. The data show that partners, older female relatives, parents, and in-laws all act as barriers in some cases, but they also facilitate care use. When people close to FTAMs understand the benefits of care, they are likely to help FTAMs seek care.

In Bauchi, partners, in-laws, and parents all facilitated FTAMs' use of care, particularly for delivery. In-laws encouraged women to go to the hospital and gave money to pay for services. Older women said they preferred health facilities over TBAs. Husbands gave money and accompanied partners to the hospital. Several FTAMs said that when they wanted to go to the hospital, they talked with their relatives to enlist their help. In Ebonyi, the same patterns were observed, but in-laws were mentioned most frequently, with partners encouraging them to ask their parents for permission. Other relatives mentioned were aunts. In only one case, a co-wife was mentioned.

In Kogi, Ondo, and Sokoto, partners were most frequently mentioned, followed by other relatives. Partners were mentioned by all groups. Older women talked about their partners supporting them, for example, and this was true for urban and rural residents. Clearly, it is important to include people close to FTAMs in interventions aimed at increasing care use, since FTAMs are often dependent on them and defer to their preferences.

Notably, community and religious leaders were not specifically mentioned as influencers, either positive or negative.

Social Capital

Social capital is a form of social and economic power that an individual or group can leverage through social networks. Social capital can mean the difference between marginalization and having the necessary ties to exercise agency. This is especially true of young people in Nigeria, who are disempowered in general and dependent on their families, and even more important for young women, who are the most disempowered members of society there. Families are one source of social capital for FTYPs; the study team saw how influential family members are for these adolescent girls. Social capital outside families is also important. There were many stories of young parents being turned out of their homes when families found out that a girl was pregnant or that a boy impregnated a girl. However, young people need help in creating social capital—through religious or secular youth groups and through activity- and school-based mentoring programs. Though these data were not ideal for measuring social capital, there is enough evidence to indicate that those with some sources of it, even if it was an association of people that had nothing to do with health, had better use of services if they desired it. These youths could leverage social support into power.

In this sample, social capital most often took the form of groups organized by churches that educated youth around marriage and family life. Not many clubs were mentioned. In Bauchi and Sokoto, there was no mention of social capital at all. There were a few comments about church groups in Cross River, but nothing that engaged adolescents together or with others in the community. There was more mention of social capital in Ebonyi than in any other state. In Ondo, people mentioned that there were friends, relatives, and neighbors in the FTAMs' networks who could help them get care and in groups formed by churches.

One consistency in the data on social capital was that it was mentioned more by users of health services than nonusers. These FTAMs mention having resources to turn to, reflecting on their own personal experience or with reference to what they would do if they were the character in the story.

On networking with people close to them in the community:

If you are in Tunde's shoes (his pregnant wife is sick), what will you do?

1) *I will meet my friends to raise money.* 2) *I will meet my elder sister.* 3) *I will meet my parents to assist me with money*
(3 FTAFs, rural Ebonyi)

Like our former chairman will organize both youths, married women at this local government here. She will invite doctors, nurses. They will teach us many things, how to conduct ourselves, how to behave when you are not yet married. They will teach all those things.
(FTAM 15–17, rural Ebonyi)

On church groups:

What kinds of services do they offer?

Like [the] church marriage seminar (FTAM 18–19, urban Ebonyi)

Being connected to a social group in the community means FTAMs get help with their newborn child. Groups can also help pay medical expenses:

If he has something he wants to do, they usually announce in church sometimes for those who have power to assist will contribute whatever they can and they will give it to the person so he can use it to do whatever he wants to do (FTAF, rural, Kogi)

They used to organize this infant and young child feeding support group twice in a month. They teach us on exclusive breastfeeding even if you want to engage in supplementary feeding how we do go about and how to keep our environment clean.
(FTAM 15–17, urban Kogi)

People in a community can be supportive and a reprieve when family falls through:

When [my wife got pregnant], the family neglected us; it's the people in our community that supported us. There is one woman...she gave us 100 pampers, then a woman beside my house, she owns a school, she gives us rice, palm oil, banana. The family only came after her delivery. They didn't stay longer than 7 days. So, one will find help mostly in the community. (FTAF, urban Ondo)

Barriers to the Utilization of Care

Nine theme areas comprise the barriers section:

1. **Adolescents are unprepared for becoming parents**, which influences the kind of care they give their children, how and whether they think about FP, and how and whether they choose to use maternal health care.
2. **The financial burden of care** refers to all economic costs incurred with seeking health services. Almost all these data are related to the cost of maternal health care.
3. **Health system-related factors** pertaining to maternal health care include the poor attitudes of staff, low quality of care (experienced or perceived), and, in some states, male providers of maternity services. The main issues raised by parents specific to the quality of care for FP/PPFP services were related to stock-outs.
4. **Ambivalent views on the healthy timing and spacing** of pregnancies include the context in which FTYPs and older women relatives discuss and make decisions about FP and modern contraceptive methods.
5. **Negative views on FP methods and side effects** refer to the fear and perception of what using modern contraceptives may cause, whether experienced or heard about.
6. **Low perceived need for care and harmful health habits** refer to thinking that traditional care is adequate for maternal health and personal care habits that are harmful, particularly around newborn health.
7. **Stigma and shame around adolescent pregnancy and parenthood** are expressed norms and views within the family, community, and wider context, including the health system.

8. **Religious barriers** affect people's views and propensity to seek care. These include spiritual illness etiologies, necessitating a traditional practitioner, and beliefs that reinforce norms that prevent women from accessing care, such as not being able to be treated by a male practitioner.
9. **Gender inequality and the powerlessness of FTAMs** include normative behaviors that prevent women from making decisions on their own, including their **dependency on partners, parents, parents-in-law, and other family**.
10. **Lack of social capital** among FTAMs reinforces their dependency and lack of individual power.

Adolescents Are Not Prepared for Parenthood

More young FTAMs (15–17 years old) than older ones (18–19 years old) expressed that adolescents are unprepared for becoming parents. Marriage was an important mediator of how people reacted to adolescent parenthood: Among unmarried FTYPs, a pregnancy provoked a certain level of distress to FTYPs and their relatives. Reactions in these cases ranged from young people being so highly stigmatized in the community that they are put out of their homes by parents, to stress and worry around what will happen; almost no one is happy about the pregnancy. When FTAMs are married, there is some stress around them being so young, but these responses were mainly happy. Married FTAMs may experience difficulty with such an early pregnancy, but they have the support of their family and community members, since norms around confirming fertility are very strong in Nigeria. Usually, having a baby soon after marriage is something for married couples to attain to demonstrate that they can have children.

In all states, there was a mix of responses, ranging from being shocked, unprepared, sorry, and focused on the difficulties of parenthood coming so early to being very happy and excited. There were comments about lost opportunities for schooling and work among older FTAMs. Most older women were happy about being a grandparent. There was no noticeable difference between urban and rural respondents. Across groups and residences in all states, if the young couple was married, they were happy—and perhaps a little nervous. If they were not married, the reactions were mainly negative: People talked of her being too young, with too much responsibility, along with reactions of shock and worry.

In Kogi and Ondo, many FTAMs, both younger and older, felt that it was difficult to be a parent. These girls worried about how they would care for their child. Among unmarried FTAMs, there was talk about family driving them out of the house, which concurred with older women's responses. A lot of older women in rural groups said they were unhappy their children were having a baby this early—especially before finishing school. In contrast to other states, people across groups in Sokoto more consistently stated that the first pregnancy was happy if a couple was married, no matter their age. Unmarried parents in this state were particularly stigmatized by family and community, underscoring the importance of marriage for the social acceptability of pregnancy.

What will her mother think of (getting pregnant so early?)

1) The mother will also be scared of the safety of her delivery because she was too young to conceive, so she will think whether the baby might have to pass through cesarean section. 2) The mother will not be worried because she knew that she wedded her early, as such she will not think of anything. The only fear will be for her to deliver safely. (2 FTAMs, 15–17, rural Bauchi)

I feel ashamed to face even my friends. Your peer group is looking at you, seeing you pregnant when you're not supposed to be, when you're in school and you were supposed to finish. I'm a student so this is very, very bad. I feel pressure from my dad and all of that, so it is quite disappointing. (FTAM 15–17, rural Cross River)

How would you feel if your daughter is 15, pregnant, and unmarried?

1) Ah! It's very, very bad. 2) It is very sad. 3) Very sad. (3 older women, rural Ebonyi)
There is no way he won't be happy, because he [Tunde] has a job, the wife also have a job, they have done their wedding, both parent are aware, and now they are blessed with the fruits of the womb. What is the usefulness of money without children? (FTAF, rural Ondo)

How would a mother in your community react if her daughter was 15, unmarried, and became pregnant?

1) The way they react to them is uncalled for. Like the one I saw, as soon as the girls got pregnant, their mother chased them out of the home. The girls can't even get money for feeding and they sleep in different places. The way they treat them is not good at all. 2) I have someone in my neighborhood now with a pregnant adolescent. The parents are annoyed that she didn't complete her education, and the mother chased her out of the house. 3) Like my niece when she was pregnant, her mother sent her packing. She only asked her to go and learn a trade, and she didn't even finish learning the trade before she got pregnant. We pleaded, but my sister sent her out of the house. (3 older women, rural Kogi)

How will Onyinye react when she finds out she is pregnant at 15?

1) She will be very happy because she is just 15 years and gotten married. 2) Since they are legally married, Tunde will be happy, and there's nothing he can do than just to be happy. 3) Since both of them have done their wedding, the beauty of marriage is that they should see children, and I think Tunde should be happy because he has seen the beauty of marriage. (3 FTAMs 18–19, urban Kogi)

Financial Burden of Health Care

The cost of obtaining maternal health care was one of the most important barriers identified by FTAMs, FTAFs, and older women across all states, regardless of urban or rural residence. In Cross River, Ebonyi, and Kogi, lack of finances for the various costs involved with seeking maternal health care was mentioned more frequently and consistently than any other barrier. In Bauchi, Ondo, and Sokoto, it was the second most frequently mentioned barrier, after health system factors. Finances were not mentioned in reference to ENC or FP/PPFP.

For FTYPs who may not have started working or who were just beginning a job, the costs of care were prohibitive. The financial burden is exacerbated by the fact that almost all FTAMs are dependent on their partners and/or other family members for facilitating and paying for their care during pregnancy and delivery. As seen in the facilitators section, partners are expected to be the primary caretakers of their wives, but since they are also very young, they often do not have the financial resources needed to pay for health service-related costs. Often, the people on whom FTYPs are dependent also lack the money to cover the cost of care.

Although services are supposed to be free in Nigeria, costs incurred for obtaining maternal health care included transport to services, hospital fees, maternity kits to bring with them, and drugs and other supplies. Often, respondents preferred to use TBAs over formal health care due to financial constraints of the couple or family. TBAs take less money, and they often take goods in kind for payment, such as cola nuts and soap. Since TBAs live in the community, there is no transport cost involved with using them.

What might stop her from going?

Since he [the husband in the story] doesn't have the money, I would call the TBA for her because she can take a small amount of money. She may collect even soap. (FTAF, rural Bauchi)

When a woman is on labor, you go to a TBA they will just receive you, and make sure that you are safe and your baby safe. But when you go to the hospital, if your bill is \$550, they will tell you give us \$275 before we do we start the work, and what if the money is not there? You will just die. (FTAM 18–19, urban Cross River)

Since the husband [in the story] is already feeling that the charges at the hospital is quite high and he cannot afford it, so she doesn't have choice than to go to a TBA center to deliver her baby. (Older woman, rural Kogi)

Using health services [for ANC and delivery] is the most paramount, she need to go injections, parents need to look after this if her husband has no money. (FTAM 15–17, urban Sokoto)

Health System-Related Barriers to Care

Health system-related barriers were almost always mentioned in reference to maternal health care. The most common health system barrier mentioned was staff attitudes. The study team saw that positive staff attitudes were not very important when people described their satisfaction with care, since attitudes were good.

However, when staff attitudes were negative, they act as a barrier to care. Staff at health facilities, including doctors, nurses, and others, were described as rude, mean, and disrespectful to patients in general. Across the states, FTAMs said that they felt staff treated them differently than they did older women (those over 20 years old). From the viewpoint of FTAMs, staff attitudes induced shame and embarrassment related to their young age. FTAMs, especially those 15–17, also stated that they were not taken seriously at health facilities because of their age. This treatment of young patients was reported based on FTAMs' own experience, by witnessing what happened to their relatives, or through word of mouth based on what happened to other people they knew.

In Bauchi, Ondo, and Sokoto, health system-related barriers were mentioned more frequently than finances. TBAs were described as giving better care than hospital staff to women and families. TBAs conferred respect and acted with warmth—women and families prefer delivering with them. In Bauchi, a few people mentioned not being able to deliver in the nearby facility because they did not attend ANC, which was required for booking a delivery. One of the health system factors in Sokoto—that male practitioners attend women—crossed with religious concerns. This was a very significant barrier for FTAFs in this state regarding where they allow their wives to deliver; it was also mentioned by women there. In Sokoto, difficulties pertaining to distance were described by a larger number of rural residents than in other states.

The FTAM herself can act as her own barrier to care. Her perception of need or beliefs about something can create a barrier to her use of health care services. Some expressed fear of having a cesarean section without their consent or other fears; the TBA is more familiar and will not do something without her consent.

Several respondents in Ebonyi mentioned a fear of unnecessary cesarean sections taking place in health facilities. In Kogi, TBA care was preferred by women because the TBA let mothers walk around at delivery, and relatives could be present. Delay in treatment once reaching facilities was also mentioned, as was the distance to facilities coupled with lack of transport and finances to pay for transport.

In the health facility, sometimes they scold and even slap the woman. That is why we prefer to deliver with TBA. (FTAM 15–17, rural Bauchi)

The first day I attended antenatal in the place when the pregnancy was still three months it did not show. So when I said that I came for antenatal, everybody was like amazed that you [are] pregnant? I said yes, I'm pregnant, that I came for antenatal to come and register. Even though they didn't say it to me directly, I know very well that they will go behind and say "Look at this girl, she has not even got to the age of getting pregnant she's coming for antenatal." So that will start saying some negative things about you. (FTAM 18–19, rural Cross River)

When I came for ANC, a nurse here asks me, are you married? I told her yes, and other asked are you sure this girl is married, and they told them yes. That is embarrassing. (FTAM 18–19, urban Ebonyi)

Most of what prevents pregnant teenagers from coming to [the] hospital is because of insults. For example, the day I came to register, I cried. The statement the woman made was that when you chose to have sex, didn't you know the end result. I have asked the question before: Are nurses taught to insult people when they go nursing school? Some don't know how to be tolerant of others. (FTAM 15–17, rural Ondo)

Some respondents commented about contraceptive stock-outs, but most of the information about health system barriers pertained to maternal health. Notably, warm and responsive care can encourage FTYPs to continue to return for ANC visits, deliver in the facility, and encourage uptake of PPFP. Alternatively, when FTYPs are deterred from seeking services due to rude treatment during pregnancy, they may be deterred from facility-based delivery and uptake of facility-based PPFP services.

Ambivalent Thoughts around the Timing and Spacing of Pregnancy

Views around what constitutes the healthy timing and spacing of pregnancy are directly related to the perception of need for the use of FP. Most of the data in this area were connected to FP/PPFP, unlike the other themes, which relate mainly to MNCH/ENC. Many respondents across states said something about spacing, but the time periods varied from 2 to 5 years. Some respondents stated that the timing of pregnancies is up to God.

In rural Bauchi, getting pregnant soon after marriage was important to many respondents across groups, while others talked about waiting. FTAMs spoke about waiting until the first child is weaned, stating 3 to 4 years before having another child. Couples may decide to use (or not use) FP, but answers varied about who finally decides: both together, the man, or, in some cases, the woman independently. Most respondents said that couples decide together. Some FTAMs had not considered FP, and pregnancies are unplanned. FTAFs also talked about spacing and deciding about FP use together. Some older women did not know much about timing and spacing, and had not considered FP. Many stated that daughters having a child at 16–17 was not a problem as long as they were married. In urban areas, respondents talked about waiting until the child walks. Some urban FTAMs stated that they would wait for the first pregnancy ideally until she has finished her education—a decision made with her husband; many of these women mention discussing FP. Some want children right away after marriage.

There are some husbands that give their wives contraceptives after marriage they because they want to rest first, but in my opinion, this is not right. The proper thing is when you get married, they should test the woman's womb to know if she can conceive or not, that is the first thing. When she gives birth, then they can go for FP. (FTAM 18–19, urban Bauchi)

Almost everyone in Cross River, regardless of residence or who they were, talked of wanting some kind of spacing. The ideal spacing varied from 2 to 5 years. Some mentioned when the couple was old enough to have a job. There were only a couple of exceptions to this: One FTAF and some older women felt like babies could come right after each other. On when to start having children, the majority of people said from 20 years old and above was ideal. Some (only FTAFs) stated that one should wait as long as age 30 for a first child. The exception was among FTAMs in an urban group, who felt that a girl should be 15–18 years old at the time of her first pregnancy—which was much younger than the rest of the sample in Cross River and other states.

It is better for the both parties to agree, but in my own case, it was the girl that decided to have the baby. (FTAF, urban Cross River)

In Ebonyi, there was no difference between the responses of 15–17 and 18–19 year olds. Most FTAMs and FTAFs mention spacing as a good option. More urban respondents than rural ones stressed the importance of spacing. On the subject of first births, there was a mix of wanting a baby right away after marriage and waiting for a short period. As in other states, most people felt that the ideal time for having children was when both partners were older than 20, after school is finished and they have a job. Many respondents across groups talked about how difficult it is to have a child when neither in the couple is gainfully employed or really started in life.

Most people in Kogi spoke of spacing children by 2 to 3 years and more. Most comments reflect that both partners are involved in decision-making, with a few people stating either the man or the woman deciding alone. Answers about the timing of a first child varied, but again, the theme of childbearing soon after marriage was expressed across groups, though most people stated that the woman should be 20 years old or more and should experience life—go to school, work—before parenthood. Some people stated that women should be younger, but only a few. All respondent types mostly agreed that women should be older when they give birth the first time.

The husband and wife are supposed to be discussing FP because wife alone cannot do it. She and the husband are supposed to know about the FP. (FTAM 18–19, rural Kogi)

There were many descriptions of women who secretly went and got contraception, especially in the form of injections, but in other cases, women were just as dependent on people close to them for FP care as well.

I will quietly [use FP] after giving birth to two children because there is no how I will stay and see my children crying for food and there's no food to give the child, after two issue, I will quickly go for FP and seal it up, take the injection and hustle, work for my children and their school fees, I will not let [my husband] know. [He] will be there thinking of another pregnancy, and it will not come. (FTAM 15-17, urban Cross River)

In Ondo, similar to other states, many people expressed that 3 years between children was ideal. When asked about using FP, most people were ambivalent. In other words, even though people express wanting to space their children, on a practical level, the same people do not do anything about it.

He can tell her to leave a gap of 3 years before having another baby. Within the space of that 3 years, they will plan, and if they work hard, they will achieve all they have planned. By the time they have another baby, they will be confident that they have what it takes to cater for the baby. (FTAF, urban Ondo)

Most of the responses across the states indicated that people think about FP use for spacing. However, among older women in Ondo, using FP was associated mainly with limiting pregnancies, with only a few exceptions. As with other states, the ideal timing for a first child was when the woman and man complete school and start working.

Most people in Sokoto across groups talked of spacing children by at least 3 years. Most people also said that husbands and wives have discussions about FP use and having a child together. Only one participant commented that the husband makes the final decision. Here, the ideal time to have a first child was earlier than in other states. There were many comments about having a child when the FTAM and FTAF were in their teens, or at least by age 20. Unlike other states, there were no comments about finishing education and starting work before considering parenthood. From this sample, early marriage and subsequent parenthood (within the context of marriage) are more the norm in Sokoto. There were also many comments about pregnancies being up to God.

For every man that knows the value of marriage and got married out of love and not out of something else, then there is a need for him to involve his wife in it (the decision). No matter what you want, in fact if you want this to succeed, then you have to involve her in decision-making. You do not live a life like this; do not underrate your wife perhaps because of her level of exposure in life. If you do not plan, then you are bound to regret later in life. (FTAF, rural Sokoto)

Negative Views of Contraceptive Methods and Side Effects

Despite generally positive views about pregnancy spacing, views about and experiences with contraceptive methods were often negative and strongly influenced the decision to use them. Two themes characterized the responses in this area across states, with some variation on the frequency of comments. First, regarding FP care, poor quality of care that included stock-outs and the inattention of staff were mentioned as factors that prevented women from using services and men from being motivated to get their wives to services. There was a difference in urban and rural respondents: If stock-outs occur in urban areas, women can look for another provider; in rural areas, women do not have this option. Most comments about contraceptive methods referred to short-acting methods (primarily pills and injectables). There were a few comments about implants, but no references to intrauterine devices were made. Injectables were by far the most commonly mentioned method in any context. The second major theme related to side effects experienced that contributed to discontinuation and myths related to side effects that inhibit contraceptive uptake.

You will find that sometimes when people come looking for FP methods, some hospital will say it is not available or it is finished they will have to order for more, so what we need is FP methods availability. (FTAM 18–19, urban Bauchi)

I used the oral pills [that I take every day]. It wanted to kill me and I stopped it. Since then, I have not used any contraceptive method. It caused me to bleed excessively during my menstruation. It was really pouring. (Older woman, rural Ebonyi)

When I first gave birth, I spoke with my husband that we should leave some space, so he told me to go and do FP. But since I have heard about its side effects that it makes people's stomach to be fat and other side effects, I said that I am not doing it. (FTAM 15–17, rural Ondo)

Low Perceived Need for Care

Low perception of the need for care negatively influences health care use. Girls and women—and in Nigeria, their partners, parents, and parents-in-law—who do not perceive the need for wellness or treatment care will be much less likely to use MNCH and FP services either for routine checks or symptoms that present during adolescence in general, and specifically during pregnancy, childbirth, and the newborn periods. An example of indirect lost opportunity is missing the information offered about preventing pregnancy and care during pregnancy, birth, and the postpartum and newborn periods. This lost experience gives rise to harmful health care habits.

Low perceived need was commonly expressed by all types of respondents. They indicated a preference for using TBAs or that pregnancy and childbirth do not require intervention. There was little variation across states.

I have not been to any hospital because I feel I can deliver at home safely. Growing up, I have seen my mother giving birth at home, and I have never seen any complication in childbirth despite giving birth at home, she gives birth at home and she will be healthy and she has no complications later on because of that I was convinced that I can also wait and see what God will do with us. (FTAM 18–19, urban Bauchi)

It is not good for one to decide the number of children one would have because you don't know how many of them that would survive. (Older woman, rural Ebonyi)

Harmful Health Care Habits

Harmful health care habits also fell into fairly uniform responses across states and respondents. Around breastfeeding, people mentioned giving water in general and in place of colostrum. Taking various drugs and undefined substances during pregnancy was another commonly named practice. The third major area pertained to cord care after birth. There were many substances that were applied to the cord—toothpaste and Vaseline were the most commonly mentioned.

After bathing the baby, I used hot water to rub the umbilical stump. But people advised me to use Close-Up toothpaste, so I tried it. (FTAM 18–19, urban Kogi)

1) [The baby] can be given some soft food to enable him gain strength. 2) She can give him milk too. 3) She can feed him with children's milk. 4) She can feed him with Cerelac [instant cereal for babies], not milk. (4 FTAMs 18–19, urban Sokoto)

People believe that that [the TBA] is the safest place to go and deliver. There was one aunty that was living at our compound in Onitsba, she met all these herbalist, they will give her something in the bottle that she will be drinking that will be reducing the size of the baby so that when the baby want to come, it will come safely and simple. It is superstitious belief, like they believe that the baby will be stronger than the one delivered in the hospital. (FTAF, rural Ebonyi)

Both low perception of the need for health care and detrimental habits based on tradition rather than medical guidance result in potential harm to the mother or child. Both areas are critical to address to improve care uptake and health outcomes for mothers and babies.

Stigma and Shame around Adolescent Pregnancy and Adolescent Parents

Across states, some FTAMs commented that going to receive ANC involves being made fun of by staff and others at the clinic because they are pregnant at such a young age, regardless of marital status, but unmarried FTAMs suffered the most stigma. The expectation of being shamed stands as a formidable deterrent to FTAMs seeking care. Most people in all respondent groups across states indicated that there is a difference

between the way FTAMs are treated compared with older mothers. Some married FTAMs said there was no difference in treatment, and they would be congratulated on the pregnancy.

What do people say about adolescents going for ANC services?

Actually, they'll treat us different from people that are married (sigh!). They not give you the kind of respect that they'll give married people. They'll maybe say that you're not at the normal age for you to have girlfriend that will have baby for you, they think that you have to pass through marriage procedure and maybe you're not buoyant enough for you to have wife before you get a baby. That's my own opinion. (FTAF, urban Cross River)

You'll face a lot of things [if you have an early pregnancy]. From friends, your friend will cut short, they'll feel maybe you've committed one sin. From you parents, I know it's normal, they have to talk, they have to quarrel, they have to get angry because of the age. Then from community, it's almost the same thing. The stress, the pains, then it happens it's not with the right person or someone who is able to take care of you. (FTAM 18–19, urban Cross River)

1) It is a shame, and they will not be happy with such a person. 2) If it so happened that it was them and a banker that comes for antenatal, the way they will address the banker will be different from the way they will address us. They will just look down on us saying "who are you?" (FTAM 18–19, rural Kogi)

Religious and Spiritual Beliefs

Religious beliefs were most commonly mentioned as drivers of health behaviors in Sokoto and Ondo. In Sokoto, many respondents stated that males attending to females in maternity wards was unacceptable for a Muslim, leading to a preference to deliver with a TBA. Some rural respondents in Sokoto also expressed beliefs in God and traditional medicine. In Ondo, comments in rural areas pertained to the etiology of maternal illness; the cause was identified as spiritual attack. There was also talk about superstition around breaking traditions about where people give birth and what would happen if they give birth elsewhere. Among urban residents, praying and blessings were mentioned as reasons to give birth outside of a health facility.

Some people, their parents already told them you don't know what I went through before I had my first pregnancy. Your father's relative or your mother's relative are the ones behind the spiritual attack that made me have miscarriage upon miscarriage. This is why I'm telling you to go to the TBAs so they can find something to do as regards your pregnancy so you won't have any miscarriage. (FTAM 18–19, rural Kogi)

We don't drink anything, nor do we go to anyone. God will help us to deliver safely. During delivery, the only thing that we do if we are sure is time for delivery is to render help to the person by giving prayer inside water. God will help for safe delivery ... when everything is from God. (Older woman, rural Sokoto)

Gender-Inequitable Roles and Norms and the Powerlessness of Adolescent Girls

FTAMs are more or less without power because of their age and sex. They are beholden to their husbands, parents, and in-laws, and they have low status in society. Across states, many comments about gender roles pertain to a husband's duty to care for his wife and children. Among users of institutional delivery services, this means getting them to the facility, paying for care, and seeing that they get everything they need (maternity kits, drugs, etc.). Among nonusers, husbands get her herbs and take her to a TBA. Whatever kind of care is deemed appropriate, the husband is involved and has the primary decision-making power around that care. GBV was explicitly mentioned in only a handful of interviews. Given that many of these FTAMs have very early sexual encounters, it is probable that a certain proportion of these FTAMs have experienced either forced or coerced sex. There is no information about this in the data, as there were no questions pertaining to this issue in the tools. Some FTAMs mentioned GBV, especially in the form of economic violence⁹ and no support.

⁹ Economic violence refers to acts of control and monitoring of the behavior of an individual in terms of the use and distribution of money and the constant threat of denying economic resources. The control mechanisms may also include controlling the victim's access to health care services, employment, etc. (See <http://eige.europa.eu/rdc/thesaurus/terms/1096>.)

Gender inequality was expressed the most in Sokoto. In this state, some male and female roles are very delineated, with no shift between what men and women do, even when the woman is pregnant or has just given birth. Another woman might help her with her chores, but her husband will not, nor would she expect or want him to do so. In other states, the man helping his wife during pregnancy or following delivery was an acceptable deviation from the norm and viewed positively by all respondents. Son preference was mentioned by all respondent types across all states, except in Kogi. There were many comments about the importance of having a son—if there were no male children, there was a push to have more children—meaning that son preference is a driver of fertility.

Some people don't understand that just the man just feels like helping the wife. So they will start saying all sorts of things, that the wife is a witch, that she bewitched the husband, or that she has turned the husband into a slave. Oh, your husband helps you cook, they will say no, your husband is helping you to fetch water. But if the woman is a nursing mother, they will not talk. Depends on the stage of the woman and what the husband is doing. (FTAM 15–17, rural Ebonyi)

1) There is one man in our area. People calls him wife's slave just because he helps his wife with house chores and not going to chat with friends. 2) Wife's slave they will call him. 3) Or they think she bewitched him. (3 FTAMs 18–19, urban Sokoto)

I told my husband that I am tired of bearing children, but he told me that he is the only one that has the right to say when I will stop having children because the children are the people he has. He also said that the number of children he wants is what I will give birth to. (Older woman, rural Ebonyi)

Musa now assists his wife with her household chores, and his friends are making fun of him. Do things like this happen in your community?

As his wife, I will ask him to stop it and let it be.

What will people in the community say about it?

People will tag him ... in addition, because of that, I as his wife will take over my chores because I do not like people thinking of him in that way. (FTAM 18–19, rural Sokoto)

In the story, the wife is very sick and needs a doctor, but the husband has objected. People are asked what she should do.

1) I think she should obey her husband's instructions. 2) I concur with what the first speaker has just said. There is need for her to accept the decision made by her husband. (2 FTAFs, rural Sokoto).

Dependency on People Who Pose Barriers to Care for FTAMs

In Bauchi, partners were mentioned most often as barriers, in that they did not give permission to seek care for both MNCH and FP. Partners preferred that women seek help locally because of distance, cost, and convenience. In contrast, in Cross River, partners were only mentioned a few times as barriers. Older female relatives were played more of a role as barriers to facility-based service use in Cross River.

In Ebonyi, respondents mentioned older female relatives, mothers, and mothers-in-law as discouraging young women from using FP. For MNCH, older female relatives influenced them to go to TBAs, since that had been their own pattern of health care use. Since FTAMs are dependent on their older relatives to pay for their care, they end up going where relatives tell them to go. Even if the FTAM wishes to seek health care, she may not be able to because her mother, older sister, or another relative thinks it is better to go to the TBA. In Ondo, many participants shared experiences of mothers, mothers-in-law, and others deciding where the FTAM would give birth (with a TBA) because again that was tradition—older women had their children there, the FTAM's mother did, her partner's mom did, etc., so that was the right place for the FTAM. This was true for urban and rural areas. Partners were mentioned as barriers because they did not take enough interest in facilitating care, more than having an opinion about where they should or should not go, but the latter took place too. In Sokoto, partners were most frequently mentioned as potential barriers. This was demonstrated by husbands not providing money or permission to go to the hospital.

I would like to go to the hospital, but my husband is totally against that, even if I requested for that, he does not like it. That is why I don't bother myself anymore. (FTAM 15–17, rural Bauchi)

There are some mothers that will prefer the traditional way. They will start telling you this—and your friends too that have gone through it, they will start putting fears in you—they will start telling you how they will tear you, how they will do this if you go to hospital. (FTAM 18–19, urban Cross River)

They are some men who don't patronize hospitals; he thinks she will encounter problems when she was taken there. (FTAM 15–17, urban Kogi)

[I don't go] because I heard him saying he doesn't want me to go for ANC. (FTAM 18–19, rural Sokoto)

Lack of Social Capital

The study team searched for instances of social capital in the sample by identifying any community groups that FTAMs were involved with and instances of social groups of friends or other community members that are intermediate family members. Almost universally, FTAMs demonstrated little, if any, social capital. Part of this may be due to the fact that the tools were not designed to measure social capital, as mentioned above. Because the overall consensus among participants in all states is that pregnancy should happen within the context of marriage and that women should have completed their education and initiated their working life, girls who become pregnant in their adolescent years, and especially those who become pregnant outside of marriage, are particularly vulnerable and lacking social capital. Because FTAMs are dependent on partners and extended family for financial support and permission to use services, and their partners themselves are dependent on the same extended relatives, building social capital among adolescents would serve to increase their levels of empowerment. This may also serve to support delayed age at first pregnancy, as girls are better able to initiate conversations about contraception with their partners and access contraceptive services. There are no quotes that document lack of social capital specifically, but the overall pattern in the data strongly indicates lack of social capital among young women.

The patterns, predictors, and very low levels of SRH care used among this population of girls in Nigeria have been thoroughly described by several waves of DHS since 2003.¹⁰ The data from this study illuminate why these patterns have persisted and how they can be changed by thoughtful interventions. The other factors that the DHS and other quantitative studies in Nigeria noted as important influences—low educational levels, low economic status, and rural residence—exacerbate the barriers and attenuate the effect of the facilitators depicted in Figure 3. While these structural factors must be addressed over the long term to sustain change, programmatic intervention can strengthen the facilitators and diminish the barriers listed in Figure 3. This will lead to an increased uptake in SRH care use and a break in the cycle of early pregnancy, which perpetuates all of these factors. Considering the various factors influencing health care use as either facilitators of or barriers to health care use simplifies how programs should be designed to influence change.

¹⁰ Mallick L, Dahiru T, MacQuarrie KLD. 2016. *Trends in Maternal Health in Nigeria, 2003–2013*. Rockville, Maryland, USA: ICF International.

Programmatic Recommendations

The two most important barriers to care across states and all groups interviewed were the financial burden and quality of health care. Finances posed a fundamental block to accessing care, as availability of money was part of the initial decision-making process. The many items and services that need to be paid for before delivery added up to a burden that could not be carried by many FTAMs and their families. High motivation is needed to bridge that barrier. There is a formidable barrier to care when financial difficulties are combined with a bad experience at a health facility, when people are treated with disrespect or there are regular stock-outs of supplies and drugs.

FP use is critical to preventing adolescent pregnancy in the first place, and then delaying the second birth to protect the health of the mother and child, and align with the mother's fertility intentions. However, early childbearing is tied to the acceptability of early marriage. While there was a lot of evidence to show that older relatives were not happy about pregnancy out of wedlock, if a couple was married, even when the girl was only 15–17 years old, it was mostly a happy occasion. The data seem to indicate that a proportion of early marriage takes place after an unplanned pregnancy, but the pregnancy is acceptable to the family when youth are married. The many comments about embarrassment around being pregnant so early and not wanting to go to ANC means that many of these young parents do not get adequate care with respect to contraception before their first sexual encounter, ANC and delivery care, ENC, and PPFP. Health system linkages in pregnancy (for ANC and delivery services) are related to PPFP. If girls are not connected to the health system before or during pregnancy, they are unlikely to be offered or seek PPFP.

Overall, there are several areas in which successful interventions can transform social norms and address systems barriers that limit service use among FTYPs. There are some important state differences that must be reflected in specific programmatic response within the general areas defined by the data. The sharpest differences are between the northern and southern regions. Respondents in Bauchi and Sokoto, as the two northern, predominantly Muslim states, were similar to each other, but they were different from those in Cross River, Ebonyi, Kogi, and Ondo. Finally, most of the barriers identified can be addressed by ensuring that facilitating factors are expanded and appropriately targeted to FTAMs.

Overall Approach for Increasing Care Use among FTYPs

The results of this study demonstrate that a comprehensive intervention involving a multisectoral approach to recognize the full breadth of FTYPs' needs will guarantee the best success in increasing care uptake and, ultimately, resulting in better health outcomes.

Specific Recommendations

Reduce Financial Burden of Care

- Develop vouchers or special funding streams for FTAMs to be used for ANC, delivery, ENC, and FP/PPFP. FTAMs and the people on whom they are dependent need to be released from the financial burden for their decision-making process about whether and where to seek care. The existing voucher program for transport in Cross River and the free services there were well tailored for people's needs and could be a model for scale at the national level. Support for movements for universal health coverage and other health financing, including voucher schemes, in Nigeria and elsewhere could contribute significantly to reducing the financial burden of care for all, including FTYPs.
- Expand and publicize existing financial relief programs, such as the vouchers for transport in Cross Rivers State, by including information about these programs in outreach to FTAMs and their influencers, and assure that those who need them are reached.

- Ensure that costs associated with services are posted at each health facility in a public area to help FTYPs plan for costs associated with service use and ensure accurate disclosure of costs.

Address Social and Gender Norms That Stigmatize Adolescent Pregnancy and Limit FTAMs' Decision-Making Power

- While it is critical to ensure that influencers of FTYPs' health-related behaviors have accurate information, programs must address the underlying gender and social norms that stigmatize young and adolescent mothers, and limit their ability to make decisions about home health care practices and health service seeking. Norms that fuel stigma, shame, and gender inequality, including FTAMs' powerlessness to make decisions about their own care, need to be addressed at the community and family levels to influence the uptake of care among FTAMs.
- There was some evidence that in the northern states, it was less acceptable for men to take on what are considered to be female roles, including helping their wives with chores, during pregnancy. Changing customs in those states may require additional effort to address these deeply embedded norms. However, men's support for women's chores during pregnancy and the postpartum period is an accepted deviation from the norm in southern states and a positive social norm on which to build.
- Promising norm-transforming programs in several countries in sub-Saharan Africa and elsewhere can be explored and tailored to the local contexts in Nigeria. These programs could involve older male mentors teaching young men skills, such as cooking and cleaning in a group, giving them a supportive, positive experience in a group of men their age to ease the stigma around traditional gender roles. A promising example could include Save the Children's "Responsible, Engaged, and Loving Fathers" program (http://irh.org/wp-content/uploads/2016/10/REAL_Fathers_Prevention_Science_2016.pdf) tested in Uganda.
- Programs must further consider that health care workers' treatment of unmarried and young parents may be driven by underlying social norms that reflect those of the community around them. Health workers are community members themselves, even if not in the same community they serve, and their norms are shaped by members of their social reference groups. To address health workers' negative treatment of young mothers, particularly those who are not married, programs must identify the social norms that shape their behavior as well as those who influence their norms.

Ensure Caring Staff Behavior, High Quality of Care, and, in Regions Where It Matters, Female Providers of SRH

- To support FTYPs' continued use of ANC, facility-based delivery, PPFP uptake, all facility interactions must be positive. Support efforts to mainstream adolescent-responsive services through all service areas and across all facility staff, including clinicians and support staff, rather than investing in separate services for adolescents. However, a one-time training is not likely to counter the deeply held social norms, reflective of those held by community members outside the facility walls, in changing provider behavior. Instead, programs need to pursue a transformative social norms approach that includes providing multiple opportunities over time for facility staff to discuss and reflect on social norms.
- In medical, midwifery, and nursing school curriculums, add a unit on the behavioral aspects of patient care, including education about the special needs of adolescent populations and building in ongoing opportunities for norms transformation, to ensure that providers are able to offer friendly and welcoming services to adolescents.
- Invest in strengthening monitoring systems to allow for reporting of age-disaggregated service statistics, particularly for use of ANC, delivery, PPFP, and postnatal services, through the national health

management information system. Ensure that age-disaggregated data are available for compiled data at the national and state levels.

- Establish systematic accountability mechanisms through which FTYPs and other clients can hold health systems accountable for quality. Encourage satisfied FTYPs to share their experiences with peers and family to counter pervasive information about unwelcoming services.
- As perceptions of quality strongly influence FTYPs' and older women's decisions to use/continue to use facility-based services and availability of drugs is associated with quality services, coordinate efforts with other initiatives to assure that facilities are well stocked with the supplies, equipment, and commodities needed for quality and effective service delivery.
- In Bauchi and Sokoto, FTAMs and the people around them, particularly their partners, are often reluctant or refuse to use SRH care provided by male providers. In these areas, the government should make sure that female practitioners are available for ANC, delivery, postnatal care, and FP.

Prepare Adolescents for Pregnancy and PFP Using Age, Life Stage, and Other Segmentation Approaches

The importance of tailoring program response to the age and life stage of adolescents and youth is well understood; the unique needs of FTYPs are the focus of this research. Findings from this study further reinforce this point and shed light on the importance of efforts before pregnancy and after.

Lay Groundwork before Pregnancy

- Because many FTYPs are unprepared for pregnancy and parenthood, they lack information to counter advice from family about potentially unhealthy practices. Invest in school- and community-based “life planning” programs that encourage adolescents to plan their future, and inform them about the healthy timing and spacing of pregnancy (including the first pregnancy) and the role of contraception in achieving life goals. Adolescents are easily reached through religious communities in all states. Churches and mosques can implement programs in their communities that offer accurate and appropriate messages about the realities of pregnancy and parenthood that will reach adolescents. Build partnerships with religious and community leaders to ensure consistency of messaging. Identify and expand existing programs to include training on expected physiological and emotional changes, good baby care, healthy timing and spacing of pregnancy, contraceptive options, and the importance of health care during all stages.
- In the northern states, where early marriage and childbearing are more common and school enrollment is lower, explore engaging adolescents at the time of engagement or marriage.

Prepare Pregnant and Parenting Adolescents

- A group-based approach has been shown to be important for providing social support for FTAMs, who may be stigmatized and socially isolated. Activities for pregnant and parenting adolescents should provide information about expected physiological and emotional changes, good baby care, healthy timing and spacing of pregnancy, contraceptive options, and the importance of health care during all stages. Programs should consider including a component of financial literacy and/or savings and loans to help FTYPs prepare financially for pregnancy and parenthood. To further foster linkages to the health system, consider holding group sessions within a local health facility and/or inviting an adolescent-friendly provider to facilitate one or more group sessions.
- When present, involve male partners in activities, and highlight the positive role of fathers during pregnancy, delivery, and the postpartum period. However, recognize that program approaches may need to be tailored according to FTAMs' marital status, as inviting male partners to participate in group discussions may further isolate the FTAMs who are not partnered. The role of marital status likely differs

between the northern states, where early marriage and childbearing are more normative and where childbearing most often occurs within the context of marriage, and the southern states.

- Social capital will also contribute to the empowerment of FTAMs and decrease their dependency on partners and others by creating a supportive, trusted network of people that they can rely on in times of need. Religious institutions appear to provide some programming that could be transformed into stronger social networks for its participants. Community-based programs around work training could also help create a network.
- During the design phase of projects to reach FTYPs, consider mapping local systems and platforms that can facilitate efforts to build FTYPs' social capital. The easiest way to implement interventions in this area is to expand on systems and platforms already in place. Because exploring social capital was not part of the specific study objectives, the data in this study did not offer much information about what might already be in place beyond groups at church. There was virtually no information shared about such programs in the north.

Consider the Holistic Needs of FTYPs

- FTYPs, particularly FTAMs, in Nigeria have limited use of health services and use unhealthy practices because they lack influence over their own decisions and because of cost barriers. Much of FTAMs' powerlessness stems from lack of education and financial resources. Connecting FTAMs with education and livelihood opportunities could help mitigate cost barriers and provide FTAMs with leverage in negotiating decision-making with partners and family. Education and work were the two pivotal elements identified as driving girls' empowerment in Nigeria.
- Explore what resources may be available to ensure that after giving birth, FTAMs are both eligible and able to continue their education and enter into job training. Implementing programs that will give girls the resources to become less dependent on family and husbands will increase the chances that they will seek care for themselves and their children. Programs should consider integrating livelihood training, opportunities, and strategies for keeping girls in school through the secondary level—whether mothers or not. Without addressing these structural factors, in addition to the specific needs of FTYPs around health, it is unlikely the uptake of care will be successful in the short or longer term.

Improve Understanding of the Role of FP and Choice of Available Methods

- Build on social norms that strongly support the ideal of child spacing for the health of mother and baby, and the harmony of the entire family. Include accurate information about available FP choices and their side effects in community programs reaching FTYPs and influential family members. Encourage satisfied users to share testimonials about their experience with FP methods to counter pervasive rumors about side effects.
- Consider religious or cultural clashes with the different contraceptive method options in program design. For example, Muslim women cannot participate in some religious activities when they are menstruating. This may mean emphasizing different options in different parts of the country to reduce the chance of side effects that cannot be tolerated by local communities.

References

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Appendix I. State-stratified results

Facilitators of SRH Care Use

Table I. Health system factors that facilitate care use by state

State	Main Themes	Illustrative Quotes
Bauchi	Good experiences with care and high-quality care strongly influence service use.	<p>Sometimes the TBA will only complicate [things] and leave you. Sometimes she will understand there is problem. But in the health facility, they will identify the issue and make a decision. (FTAM 15–19, rural)</p> <p>I was very happy for a safe delivery without any problem, and this was due to care and support [I received] from the hospital and other organizations. (FTAM 18–19, rural)</p> <p>Frankly speaking, TBAs and hospital attendants are quite different. TBAs will only give you herbs. [The] hospital will welcome her ... and put her in bed, give you necessary care before the date of your delivery. (FTAF, rural)</p> <p>Why do you go to the health facility? 1) Anytime we went [to the health facility] and complained about our health problem, they give us the right drug. They give us bed nets and some drugs for free. 2) They take good care of us. All we have to say is thank God and also thank the health workers. (2 older women, rural)</p> <p>What encouraged you and your spouse to go to the hospital? 1) They carefully deal with us and if they do not have [what we need], they refer us and they give us [a prescription], and they politely talk to us. That is what really encouraged us. 2) When I went, they happily welcomed me, and the things they did to me, I was happy. They told us to eat good and healthy food. They said that we should take very good care of ourselves and that we should visit the hospital for ANC for the unborn child. And they advise us to take very good care of our child. (2 FTAMs 18–19, urban)</p>
Cross River	Programs that aid in financial relief or bridge logistics motivate care use, as do good experiences with health care.	<p>There's this new system that the government just started. They will give you a voucher if you want to deliver if somebody is not there with you. They will give you a phone number [to] just call, and the person will be there to take you to [a health facility]—even if it is in the night, the cyclist will come and [bring you] where you are registered. (FTAM 18–19, rural)</p> <p>I found out that in the hospital, if you are from Cross River, if your husband is from Cross River State... Respondents chorus simultaneously: [Care] is free, is free! (FTAM 18–19, urban)</p> <p>Why did you seek care there? They told me about how the health center cares for the baby and the mother also, and they did not collect any money. (FTAM 15–17, urban)</p> <p>I went to that particular hospital because they give attention more than any other one in my town. (FTAM 15–17, rural)</p> <p>The nurses there, they are active, they attend to their patient and do their best. (FTAM 18–19, rural)</p>

State	Main Themes	Illustrative Quotes
		<p>What do you like best about their services? I like the way the nurse behaves with people. They are polite, they are kind. And the way they attend to people. Yes, their character is mostly what brought me here. (FTAM 18–19, urban)</p>
Ebonyi	Quality of care available at health facilities is a major factor in decisions to use health services.	<p>I like [the hospital] because everything you need is there. Even the doctors and nurses approach you courteously. The way they attend to you will make you okay. That is why I love to go there. (Older woman, rural)</p> <p>What motivates you to go (to the facility)? It is because they take care of you. They will teach you what you do not know: [how] to eat, food to avoid sickness. So that is why some of us, especially me, come to hospital to learn. (FTAM 15–17, rural)</p> <p>1) The knowledge or the medical attention given by the health workers. 2) Their services and medical care and attention, like drugs, available drugs, available doctor. (2 FTAFs, rural)</p> <p>Why did you choose to go there? Those who go there to deliver, deliver safely. (FTAM 18–19, urban)</p>
Kogi	Quality of care available at health facilities; prayers being offered in health facilities was also an incentive, as well as getting a birth certificate.	<p>They wrote drugs for me, and they did an exam. And if I have a complaint, I tell them, and they will take care of me. They gave me injection too, and drugs, they wrote drugs for me that I bought. (FTAM 18–19, urban)</p> <p>If you go to the hospital to deliver, the doctor will take care of you, and you will not have a problem. (FTAM 18–19, urban)</p> <p>The hospital [provides] complete care to someone that is pregnant, whether it is blood or something [else] in a pregnant woman, they will do it for her. (FTAM 18–19, rural)</p> <p>I will not want to go to a different place simply because I enjoyed the delivery services I got at that hospital, especially their help in terms of prayers. (FTAM 15–17, rural)</p> <p>So can you describe to me what motivated or encouraged you to go to the health center? I know that if I go to the center, the doctors will attend to me very well, and they will teach, will learn more and more from there. (FTAM 15–17, urban)</p> <p>To me, some people believe that hospital will be more perfect than traditional [care] because during that traditional birth, they might end up using unsterilized equipment. (FTAF, urban)</p>

State	Main Themes	Illustrative Quotes
Ondo	Good experience with care, perceived quality of care, and obtaining a birth certificate. The last quote sums up why being professional and treating everyone well is so important. It is their job to be polite, and it is not remarkable when they are.	<p>MNCH: When one sees how they take care of people, then one can say this is where I will deliver my child. Because if the child does not come out on time, they can give her a drip that will hasten the delivery. But if you go to traditional birth homes, they give her different leaves to drink that will even affect the child. (FTAM 18–19, rural)</p> <p>The way those nurses relate [to people] motivates some people and that will make her come. When someone gives birth here [in the facility], we usually observe how they treat them; they usually attend to them quickly. After giving birth, they will bathe the baby, they will do everything. If you give birth in some other places (clinics), before they will attend to you and they may even be shouting on you. But here, they take good care of people. That is why some people prefer to give birth here. (FTAM 15–17 rural)</p> <p>At the TBA's place, they do not do tests. If she has stomach ache, they do not give injection. At the TBAs, they only give herbs. But if one is sick and goes to the hospital, they will carry out tests, give injection and medications. (FTAM 18–19, urban)</p> <p>The reason I feel people prefer the hospital is that they know that delivering in hospital will enable them to obtain a birth certificate. (FTAF, rural)</p> <p>How courteously the nurses and doctors treated you? They did their job as they ought to. I was very satisfied. (FTAM 15–17, rural)</p> <p>FP/PPFP: The nurses will say, "Mummy what can we do for you?" I said they themselves sensitize people on FP. (Older woman, rural)</p> <p>[At] the [clinic], they will educate you on what to do. They will run tests, and they will educate the person on what to do, how to use it so that pregnancy does not occur. That is why we go. (Older woman, rural)</p>
Sokoto	Quality of care and the importance of safety during delivery; there were no comments about these factors from older women in this state.	<p>1) it is wise to deliver in hospital; it is cleaner. Most of the time, those that gave birth at home cannot even get cleaned. 2) If you gave birth at home, there is a lack of care, but at the hospitals, they will make sure both you and the baby are safe. (2 FTAMs 15–17, urban)</p> <p>Why do some prefer a health facility? 1) Because they attend to you. 2) Giving birth at hospital is safer than home. (2 FTAMs 15–17, urban)</p> <p>Health facilities are meant to treat and give care to people that are ill, and pregnant women are ill. It will never be like health facilities when they give trainings to the TBAs. We have had situations that the TBA refers to health facilities, then why not go the health facility right from the word go. (FTAF, rural)</p> <p>Now why do you think people prefer health facilities to TBAs? It is because of the care given by health workers. For example, the IVs and injections given to women in labor, unlike the TBA who uses rags and keep pressing the woman's abdomen. In [a] health facility, she will deliver safely and stronger. (FTAF, rural)</p>

Table 2. Perception of need and beneficial health care habits by state

State	Main Themes	Illustrative Quotes
Bauchi	<p>MNCH: There is a general feeling that health facilities offer the best care for MNCH. Everyone agreed that partners are responsible for facilitating her care.</p> <p>FP/PPFP: The desire for FP is there, but sometimes traditional methods are tried first.</p>	<p>MNCH: 1) You have to send her to hospital for a medical checkup because you will be more comfortable. It is important for you to go for a medical checkup, not when you are sick. 2) When you neglect yourself, anything can happen with you, but when you are going to the hospital for a checkup, things will come easy. (2 FTAFs, rural)</p> <p>In the case of illness, the TBAs do not know what drugs to prescribe. Likewise, in case of any incident during delivery, they may not know how to handle the case. (FTAM 18–19, rural)</p> <p>What motivated me to come to the facility is I want to have a healthy life. This is a guarantee because if you are pregnant, you will be having some minor ailments. (FTAM 18–19, rural)</p> <p>She (an FTAM) can be told, you are having your first pregnancy. If you are ill, you should immediately visit a nearby hospital. Once the pregnancy reaches 4 months, she should visit the hospital for ANC because some pregnant women experience anemia and eclampsia during childbirth. As they explain to us at the hospital, these problems can be prevented earlier. If the husband will not agree, we will call him for a discussion that she is supposed to visit hospital for ANC. (Older woman, rural)</p> <p>Do you advise mothers to use the service of TBAs that are in the community? 1) Times have changed; those are things of the past. 2) Nobody would want to take traditional medications now. 3) We made use of traditional medicine then, but now things have changed. 4) Now everybody goes to the hospital. (4 older women, urban)</p> <p>1) Honestly, when she asked Musa [to go to the health facility], he should not deny her. He is supposed to support her by taking her to hospital or giving her transport money. He should not stop her from going; she will feel very bad. 2) If I were Musa, I know that I do not have the money, I would try my best to get the money in order to take her to the hospital. I have tried my best to marry her, so equally to take her to the hospital. That is my opinion. (2 FTAFs, rural)</p> <p>FP/PPFP: We practiced traditional family planning. But were used and were unsuccessful. (FTAF, rural)</p> <p>I used to deliver frequently. Initially, that is why I decided to use the contraceptive, and God can now have some time to rest and take care of my children well. (Older woman, rural)</p> <p>FP is very good, so there is time that a husband and wife can make a decision in their homes without consulting their parents. They live together and sleep together, and thereby know what is between them. (FTAF, urban)</p>

State	Main Themes	Illustrative Quotes
		<p>Do you give advice on FP? (All) Yes, of course.</p> <p>1) Now times have changed; you need it. 2) We did not do it during our time, but we give advice for our children to do it. Do you advise newly married couples to use them? 3) Yes, we do, to them most especially. 5) Yes, we tell them. (4 older women, urban)</p> <p>Is there a time that you will want to do FP in future? Yes, I would want to do that in future, but now I am not doing anything, and I am a little bit afraid [of getting pregnant]. (FTAM 15–17, urban)</p>
Cross River	<p>MNCH: It is better and safer to delivery in a health facility for both mother and child.</p> <p>FP/PPFP: Health facilities educate people and provide quality services.</p>	<p>MNCH: Whenever a woman gives birth in the hospital, they will try to check your system and [give] some drugs to help you. When you give birth outside the hospital, there are somethings that those people will not do that tomorrow that might affect you, so I would not recommend it (giving birth outside the hospital) for any of my person. (FTAM 18–19, rural)</p> <p>I prefer delivering at a health facility because life is not two, it is one. [At the] TBA, there are no drugs, no oxygen. [At the] hospital, there will be injection if you cannot deliver or the baby is not coming out; you will deliver very fast [after the drug]. (FTAM 15–17, urban)</p> <p>Because people that are in the health facility have been trained, the delivery will be easier, and you will know if they will be able to deliver on their own or not. (Older woman, urban)</p> <p>I know the risks about all those things [around delivery]. I know and I believe, I can even say I am a 110% sure that it is better to go to the primary health center; it is safer there. (FTAF, rural)</p> <p>Some prefer the health facility because they feel that the health center is safer than the native way. They will be safe, and they will put to bed safely. (FTAM 18–19, urban)</p> <p>FP/PPFP: [At the] health facility, they will educate you on how to use it and how the risk if any risk about it, but just taking it from the chemist or other things might be risky. (Older woman, rural)</p> <p>I will recommend they use a modern FP method because sometimes they are still young, some of them do not even know how to use calendar method. So to prevent having another baby when the other one has not grown, it is better for them to use FP method. (Older woman, rural)</p>
Ebonyi	<p>MNCH: Most feel that health facilities offer the best care for MNCH. The perception of need for both types of care was expressed by all groups.</p>	<p>MNCH: For a pregnant woman, it is very necessary for her to go for ANC for her baby inside her stomach to be cared for. (Older woman, rural)</p> <p>I think she should go to the hospital because it will benefit her so much, they will take good care of her there, so it is good for her to go to the hospital rather than to the traditionalist. (FTAM 15–17, rural)</p>

State	Main Themes	Illustrative Quotes
	<p>FP/PPFP: Spacing and limiting are beneficial.</p>	<p>If someone that loves his wife, he should tell her to go to hospital and not to herbalist. I do not trust those herbalist things that they are doing because somebody might die in that place. If you die, your husband will go and marry another wife. So you have to go to hospital and deliver. (FTAF, rural)</p> <p>FP/PPFP: Why do you think they (the people in the story scenario) will start using FP? 1) It will help them to reduce the [number of] children they will have. 2) The problem is not even birth alone because any family without planning, I do not see it as a good family. So they must [use FP] so that the family will stand very strong. (2 FTAFs, rural)</p> <p>There are lot of benefits to child spacing. If you space your children, it helps in raising them and in the economic sense. If you do not space, one finds it difficult. If you space your births, you will be able to plan on how to send them to school and feed them. (Older woman, rural)</p> <p>It is best they start doing FP that space to be able to make their future right. (FTAM 18–19, rural)</p> <p>What services would you like to receive about FP? I would like them to make me not get pregnant again [for now]. (FTAM 15–17, rural)</p>
Kogi	<p>MNCH: Most feel that health facilities offer the best care for MNCH.</p> <p>FP/PPFP: As in other states, FP was spoken of in the context of spacing.</p>	<p>MNCH: And you going to antenatal is to protect yourself and the baby inside you so that you will know how the baby is, is doing inside you, and nurses and doctor will take care of you and know how you feel inside. (FTAM 18–19, rural)</p> <p>She should take the child for a checkup because she does not know the kind of ailment that that child may have after she finished giving birth or which kind of water have they given her to drink or where she is. (FTAM 18–19, rural)</p> <p>I would be coming to the hospital for immunization and checkup doing other things about myself and the baby just to make sure that we are fit. (FTAM 18–19, urban)</p> <p>FP/PPFP: 1) Child spacing is good because these children will be able to assist themselves. The parent will have peace of mind. 2) If there is gap between children, it gives good health. They will be able to help their younger ones, like bathing for them, taking them to school, etc., so that the parent too can have peace of mind. 3) It gives parent a chance to send the elder ones on errands, like bring the feeding bottle, etc. It gives parents rest of mind to allow space in between their children. (3 older women, rural)</p>
Ondo	<p>MNCH: Quality of care; to ensure good health for the mother and baby</p>	<p>MNCH: She should go to the hospital [for delivery] because if she goes to the traditional home, they might give her drugs, but it cannot be like the ones in hospital where they will give them injection. (Older woman, rural)</p>

State	Main Themes	Illustrative Quotes
	<p>FP/PPFP: On FP, spacing is better for the health of the mother and baby. In this state, perceived need was not expressed among younger women.</p>	<p>1) People consider that delivery in a maternity [facility] is better because it is safer. Some of those TBAs may not know what to do in case there is excessive bleeding. But in maternity, they will know what to do. 2) I think women consider maternity because the doctors have a better understanding of the kind of drugs the women will need, unlike the TBAs. (2 FTAFs, rural)</p> <p>Those TBAs cannot provide quality [care] and [ensure] sound health. They will tell you that they will pray, bring oil, take prayer water, and they will not know what to do if complication arises. When a complication arises, before they get to the hospital, the woman and the child may die. I cannot advise them to go to the TBAs, but if they insist going to the TBA, I will also advise them to register in either private or public hospital. (Older woman, urban)</p> <p>...should go to the hospital because they will do a body check for her. The local traditional drugs she wants to use, she can use them so that she can give birth on time, but it cannot be like hospital because they will see how the baby is positioned. (FTAM 18–19, rural)</p> <p>When I wanted to give birth, I discussed with my husband that I will deliver at the clinic because of safe delivery and I do not want complications. (FTAM 18–19, urban)</p>
Sokoto	<p>MNCH/ENC: People expressed perceived need, describing that they felt they were safer and better for mothers and babies, as in other states.</p> <p>FP/PPFP: Spacing is beneficial for different reasons. Several people mentioned that breastfeeding a baby while the mother is pregnant is bad for the baby.</p>	<p>MNCH/ENC: <i>Do you think Aisha (mom in the story) will go back to that facility for a follow-up check on her and the child?</i> Sure! She should go for checkups on her and the baby. (FTAF, urban)</p> <p>She will go back because there are some set of injections administered to the child at 2 weeks after birth. (FTAM 18–19, rural)</p> <p>What would motivate you and your partner to come to the health facility? 1) To look after your health when pregnant. 2) I am of the opinion to come to hospital for checkups. (2 FTAMs 15–17, rural)</p> <p>What I think is when we go to hospital, we get advised on health issues, hygiene, and what kind of food you eat for healthy delivery. (FTAM 18–19, urban)</p> <p>FP/PPFP: There are men that once their wives have started menstruating [after childbirth], they take action. They believe that the moment a child is breastfed while the wife is pregnant, the child will become ill. Due to that, some will use FP. Either they find pills or injections for the wife, or they go to the extent of finding implant for them. All they want is their child to stay healthy. (FTAM 18–19, rural)</p> <p>The good thing about child spacing is that otherwise, you have hands full with children, and their upbringing and their health issues becomes hard to handle. (FTAM 15–17, urban)</p>

Table 3. Gender equality and empowerment by state

State	Main Themes	Illustrative Quotes
Bauchi	<p>Women's empowerment was not mentioned.</p> <p>Couples make decisions together about FP.</p>	<p>I have a wife, and we discussed [using FP] together. (FTAF, rural)</p> <p>In a nutshell, [the] decision [about FP] is taken together. (FTAF, urban)</p> <p>We sit together to make [a] decision on health issues. He can advise me or we discuss together. (Older woman, rural)</p> <p>We agreed between us [about FP use]. (FTAM 15–17, rural)</p>
Cross River	<p>Women's empowerment was not mentioned.</p> <p>Couples make decisions together about FP.</p>	<p>For me, that decision [about delivery care] is supposed to be made by the couple. If they choose a hospital, even if they do not have the resources, I believe that they will look for a way. Maybe they can seek help either from their parents or other relatives. So if they make the decision that they want to go to the hospital, no matter what and they stick by that, they will go to the hospital. (FTAF, urban)</p> <p>It is an agreement between the two of them. With time, they will have second child, when everything is well with them. (Older woman, urban)</p> <p>If the husband can understand the wife very well, they will sit down and discuss. Maybe the husband will decide that, OK! Yes! I have heard my wife. Maybe she wants to go back to school because she has not finished her education or she wants to go back to work. Let her see whether she will have a job. Maybe the husband will understand with her. (FTAM 18–19, rural)</p> <p>Both of them must come to a concrete agreement, like after getting married. (FTAM 15–17, urban)</p>
Ebonyi	<p>Women's empowerment comes from advanced schooling and working.</p> <p>Couples make decisions together about FP.</p>	<p>I will go back to school and work for the government. So you too can do this so that if you are married or if you get married or if you have a child, you can know how to control your own, so that I can have voice in public, to talk to my child, and I will have my own identification, and my own certificate, so that even if I am going out to do anything, they will say look at that woman, it is true, oh, she has given birth before, but now she is a graduate. I will have a voice in the community. (FTAM 15–17, rural)</p> <p>My own idea is that when you finish your university and finish your service, and you have a better job, at least when the father of your baby is not responsible in any way (meaning he is not involved), you can still head the family. (FTAM 15–17, rural)</p> <p><i>Does your husband support you to make decisions on your own, or does he like to make the decisions?</i></p> <p>1) We do it together; we exchange ideas before we decide on what to do. 2) We do it together. 3) We do it together. (Older women, rural)</p> <p>The decision is for the both of them because if they decide it will be a male child, if they put it in prayer, God will answer them, and they will give birth to male child. Any family that does not decide as a couple, if one person carries a case in his or her mind, I do not think the family will stand, so the decision will be made by both of them. (FTAF, rural)</p>

State	Main Themes	Illustrative Quotes
Kogi	<p>Women's empowerment comes from advanced schooling and working.</p> <p>Couples make decisions together about FP.</p>	<p>[I tell my daughters]: You need to get education and face your work squarely so that you will not become a beggar. I always tell them this from time to time. (Older woman, rural)</p> <p>Like in my own community, like in our own house. If my wife just delivered, there are so many works that she will stop doing. I need to at least make her happy...reduce her stress. I need to give her a helping hand to make sure that I am always there for her, so it happens a lot (doing women's chores). (FTAF, urban)</p> <p>1) If I can see an opportunity to perfect the work I am doing, and I am able to work and take care of my children so that my family can start as a happy family. 2) It is my desire to finish up with the job training I am undergoing and to finish my school so that I can take care of my baby and I can also take care of my mother. (2 FTAMs 18–19, rural)</p>
Ondo	<p>Women's empowerment comes from advanced schooling and working.</p> <p>Couples make decisions together about FP.</p>	<p>They will sit down to...She will tell him to let them do FP, he can tell her to leave a gap of 3 years before having another baby. Within the space of that 3 years, they will plan, and if they work hard, they will achieve all they have planned. By the time they have another baby, they will be confident that they have what it takes to cater for the baby. (FTAF, urban)</p> <p>My thought is that when my child's baby is 3 months, I will babysit for her so that she can go and learn a trade, because if she is earning a living, in the future, she will not be depending on me to share the little I have with her. I know if she has more than enough, she will remember me. I will even be the one to send for her assistance. (Older woman, rural)</p> <p>(Speaking of the advice her elder brother has given her) He would say when I have delivered my baby [after a few months] and the West African Examination Council exam is near, I should register for the exam and make sure I pass. If I decide that I want to learn any trade, I should learn, and I should not rely on any man. That men tend to deceive people. (FTAM 18–19, rural)</p> <p>1) Couples sit down together and make decisions. That is how it should be. The man cannot make decision alone, so also the wife cannot make decision alone. Couples sit down together and make decisions concerning their home, their children. 2) We make decisions together with our husbands, and we discuss very well. (2 older women, rural)</p> <p>The FP that I did, it was a joint agreement with my husband. (Older woman, urban)</p> <p>1) With respect to the question, the man and the woman, once they are ready to start having children, the man will call the wife and discuss with her and before the arrival of the child. 2) Husband and wife, the way they plan to have their first child is that if they want to give birth to the first child, they will sit and discuss. They also discuss about the sex of the child. For example, if the child is a male, they will send him to such school to get educated. At times, they also plan for the name of the child before the arrival of the child. (2 FTAFs, rural)</p> <p>Yes, couples do talk about child spacing. Monetary conditions do make couples to talk about child spacing. (FTAF, urban)</p>

State	Main Themes	Illustrative Quotes
		<p>It is the husband that will talk to his wife and if the wife agrees, they will both agree with each other. If the wife says it is not yet time, the husband will have to wait.</p> <p>So, is it both couples that decide to have a child? 1) Yes. 2) It is the two of them that will decide to have a child. 3) It is the two of them that will decide to have a child. (4 FTAMs 15–17, urban)</p>
Sokoto	<p>Women's empowerment was not mentioned. One FGD of older FTAMs stated that husbands can help their wives do their chores, but FTAFs and older women felt that this was not possible without incurring stigma.</p> <p>Couples make decisions together about FP.</p>	<p>For every man that knows the value of marriage and got married out of love and not out of something, then there is need for him to involve his wife in it. You do not underrate your wife. If you do not plan, then you are bound to regret later in life. (FTAF, rural)</p> <p>It is always best to discuss it with your husband. He can even agree to child spacing for a year or two, and mostly you began discussing about it before the marriage. (FTAM 15–17, rural)</p> <p>Now what do you think about this, a husband assisting his wife? 1) It is a sort of respect and love between the couples. 2) He is being nice to her, and when she is doing such chores, he decides to assist her. 3) Truly, it strengthened the relationship between the couples. (3 FTAMs 18–19, rural)</p>

Table 4. Ambivalent thoughts about the healthy timing and spacing of pregnancies by state

State	Main Themes	Illustrative Quotes
Bauchi	<p>Husbands' approval can determine FP use. While some husbands want to begin childbearing right after marriage, others value completion of education.</p>	<p>There are some husbands that give their wives contraceptives after marriage they because they want to rest first, but in my opinion, this is not right. The proper thing is when you get married, they should test the woman's womb to know if she can conceive or not, that is the first thing. When she gives birth, then they can go for FP. (FTAM 18–19, urban)</p> <p>Was there a time you wanted not getting pregnant? Yes, when we got married, I had not finished secondary school, and he wanted me to be educated. We went and they put implant for me. My husband sees me as a small girl that cannot start having children yet. But when they did [the implant], I was afraid it can cause some problems, but surprisingly, they removed it, and after few months, I became pregnant. (FTAM 18–19, urban)</p> <p>Like me, there is the issue of FP, but I am in school, and my wife will start school next year. I told her that since she has started FP, we will not stop until I finish my school completely and obtain a job; she also will have to finish school. She said that she cannot continue because it is disturbing her, but I told her to be patient, and we should not take chances because of the side effects. Right now, we are facing problems. She said she will remove it after 2 years. But I still stand on my decision that until we finish school before we have another child. (FTAF, urban)</p> <p>I have never used one [FP method], but all my children are spaced for 2 years except the last one. I got pregnant at an old age, and it came just as a space of one and half years, so I became worried. (Older woman, urban)</p>

State	Main Themes	Illustrative Quotes
Cross River	Women enjoy more decision-making in choice to use FP.	<p>I want to [use FP] and have a rest. I want to do my own, even if it is within 1 year, if I can have the four [children] within 1 year [of each other], I will just stop there. (FTAF, rural)</p> <p>It is better for the both parties to agree, but in my own case, it was the girl that decided to have the baby. (FTAF, urban)</p> <p>I like to have a child very quick because some people are having, they have child, and they train their children very well, and they take care of them. I like the way they are treating their children, and I will also like to have a child. (FTAF, rural)</p>
Ebonyi	Child spacing is valued and a main factor in the decision to use FP.	<p><i>Have you spent time talking with your adolescent child or adolescent relative about becoming a mother or father?</i> Yes, because she gave birth through operation. I now told her to give space of every 2–3 years before getting pregnant again. (Older woman, rural)</p> <p><i>When should you have another child?</i> Two years after first child at least; the child should start school. (FTAF, rural)</p>
Kogi	FP decision-making should be done as a couple. Child spacing is valued.	<p>Whenever I give birth, I give a space of 3 years between my children. (Older woman, rural)</p> <p>The husband and wife are supposed to be discussing FP because wife alone cannot do it. She and the husband are supposed to know about the FP. (FTAM 18–19, rural)</p>
Ondo	Responses on spacing seem idealistic, not realistic. Child spacing is highly valued, and couples are encouraged to complete their education before beginning their reproductive lives.	<p>I said we can do FP after 6 weeks so that our husbands will not start having extramarital affairs, and we will also be able to do whatever they want. (Older woman, rural)</p> <p>1) An FP method can be used after three children. 2) After giving birth to three, four, five children. (Older women, rural)</p> <p>1) The best time to give birth to a second child is when the first child is already 5 years old, 3 years, 5 years, or 6 years, one can give birth again. 2) If the first child is about 5 to 6 years, one can give birth again. Some may become pregnant with their second child if the first child is just 1 year old. This is not good enough. (2 older women, rural)</p> <p>His baby should be up to 2 or 3 years before we have another baby. (FTAF, urban)</p> <p>He can tell her to leave a gap of 3 years before having another baby. Within the space of that 3 years, they will plan, and if they work hard, they will achieve all they have planned. By the time they have another baby, they will be confident that they have what it takes to cater for the baby. (FTAF, urban)</p> <p>The womb is like a balloon. You know, the more you blow the balloon, the thinner it becomes. If one is not patient enough and gets pregnant too quickly, even the body will not be at peace, the womb will not recuperate well enough, at least a woman should wait for 2 years before getting pregnant again. (Older woman, urban)</p>

State	Main Themes	Illustrative Quotes
		<p>We are supposed to use an FP method after delivering our last baby. It is good to do FP so as to plan and cater properly for the kids on ground, so we should do. (Older woman, urban)</p> <p>Immediately, he heard that the wife is pregnant, he will be happy at first and say this is what he has been expecting for a long time, he will be very happy. Before he now thinks about it that he does not have a job and he is still managing with his boss. But he will still be happy, he will say that even if he is not working, the little amount they give him, he will use to take care of them and will also think that he has been catering for her even when she was not pregnant and she was staying with him, he is free. He will also think that there is no time pregnancy cannot occur, so anytime pregnancy occurs, it is with ease. It is not something that will knock that please open the door for me let me come in; it is a sudden issue that the person carrying the pregnancy would not know. (FTAM 18–19, rural)</p> <p><i>Did you speak with your adolescent child or adolescent relative about the ideal time to have their first child?</i></p> <p>We do tell them “Wait till you are 25 so that you can complete your studies.” Some of them will hiss on us, “Some of them will say are you my parent that you are lecturing me and talking to me like this?” “Complete your studies, wait till you are 25 before you get married so that you will be given your rights by your parent. Even as your parent, we will give you what is rightfully yours.” But when they will not be patient enough to receive their rights, what can we do? (Older woman, rural)</p> <p>1) The best time that one can start giving birth is 25 years of age because at that age, he must have most of the things he needs as a man. Even if he wants to learn a work, he would have done that, and once he has what is required to satisfy his family. 2) The best time to start having children is 30 years because one should go to school or learn a work and also become independent. The mistake I made was that I was not supposed to marry when I did; I was supposed to be independent and have my house and be okay, then get married because woman is the last property a man should have in this life. That is my reason. 3) The best time to start giving birth is at the age of maturity once you are mature, which is put at 18 years. At times, one can still be schooling and still get married. So the right time is at the age of 18 years. (3 FTAFs, rural)</p>
Sokoto	<p>Child spacing is valued for health and family harmony. Limiting is not accepted; God should determine the number of children.</p>	<p>Because when you have another pregnancy while breastfeeding, it is bad omen for the child because he might be sick and the mother also, he will not get full attention, so as the father, but when you have child spacing, the newborn will get support from the brother. (FTAM 15–17, urban)</p> <p>My wife is pregnant now, though I do not know what God has planned for me. However, my opinion is to have the second child in 3 to 4 years’ time when the child must have become stronger and my wife had enough rest. (FTAF, rural)</p> <p>I will say something but not as Musa, I think as couples there is every need for them to sit, and every one of them has bring facts to convince the other. If Musa has more facts to back his claim for 10 children, they should work with it. If Aisha has more facts, then Musa has to agree with her and go for only two children. Now if I were Musa and I tried to convince her but she did not agree, I will simply marry another wife. Only God knows the future. Among those children, there could be a wealthy person. Anything can happen, there could be good people among them, and there could be bad ones. (FTAF, rural)</p>

State	Main Themes	Illustrative Quotes
		For every man that knows the value of marriage and got married out of love and not out of something else, then there is a need for him to involve his wife in it (the decision). No matter what you want, in fact if you want this to succeed, then you have to involve her in decision-making. You do not live a life like this; do not underrate your wife perhaps because of her level of exposure in life. If you do not plan, then you are bound to regret later in life. (FTAF rural)

Table 5. People who positively influence use of care by state

State	Main Themes	Illustrative Quotes
Bauchi	Partners, in-laws, and parents facilitate care use.	<p>MNCH: As a head of the house, am the one responsible for my family. I can take her (wife) to the hospital with nobody else (i.e., other relatives) concerned. I will save some money for the plan or I should sell something for her delivery plan. (FTAF, rural)</p>
Cross River	<p>Apart from parents and in-laws, who will give FTYPs money to seek care, partners are considered responsible for their wives' care.</p> <p>Peers and friends were mentioned by several people in the context of FP. One woman reported that she decided on her own. Relatives talked to FTAMs about FP.</p>	<p>MNCH: My father-in-law tell me I should go to the hospital and register. Then I went there. (FTAM 15–17, rural)</p> <p>Like my mom, she will not allow me I should go and deliver in these women in the house. She would prefer me, I should come and deliver here in this hospital than to go and deliver in the house. (FTAM 18–19, urban)</p> <p>1) [The husband] will take her to the hospital for nurses to check you whether is labor or something, so he will have to take her to the hospital let them check you. 2) [The husband] will take her to the hospital and be there with her. 3) If [the husband] does not want to go with her, he will give her money to go to the clinic by herself. (3 FTAMs 15–17, rural)</p> <p>Who advised you to come for antenatal? It was my husband too that said I should start antenatal, and my mum too. (FTAM 15–17, urban)</p> <p>Did anyone or anything help or support you in choosing this facility for you and your child? No, I chose it by myself. (Older woman, urban)</p> <p>Who else was helpful to you in making decisions to use FP method or contraceptive to delay getting pregnancy? 1) Peers. 2) Yes, friends. (2 FTAMs 18–19, urban)</p> <p>FP/PPFP: Have you ever spoken to your child about child spacing? Yes. I used to talk with her so that she will go to the hospital and make FP so that she will not get the baby. (Older woman, urban)</p>

State	Main Themes	Illustrative Quotes
Ebonyi	<p>Parents and parents-in-law take care of FTYPs. Partners provide money, help with transport, and are expected to care for their wives. Partners motivated for getting care for their wives were very determined. Again, some FTAMs said it was their choice to go.</p> <p>Mothers advised daughters about using FP.</p>	<p>MNCH: I do not think my wife will go near that herbalist. If I do not have money, I can come to the hospital, and they will give me one path to be cleaning for them. Maybe in a month, my wife will go, provided that I am sleeping in the hospital and cleaning the place for them. It is not a problem. (FTAF, rural)</p> <p>I will tell my mother or my father to help me because I do not have any money to help my wife to go to the hospital. (FTAF, rural)</p> <p>1) I will look for money or go to my neighbors to look for money so that I will go to the hospital. 2) I would go to meet my mother; my mummy will give money to go to the hospital. (2 FTAMs 18–19, urban)</p> <p>We advise them to go to the hospital so that the experts will take care of them do what they are supposed to do, and if they see that the person will have problem during childbirth, they will give her date. She will be told from this time to this time, pack your things and come to the hospital. (FTAF, rural)</p> <p>What motivated or encouraged you to go to the health center? To see that my baby and I are very OK. (FTAM 18–19, urban)</p> <p>FP/PPFP: Have you ever spoken to your adolescent child/relative about child spacing? 1) Yes, what I do tell her is that so that her baby will be healthy and stronger. 2) Yes, my daughter that gave birth using operation, I personally took her to the clinic for implant, until she wants to remove it. (2 older women, rural)</p>
Kogi	<p>Partners play a major role in facilitating care, as well as parents and parents-in-law.</p>	<p>1) He [husband] plays a major role by providing all is required. 2) He will be there in case they need anything. 3) It is paramount the husband stays close, especially if they encounter problem, especially with first birth. (3 FTAMs 15–17, urban)</p> <p>If it is me, I will take her to hospital so that doctors will confirm me the pregnancy, as assist when necessary. (FTAF, urban)</p> <p>Who helps make decisions about health or seeking health services and accessing them? 1) Nobody does that except their husbands. They are their partners; they know them better and know their problems. 2) The husbands are in a good position to do that. They know everything about them. 3) And as far as I am concerned, they (partners) should be the first to assist or guide them. (FTAFs, rural)</p> <p>Do you advise any young mother to come to the hospital or antenatal or on taking care of their health and their baby? (All) Yes, very well. 1) I swear very well, very well, even now they normally call us at night and tell us there is labor. Then we will ask them to follow us to the hospital; they will give birth there, clean up the baby, and give back their babies, then they go back home with their baby, and we advise them well. (Older women, rural)</p>

State	Main Themes	Illustrative Quotes
Ondo	Partners are mentioned by everyone. Parents and parents-in-law were also named as helpers.	<p>When they are pregnant, [the husband] gives them money to come and obtain the card, and when it is around the time to give birth, he comes along with them to the health center. When we get home after their childbirth, he buys drugs for them. (Older woman, rural)</p> <p>If her mother or mother in-law is not staying with them or not around, and Tunde (the man in the story) is behaving like this (not taking her to the clinic when she is sick), she can put a call through to them and explain what was going on with her and what her husband's response was. They definitely will come and take her to the hospital, where she will be giving medications and will be more attended to. (FTAF, rural)</p> <p>If I am the one [in the story], I will go to my mother-in-law and tell her that it appears I am in labor, that I do not understand how my body feels, and she should give me transport fare so that I can go to the maternity for examinations. (FTAM 15–17, rural)</p> <p>Oyinye (girl in the story) should not listen to her mother-in-law (who advised her against breastfeeding right away) because breast milk is good for the child, and she will tell the mother-in-law at the hospital that she was told the child must take the first breast milk very well on the delivery day. If the mother-in-law does not agree, she too will not agree with her. She will not even say she wants to give the child any local herbs or water so it will not affect the child. (FTAM 18–19, rural)</p>
Sokoto	As in other states, the husband is expected to facilitate the care his wife needs. Other relatives also step in, but husbands appear to have a stronger role here than in other states. However, husbands are directly influenced by parents.	<p>MNCH/ENC: Our parents say delivery in hospitals is safer because they take care of you. (FTAF, urban)</p> <p>Well, his (the husband's) first role is to ensure that she is attending ANC unfailingly, and [he] must provide transport for her if he has no vehicle. Secondly, he must buy all drugs prescribed for her by the health workers and abide by their instructions. (FTAF, rural)</p> <p><i>Did your partner or spouse support you during your current or last pregnancy (before delivery)?</i> He helped me so much. Anything that concerns my health. In any way he can. Since my pregnancy, I have not fetched water. He normally brings me to the hospital. Today he was away, that is why he did not come with me. He gives me money. (FTAM 18–19, rural)</p> <p>His parents and sisters can persuade him to allow his wife to go hospital. (FTAF, urban)</p> <p>FP/PPFP: As the husband, I will take her for FP. (FTAF, urban)</p> <p><i>Have you ever spoken to your adolescent child/relative about child spacing? About using FP methods?</i> 1) I did. It is my daughter, and she still abide. 2) I gave my grandchildren advice to use a rubber after given birth. 3) I used to advice, and they abide. 4) I have two children. All of them gave casual birth. I asked them to do FP. One used injection, and the other uses rubber. (Older women, urban)</p>

Barriers to SRH Care Use

Table 6. Adolescents are unprepared for parenthood by state

State	Main Themes	Illustrative Quotes
Bauchi	Younger FTAMs were likely to express shock, dismay, and anxiety. Older FTAMs expressed a loss of educational and work opportunities. FTAFs expressed concern and happiness. Older women were happy to be grandmothers.	<p><i>What will her mother think of (getting pregnant so early?)</i> 1) The mother will also be scared of the safety of her delivery because she was too young to conceive, so she will think whether the baby might have to pass through cesarean section. 2) The mother will not be worried because she knew that she wedded her early, as such she will not think of anything. The only fear will be for her to deliver safely. (2 FTAMs 15–17, rural)</p> <p><i>How does it feel to be a first father?</i> 1) I know there is a burden of responsibility on me. Before, we were two, and now, Allah has blessed us with a baby, who is another responsibility. 2) I am grateful to Allah, as before I have no child, but has now Allah blessed my wife to be pregnant and after that delivered safely. 3) I show my thanks and gratitude Allah for giving addition responsibility of our children upon us. 4) All praise and gratitude be to Allah for the blessing of a child to us. Before, we were two, while now, we are three. The care of the baby is what we supposed to pay attention on, in addition to its hygiene. (4 FTAFs, rural)</p> <p><i>How does it feel to be first-time father?</i> 1) Actually, is not a small thing. You found yourself in some responsibilities that you never expect. 2) Actually, there are a lot of issues that will come due to immaturity and lack of money. She will say she want this thing though we do not have that money, but we will try our best. (2 FTAFs, urban)</p> <p><i>How do you feel being a parent or relative of an adolescent mother or father and starting a family?</i> 1) We were happy we have increased in number. 2) The day I became a grandmother, I was very happy and was seriously celebrating. I had to give out money as a gift. 3) When I got my grandchild, I thanked my God for giving us the baby. 4) We were very happy both from the mother's side and the father side, as we were the first to get a grandchild. (4 older women, rural)</p>
Cross River	Younger FTAMs were very concerned, and many expressed shame. Older FTAMs expressed a mix of feelings. FTAFs were concerned. Again, here, as everywhere, if the couple is married, it is more positive than negative. Older women were not very happy.	<p>I feel ashamed to face even my friends. Your peer group is looking at you, seeing you pregnant when you are not supposed to be, when you are in school and you were supposed to finish. I am a student, so this is...very, very bad. I feel pressure from my dad and all of that, so it is quite disappointing. (FTAM 15–17, rural)</p> <p><i>What did Onyinye think about and feel when she heard the news that she was definitely pregnant?</i> She will be happy. They are married, and the family blessed their marital life. (FTAM 18–19, rural)</p> <p><i>What did Onyinye think about and feel when she heard the news that she was definitely pregnant?</i> 1) I will not be happy. 2) I will not be happy because she will not be able to take care of the baby. 3) As a mother, one will not be happy mostly, but all the same, you cannot throw the child away. You still help the child (her daughter) and see if you can assist her in one way or the other. (Some respondents nod their heads in agreement.) (3 older women, rural)</p>

State	Main Themes	Illustrative Quotes
		<p>How does it feel to be the parent or relative of an adolescent mother or father and starting a family?</p> <p>1) From the beginning, you will feel sad about it because you do not expect the child to behave that way. 2) For me, is an embarrassment to the family. 3) To me, at first, you will see it as an embarrassment, but as time goes on, to prevent an abortion. You have to give thanks to God because whatever happens, you take it like that God has a reason for everything. 4) If it has happened, it has happened; you cannot question God. (4 older women, rural)</p> <p>A mother cannot be happy to see a daughter go carry a baby at 16 years or 17 years ... no way to finish school, no way to work. It is not a happy thing for a mother with that kind of daughter (shakes head). (Older woman, urban)</p> <p>Well, it is something that is not what you really planned for, like as for me, I am not legally married yet, so the pregnancy of my spouse to be came unexpectedly due to one or two careless sexual encounters. I had a lot of challenges from my family and from the family of my girlfriend, and I am still in school, so it come as a shock. But some family members were there for me that helped me to overcome all the trauma and stress that came with it, but all I can say is that it was challenging. (FTAF, rural)</p> <p>(The birth of the child when the girl is young, but married): 1) It is a thing of joy, they can even, if it were to be my mother, once she hears that my wife is pregnant, she will pack her load and come and wait till the child is born because she will be too much happy. 2) As for me, as my friend notice that my wife is pregnant, every of them would just come to me and congratulate me. (2 FTAFs, rural)</p>
Ebonyi	There were many negative responses, especially among and about younger FTAMs. In the case of the couple not being married, there was stigma and shame. In some situations, there was family support.	<p>How would you feel if your daughter is 15, pregnant, and unmarried?</p> <p>1) Ah! It is very, very bad. 2) It is very sad. 3) Very sad. (3 older women, rural)</p> <p>The thing is, you have to have some work so that you can have some money to train up the baby, even at school or some food to eat or dress so that the baby will grow well. (FTAM 15–17, rural)</p> <p>So how do they treat young people who are starting their family but are not married?</p> <p>1) It differs from family to family. Some families, like my own, threw me out of the house. It still is very bad. I am not yet living with my parents. 2) The experience I had on my own. My father built a bigger house, and he asked me to move to one room so that I can take care of her. (2 FTAFs, rural)</p> <p>The reason she will not be happy is that her daughter has not reached the age to marry. The reason why I am saying that is because my mother was not happy with me the time I was pregnant because my sisters who are senior to me have not gotten married, and I have already given birth to this girl. (FTAM 18–19, rural)</p> <p>My mum, she also took good care of me when I was pregnant. On the other hand, she was angry with me. (FTAM 18–19, urban)</p>

State	Main Themes	Illustrative Quotes
Kogi	There was a lot of stigma around pregnancy out of wedlock among all women respondents, but marriage mediated the responses, as in other states. In some cases, there was pride among men regardless of marriage because their fertility was demonstrated.	<p><i>How would a mother in your community react if her daughter was 15, unmarried and became pregnant?</i> 1) The way they react to them is uncalled for. Like the one I saw, as soon as the girls got pregnant, their mother chased them out of the home. The girls cannot even get money for feeding, and they sleep in different places. The way they treat them is not good at all. 2) I have someone in my neighborhood now with a pregnant adolescent. The parents are annoyed that she did not complete her education, and the mother chased her out of the house. 3) Like my niece when she was pregnant, her mother sent her packing. She only asked her to go and learn a trade, and she did not even finish learning the trade before she got pregnant. We pleaded, but my sister sent her out of the house. (3 older women, rural)</p> <p><i>How will Onyinye react when she finds out she is pregnant at 15?</i> 1) She will be very happy because her daughter is just 15 years and gotten married. 2) Since they are legally married, Tunde will be happy, and there's nothing he can do than just to be happy. 3) Since it is that the both of them have done their wedding, the beauty of marriage is that they should see children, and what I think Tunde should do is that he should be happy because he has seen the beauty of marriage. (3 FTAMs 18–19, urban)</p> <p><i>What did his mother and father say (about a young married male age 17 who has a pregnant wife)?</i> 1) When Tunde and Onyinye's family saw that their children are pregnant, they will say that they will see their grandchildren, when they are still alive. 2) It will be a thing of joy to the parents of the both of them because after their wedding, they saw a good fruit from their children. (2 FTAFs, rural)</p> <p><i>What did his friends say (when he became a father)?</i> His friends should say is that he has now become the father of a child and that he has left the group of the singles. (FTAF, rural)</p> <p>1) I just feel happy because some people get married and try for more than a year, they cannot get pregnant, but me, for the first thing, just 2 months after getting married, my wife is pregnant, so I am happy. 2) To be a father is great. The day that your wife tells you she is pregnant. That is why you will be happy to what your wife told you. (2 FTAFs, urban)</p>
Ondo	Again, marriage mediates responses from negative to positive. There was remorse over lost opportunities. If a man was working and the couple was married, respondents described the situation as a happy one. If the couple was not married, family and community reactions could be severe.	<p>I told her am not her happy with her. Even my son that impregnated his partner was begging, and I was like, everything is just somehow all of you impregnated your partners and you, you now have a baby, I paid for school, you did not sit for the exams, we are not happy. As parents, we are not happy that we have children that are not in school. There is no one that will be happy. (Older woman, rural)</p> <p>I was happy and delighted when he impregnated her, and I do not pray that she should be terminating pregnancy, but she must go back to school. (Older woman, rural)</p> <p>There is no way he will not be happy because he has a job, the wife also have a job, they have done their wedding, both parent are aware, and now they are blessed with the fruits of the womb. What is the usefulness of money without children? (FTAF, rural)</p>

State	Main Themes	Illustrative Quotes
		<p>My experience was that when the incident first happened, the wife's parents were not happy. They were very angry with me ... that was why I was relocated here. (FTAF, urban)</p> <p>When I impregnated a lady, she told my neighbors that she is carrying my child and she does not know how to inform me. The people called me and told me. After they told me, she came to meet me, I told her there is no problem that she is pregnant and I cannot ask a lady to abort because there has been a prophecy concerning me. She now said how will she do the pregnancy? I told her not to worry, and I took her to my mother and told her I have impregnated someone that I have done wrong, but she accepted the child truly. Later on, her mother arrested me with police for impregnating her daughter, and she said the pregnancy must be aborted. The pills did not spoil the pregnancy. At the hospital, they said no problem, that I am old enough to have a wife. (FTAF, urban)</p> <p>When I became pregnant, I was not able to eat. When I want to sleep, it will be as if the baby wants to detach, if the baby wants to move, I do not normally have appetite whenever I want to eat, and I do vomit. Sometimes I could not have my bath, could not wash my clothes, and could not do anything. (FTAM 15–17, rural)</p>
Sokoto	Here, reactions were very severe if an unmarried woman became pregnant. But no matter what her age, if she was married, it was a happy occasion. There seems to be more acceptance of early marriage in this state.	<p>How does it feel to be the parent or relative of an adolescent mother or father and starting a family? 1) Happy (laughs). 2) He feels happy. 3) He will be much excited that he is going to have a grandchild. (3 older women, rural)</p> <p>From the same group of women: How would a mother in your community react if her daughter was 15, unmarried, and became pregnant? 1) Oh! 2) Oh my God. 3) Sadness. 4) Sadness really. (4 older women, rural)</p> <p>I feel very happy when I saw my baby boy. I was happy because God has blessed me. (FTAM 18–19, rural)</p> <p>What will his parents think? 1) They will rejoice with him. 2) They will be happy. 3) They will be happy that their daughter-in-law is pregnant, meaning that they will soon become grandparents. 4) Nothing will make them happy except that the fact that they will soon have a grandchild, even though there is a Hausa saying that “Jika wahalar da kaka” meaning, a grandchild will make his grandparent suffer. They will have a grandchild to play with. (4 FTAFs, rural)</p> <p>Just as you said, he will extremely happy, especially if he is financially buoyant. (FTAF, rural)</p>

Table 7. Financial burden of care by state

State	Main Themes	Illustrative Quotes
Bauchi	<p>Health system factors were mentioned more frequently than financial barriers, but lack of money was mentioned by all respondent groups in both urban and rural areas.</p> <p>TBAs are less expensive than health services and take goods instead of money.</p>	<p>If it (birth) is in the health facility, there is some spending of money, but the traditional birth attendant does not take money. (FTAM 15–17, rural)</p> <p>Since he (the husband) does not have the money, I would call the TBA for her because she can take a small amount of money. She may collect even soap. (FTAF, rural)</p> <p>Even my delivery, I tried to go to the hospital, but he said no. I asked him why cannot we go to the hospital, and he replied to me that he does not have money. I got angry, just put on my hijab, and left the room. We live together with his parents, so when I started feeling pain, I went to my mother in-law and she asked, what is happening? I told her that I want to go to hospital, but my husband said no, he do not have money. She said, stand up, let's go. She held my hand and took me to my father in-law and narrated the story to him. He gave money to my mother in-law and told her to take me to hospital, and that was what happened. (FTAM 18–19, urban)</p> <p>Husbands do not allow their wives to go to hospital that is far. They prefer her to go to the village facility so as to avoid spending much money. (Older woman, rural)</p>
Cross River	<p>Financial factors were by far the most important barriers defined by all respondents.</p> <p>TBAs are less expensive than health services and are seen as providing good care, regardless of finances.</p>	<p>In our community, what really determines where our pregnant wives or mothers go to deliver is their financial strength. You have [the] hospital here. It is a mission hospital, and their charges are always higher than the government hospital, although they have better services there. (FTAF, rural)</p> <p>When a woman is in labor, you go to a TBA. They will just receive you, and make sure that you are safe and your baby safe. But when you go to the hospital, if your bill is \$550, they will tell you give us \$275 before we do we start the work, and what if the money is not there? You will just die. (FTAM 18–19, urban)</p> <p>I like the TBA because even though you do not have money, the woman will help you deliver the baby, take care of you. Sometimes you are not with money, you rush go to hospital, but if you do not have money, they tell you to wait until you bring someone to sign for you. (Older women, urban)</p>
Ebonyi	<p>Financial factors were the most important barriers mentioned, across respondent types.</p> <p>Using health services costs more than people can afford.</p>	<p>If you do not have money, it is difficult to access health services. You feel reluctant to go to the hospital. (Older woman, rural)</p> <p>(Respondent said she had no money)</p> <p><i>If you had money, would you have gone elsewhere?</i> Yes. If I had money, I would have come to the health center. (FTAM 15–17, urban)</p>

State	Main Themes	Illustrative Quotes
Kogi	<p>Lack of finances was mentioned more frequently here than other reasons for not using care. All respondents mentioned finances.</p> <p>Health services cost too much, and FTYPs are dependent on others who also lack the money.</p>	<p>I have not visited once for antenatal because I do not have money and the father does not have. Why some people like delivery at home is that they, they look, they will not have enough money to pay, to pay in the hospital in the time of delivery. (FTAM 18–19, urban)</p> <p>Since the husband is already feeling that the charges at the hospital are quite high and he cannot afford it, so she does not have choice than to go to a TBA center to deliver her baby. (Older woman, rural)</p> <p>1) Most people face the problem of lack of money. That is why. But for me, now am already having my money because I do not want to leave my wife at home, I want to take her to hospital. 2) Exactly for me too, just because of lack of money, that is why people will decide to take her to this local place. (2 FTAFs, urban)</p>
Ondo	<p>The high cost of health services compared to TBAs was the most important barrier mentioned. All respondents mentioned finances.</p> <p>Health services cost too much, and FTYPs are dependent on others who also lack the money. TBAs charge a fair price.</p>	<p>The impact they (husbands) have is they may go and ask from those that have delivered once at the hospital at first or the traditional birth home. If the person says hospital, the husband will ask how much is being paid, and he will then decide if he will take his wife to the hospital or the TBA's place. (FTAM 18–19, rural)</p> <p>Why don't you go to hospital? I cannot go for many reasons. Those in hospital collect a lot of money, they dupe people. There's money for the form, money for a urine test, money before they register me. After delivery, you still have to pay a lot of money. That is why I resorted to the TBA. The TBA will not add to the registration fee, and she will also take care of you if you are ill and will not ask for more money. (FTAM 15–17, urban)</p> <p>If there is money, there is no place one cannot go to take care of one's wife. When there is no money, one looks for a place that charges less...It all depends on money. (FTAF, urban)</p>
Sokoto	<p>Finances were less important than health system-related and religious factors, but they were still a significant barrier.</p>	<p>Some patronize TBAs because of the high charges in the health facilities. One has to pay in hundreds [of naira]. (FTAF, rural)</p> <p>Using health services (for ANC and delivery) is the most paramount, she need to go injections, parents need to look after this.</p> <p>What might stop her from going? If her husband has no money. (FTAM 15–17, urban)</p>

Table 8. Health system-related barriers by state

State	Main Themes	Illustrative Quotes
Bauchi	<p>Health system factors were paramount among other barriers mentioned. Staff were reported as rude and uncaring. Quality of care is low.</p>	<p>That is why you see people with their prescription going to chemist because it is easier and friendliness is key. If you are well received, you will be very happy. If they behave like this, one will be confident, and you will say all that is wrong with you, no fear. But when they are asking you and frowning their faces, "What is wrong with you?" Or "What is next?" You become confused coupled with the sickness. (FTAF, urban)</p> <p>In the health facility, sometimes they scold and even slap the woman. That is why we prefer to deliver with TBA. (FTAM 15–17, rural)</p>

State	Main Themes	Illustrative Quotes
		...But the biggest problem we face is that if you go to such hospitals there are no qualified staff to attend to you. The senior staff just go out and leave these students to run the affairs of the hospital while they are not yet qualified. At times, you will not meet the qualified doctors because they have their private clinics. (FTAF, urban)
Cross River	<p>Health system barriers followed financial factors in order of importance, but they were universally mentioned by all respondent types.</p> <p>Facilities lack supplies, drugs, and staff. The attitude of health staff was mentioned most frequently in this area. Attitudes included embarrassing FTAMs. Several respondents mentioned fear of cesarean sections, associated with doctors' desire for money rather than it being good treatment.</p>	<p>The first day I attended antenatal in the place when the pregnancy was still 3 months; it did not show. So when I said that I came for antenatal, everybody was like amazed that you ... pregnant? I said yes, I am pregnant, that I came for antenatal to come and register. Even though they did not say it to me directly, I know very well that they will go behind and say, "Look at this girl, she has not even got to the age of getting pregnant and she is coming for antenatal." So that will start saying some negative things about you. (FTAM 18–19, rural)</p> <p>This last child that my aunty delivered, so they told her [she needs] a cesarean section, but she said will push it out, and she pushed it out. There is some doctor that like money, oh! (FTAM 18–19, urban)</p> <p>Some nurses will say this girl is very small, this one is too small, ah! See this little girl, ooo! That she is pregnant just get into, ehh! (FTAM 15–17, rural)</p>
Ebonyi	Barriers mentioned included shaming and negative attitudes of health workers, fear of cesarean sections, and a few mentions of wanting female practitioners.	<p>When I came for ANC, a nurse here asks me, are you married? I told her yes, and other asked, are you sure this girl is married, and they told them yes. That is embarrassing. (FTAM 18–19, urban)</p> <p>If it is at [the hospital rather than at a TBA], they would not be that patient. If the baby delays in coming, they will operate on you immediately. (Older woman, urban)</p> <p>1) Some of the staff do take bribe. When the truthful ones come, they tell you to pay exactly what is written on paper. Some take more than required. 2) If you do not have the amount they ask you to bring, they will not take care of you. (2 FTAFs, rural)</p> <p>So who would you have preferred to attend to you? A female doctor. (FTAM 15–17, rural)</p>
Kogi	Barriers mentioned included shaming and negative attitudes of staff, preference for care with a TBA, and logistics around lack of transport.	Even in the hospital, when you told them you come for antenatal, some nurse will be looking as if this one is very small (young). They do not really attend to them. That is why some of the adolescent mothers do not really want to go to the hospital or even for antenatal because instead of encouraging and giving advice, they will insult and abandon them. (FTAM 18–19, urban)

State	Main Themes	Illustrative Quotes
		<p>The TBA women do exercise patients very well if it is in the hospital and they see that the woman is laboring and she is delaying in child delivery. The next thing is that they will say they should operate her and bring the baby out. (FTAF, rural).</p> <p>...All those nurses, the way they use to shout on patients, I do not like it. They create fear in our heart. (FTAM 15–17, urban)</p>
Ondo	Most comments related to the shaming and negative attitudes of staff, particularly toward adolescents. There was also stigma and shame if a maternity kit was not brought to the hospital.	<p>1) There is a health center. The way they related, I did not like it. 2) Some nurses are always cranky toward patients. Some will just shout on you and will not give very good advice. 3) Some people will shout that what have you come to do today, were you told to come? That is why some people do not go to hospital. (3 older women, rural)</p> <p>Most of what prevents pregnant teenagers from coming to [the] hospital is because of insults. For example, the day I came to register, I cried. The statement the woman made was that when you chose to have sex, did not you know the end result? I have asked the question before, that are nurses taught to insult people when they go to school of nursing. Some do not know how to be tolerant of others. (FTAM 15–17, rural)</p> <p>Why I do not want to register is because they abuse us, that this young girl is pregnant. If they even ask us to come to the maternity, they start abusing us from the clothes we wear and even say ... we do not know the date of our menstrual cycle. They abuse us; that is why I did not register. (FTAM 18–19, rural)</p> <p>Since she is attending ANC, when we got there, we were given a list of things to buy. They are not concerned with what you have at home but about what you will bring to the hospital. You will be greatly rebuked if you do not bring them. (FTAF, urban)</p>
Sokoto	In this state, it was not acceptable for male practitioners to attend women for pregnancy and delivery. Quality of care was a concern, as were the attitudes of staff.	<p>1) I prefer my wife to deliver at home in the hands of TBAs because most of the time, male doctors take care of our wives. 2) When my wife is about to deliver, on reaching [the hospital], I saw a lot of men taking care of married women. I just returned home, where she delivers. 3) Some women prefer to be attended to by a woman and not a man. There is every possibility that there is no female health worker in the facility; all are men, and this is just it. (3 FTAFs, urban)</p> <p>The reason of not going to hospitals is mostly men take care of females. (FTAM 15–17, urban)</p> <p>A woman may be in labor, and when you go there, they have to go out and start looking for a health worker. They should be there all the time. (FTAM 18–19, rural)</p> <p>What did you like least? During ANC sessions, some nurses tend to shout on you. (FTAM 15–17, urban)</p>

Table 9. Negative views of FP, methods, and side effects by state

State	Main Themes	Illustrative Quotes
Bauchi	Negative views were expressed about stock-out of supplies, poor quality of care, and some fatalistic/religious barriers.	<p>You will find that sometimes when people come looking for FP methods, some hospital will say it is not available or it is finished and they will have to order for more, so what we need is FP methods availability. (FTAM 18–19, urban)</p> <p>I came back and took injection, and yet I conceived. I went back to [the health facility] and told her I am pregnant despite the injection. She told me that maybe she forgot to check the expiry date before administering the injection. (Older woman, rural)</p> <p>We started going to the nearby hospital, and they told us that they do not have the injection. Then we went to the teaching hospital and did it, and we had to go to a bigger hospital. (FTAM 18–19, urban).</p> <p><i>Are you doing anything to delay getting pregnant?</i> No, I cannot prevent myself from what God has given me. (FTAM 15–17, rural)</p>
Cross River	Fear of side effects keep women from starting FP in the first place, since they feel it may affect their ability to get pregnant when they want to, and women complained about stock-outs.	<p>Like me specifically, my girlfriend, we used to go to hospital to get some of the necessary drugs because you will come they will tell you that yes, these drugs were supposed to be given, but it has not been made available. So that is the challenges that we really have. (FTAF, rural)</p> <p>(When asked if a young person who has been pregnant will start FP) Some will not start it because it used to affect some women, they will not give birth to a child again. (FTAM 15–17, rural)</p>
Ebonyi	<p>Fear of side effects posed barriers for using care. Most of the information was obtained through word of mouth. This included: It was hard to get pregnant again after using injectables, and the side effects while using them were bad.</p> <p>Older female relatives discourage using FP, and partners are disapproving.</p>	<p>I used the oral pills [that I take every day]. It wanted to kill me, and I stopped it. Since then, I have not used any contraceptive method. It caused me to bleed excessively during my menstruation. It was really pouring. (Older woman, rural)</p> <p>Some men do not support it. It seems, if you tell them FP, [he thinks], “Hey, look at this woman—maybe she thinks this that is the only child that I want in my whole life” (meaning he wants more children and she wants to use FP). (FTAM 18–19, urban)</p>
Kogi	There were no negative comments pertaining to FP in Kogi.	

State	Main Themes	Illustrative Quotes
Ondo	Fear of side effects—perceived and experienced—prevents women from using FP.	<p>When I first gave birth, I spoke with my husband that we should leave some space, so he told me to go and do FP. But since I have heard about its side effects, that it makes people's stomach to be fat and other side effects, I said that I am not doing it. (FTAM 15–17, rural)</p> <p>After I did FP, I started losing weight. It made me lose a lot of weight so I removed it, but immediately after removing it, I will be relieved, but I will get pregnant. Those were my experiences, and then my period was not regular. (Older woman, urban)</p>
Sokoto	There were no negative comments about FP in Sokoto.	

Table 10. Low perceived need for care and harmful health habits by state

State	Main Themes	Illustrative Quotes
Bauchi	People are used to traditional medicine and do not see the benefit of other care.	<p>Do you go the hospital for your baby's health care? 1) No, I have never taken her to the hospital. If she is sick, we just give her traditional medicine, but I have never taken her to the hospital. I was persuaded to take her, but I refused. 2) I do not go anywhere for health care since we use traditional medicine more. (2 FTAMs 18–19, urban)</p> <p>I have not been to any hospital because I feel I can deliver at home safely. Growing up, I have seen my mother giving birth at home, and I have never seen any complication in childbirth despite giving birth at home. She gives birth at home, and she will be healthy, and she has no complications later on. Because of that, I was convinced that I can also wait and see what God will do with us. (FTAM 18–19, urban)</p>
Cross River	There were many comments related to the perception of need for care, with only a few who expressed none.	I have noticed some family members prefer to deliver with traditional attendants due to their beliefs. If they are not really Christians...because they grew up from where their fathers and forefather always believed in this traditional way. They see [the hospital] like something that is a bad omen. They see the hospital as something that is not part of their life. (FTAF, rural)
Ebonyi	Most comments were made by people in rural areas, but there were many more rural than urban interviews in this state, so it is hard to know if these comments mean anything.	<p>MNCH/ENC: Why I like this TBA is because the lady will treat you well. They will scan the baby if the baby is not OK in your womb, they will make the baby to be OK. If maybe something like [intestinal worms] or something like that, the lady will give you drugs, you will drink, and your baby will be OK. And from my own understanding, I like it. I think that the best idea is that TBA. (FTAF, rural)</p> <p>Did you go for a checkup for your baby? No, I did not go to anywhere.</p> <p>Why not? She was healthy, so I did not think of taking her to the hospital. (FTAM 18–19, rural)</p>

State	Main Themes	Illustrative Quotes
		<p>People believe that that [the TBA] is the safest place to go and deliver. There was one aunty that was living at our compound in Onitsha, she met all these herbalist, they will give her something in the bottle that she will be drinking that will be reducing the size of the baby so that when the baby want to come, it will come safely and simple. It is superstitious belief, like they believe that the baby will be stronger than the one delivered in the hospital. (FTAF, rural)</p> <p>FP/PPFP: It is not good for one to decide the number of children one would have because you do not know how many of them that would survive. (Older woman, rural)</p> <p>Harmful health care habits: I said, “Mummy, I am feeling some pains, mummy, please let me breastfeed,” and she said I should not because the thing is yellow. They said I should use my white cloth, I should just let the breast milk flow onto the white cloth, and as she did, the thing was colored, and they said that is how my baby will be colored if I breastfed, so I did not. I listened to them. (FTAM 15–17, rural)</p>
Kogi		<p>If the breast milk did not satisfy her, they should be buying baby food for her. (FTAM 18–19, rural)</p> <p>After bathing the baby, I used hot water to rub the umbilical stump. But people advised me to use Close-Up toothpaste, so I tried it. (FTAM 18–19, urban)</p>
Ondo	Most noted a preference for TBA care or other care.	<p><i>Now I want you to think about your present state, your pregnancy. How are you preparing during this period?</i> I registered with the TBA at the other side [of the village] and the TBA in this place too. I went there because I know she is experienced and also capable of handling any delivery complications. (FTAM 18–19, rural)</p> <p>I prefer the church.</p> <p><i>What type of services do they render for you at the church?</i> They pray for us. (FTAM 18–19, rural)</p> <p>Whenever someone just gave birth, the care they give is that the first day when we get home, they will put herbs on the fire. After they have bathed the baby in the maternity, in our community, they usually say that they do not bathe newborns very well in the maternity. So when they take the newborn home on the first day, they will cook the herbs, and they will bathe the baby, massage the body with the hot herbs, and thereafter they will give the baby to the mother to breastfeed if the baby has not started. (FTAM 15–17, rural)</p>
Sokoto		<p>1) [The baby] can be given some soft food to enable him gain strength. 2) She can give him milk too. 3) She can feed him with children’s milk. 4) She can feed him with Cerelac (brand of instant cereal for infants), not milk. (4 FTAMs 18–19, urban)</p>

Table 11. Stigma around adolescent pregnancy and parents by state

State	Main Themes	Illustrative Quotes
Bauchi	There were very few comments about stigma or being treated differently because they were so young. Most comments pertained to early marriage, which was acceptable.	Yes, some people will say she got pregnant too soon, so she is not supposed to go to the clinic because it is a shameful act. (FTAM, 15–17, rural)
Cross River	Comments included a mix of shame and about being treated as if they have no status and no financial position. Being married mediates this community reaction; married women do not face the same kind of reaction that unmarried pregnant adolescents do.	<p>What do people think of pregnancy at an early age?</p> <p>It is not all parents that will get angry, even though they will talk, but, like my mother, she is always there for me, whenever I need her help, she will be there. And the community, they did not see it as a crime. Even if though they might talk, but it was not all that, so they will still accept us as their own. (FTAM 18–19, urban)</p> <p>Actually, they will treat us different from people that are married (sigh!). They not give you the kind of respect that they will give married people. They will maybe said that you are not at the normal age for you to have girlfriend that will have baby for you. They think that you have to pass through marriage procedure and maybe you are not buoyant enough for you to have wife before you get a baby. That is my own opinion. (FTAF, urban)</p> <p>To me, teenage pregnancy comes with a lot of discrimination, especially when finances are not available to take care, when you are heaping your responsibilities on another person. That is the way I see it too. (FTAF, urban)</p> <p>I did not feel bad because I like young children having their babies when they are young, and a long time have not had and for a long time have not had a baby in my house, so when it came, I was happy, but the only thing I encouraged her was when she finish, she should go back to school. Because even myself after having my children, I had to go back to school. So I went back to school to become what I am today. So she should also go back to school. (Older woman, urban)</p> <p>The people that are married, especially the ones that wear ring, they see you, you are not wearing ring, (she laughs) they will look down on you. Some will be doing anyhow as if you are nobody. (FTAM 15–17, rural)</p> <p>It is the normal thing that you will be, you will face a lot of things. Your parents have to treat you badly so that you will know that what you have done is wrong. The normal thing you have to face that. But there are some parents, even if their child got pregnant at the early age, they still took care of the baby, they sponsored every need of the baby. But that does not mean that she is not angry with what you have done. She is angry, but she just have to accept it. There's nothing she can do about it. (FTAM 18–19, urban)</p>

State	Main Themes	Illustrative Quotes
		<p>[Adolescent pregnancy] is shameful and embarrassing and disappointing, at the appropriate time it happens, but that will not make us to feel bad and desert or said he longingly. It has happened, it has happened. That is what am saying, I feel disappointed, embarrassed, and ashamed, but that did not make me throw her away. I have to drag her back, encourage her, teach her what she did not know. Let her realize her mistakes, send her to the hospital, given her necessary care and attention at the appropriate time. (Older woman, urban)</p> <p>You will face a lot of things [if you have an early pregnancy]. From friends, your friends will cut short, they will feel maybe you have committed one sin. From your parents, I know it is normal, they have to talk, they have to quarrel, they have to get angry because of the age. Then from community, it is almost the same thing. The stress, the pains, then it happens it is not with the right person or someone who is able to take care of you. (FTAM 18–19, urban)</p> <p>I think the discrimination as the other speaker said will come in when you are not properly married, and then most culture frown at people that are not married and having children outside wedlock and those that are properly married. (FTAF, urban)</p> <p>Some, if you deliver a baby girl, your husband will say, me, I am looking for a male child, not female child. (FTAM 15–17, rural)</p> <p>Yeah, looking at my own background where I come from, we actually value the male child, and if the first child turns out to be a female, we want to go into an FP that will not be long term or maybe using condom so that as soon as the child mature enough, we can try the second one. (FTAF, urban)</p>
Ebonyi	Crossing lines in gender roles is difficult for some people. Husbands may feel like helping their wives but will face stigma in the community.	<p>Some people do not understand that just the man just feels like helping the wife. So they will start saying all sorts of things, that the wife is a witch that she bewitched the husband or that she has turned the husband into a slave. ...Oh, your husband helps you cook, they will say no, your husband is helping you to fetch water...but if the woman is a nursing mother, they will not talk. Depends on the stage of the woman and what the husband is doing. (FTAM 15-17, rural)</p> <p>(if you help your wife to do her work in the house) Some will say that you are the handbag of your wife. That your wife normally says anything and you will do it. (FTAM 15-17 rural)</p> <p>Some of your friend will talk bad against you not in your presence but behind your back and some will talk about you and those that talk good about you are those that like the work that you are doing ... that is my own understanding. (FTAF, rural)</p>

State	Main Themes	Illustrative Quotes
Kogi	There were a lot of comments about shame associated with an early pregnancy, especially if FTYPs are of low financial status.	<p>Like me now when I have the baby pregnancy, I went for antenatal, but the place I went for antenatal is not a hospital, but it is just like clinic because I am even ashamed of carrying this pregnancy, pregnancy outside the street because I have not married. (FTAM 18–19, urban)</p> <p>What do people say about adolescents going for ANC services? 1) It is a shame, and they will not be happy with such a person. 2) If it so happened that it was them and a banker that comes for antenatal, the way they will address the banker will be different from the way they will address us. They will just look down on us saying “Who are you?” (FTAM 18–19, rural)</p> <p>People lashed out at those young adolescents that got pregnant at that age. Because if you sit down with a woman that sees a pregnant adolescent, whether it is her own daughter or not, they will react unfavorably to them. Truly, what they did is not commendable, but a Yoruba adage says, “nnkan eni ki di meji ki inu bi eni,” which means “Your property can be doubled, and you are still angry.” Even if it is not your child and it is someone else’s, you need to be praying for them that they should deliver safely. The way some people see them is critical. (Older women, rural)</p> <p>If you are not married as in the kind of face they will be looking at you outside is not the proper is not, as in nobody will give you respect, that respect you have when you are married. (FTAM 18–19, urban)</p> <p>If you happened to be a youth who is not married, and you are in the midst of those who have been legally married, you do not have any say there at all because they will be telling you do not know how to take care of a home or you have not known the beauty of marriage, and you might not have a say to talk in such environment, and besides, they are looking at the fact that see this one, he brought a woman home, and he did not make any payment on her, so at any time, the parent of the girl can decide to come and collect their daughter back from him. (FTAF, rural)</p> <p>In my own, in this environment, they do not look at them in the same way. They used to look at it that they have not gotten to the stage that they are supposed to give birth that they are already giving birth, and they will look at it that they are still under 18 and are still supposed to be under their parents, and that is why. (FTAF, rural)</p> <p>Do you think people in this community treat young couples who have children or are starting a family differently, than couples in their early 20s? Yes. Because when they are not supposed to [be pregnant but are pregnant], the community will start restricting them and limiting them to some things like, they will say they should stop attending school . . . So they will feel humiliated. (FTAF, urban)</p> <p>Yes, like in our own place when you are not married and you have family, some people will even hate you. How come? Because they, like me, are Muslims. If you do not marry, you have family thinking that you are, you are just have child that is not even belongs to you. You are just even claiming it. But other for place, is not in some, some even have to have a child before getting marry. But for our place, no, no people will even hate you because if you does not marry but you have child. (FTAF, urban)</p>

State	Main Themes	Illustrative Quotes
Ondo	Son preference was clear here, and there is stigma attached to families in which adolescent mothers reside.	<p>People will be looking at the person's mother like someone that allowed her child's life to be destroyed. If the child eventually gets pregnant, they will say that they have said it earlier that the child's life will eventually be destroyed. That is what I want to say. (FTAM 15–17, rural)</p> <p>If their first baby is a girl, what do you think Tunde and Onyinye would do? 1) They will plan on having a male child. 2) They will plan on having a male child. (2 FTAMs 18–19, rural)</p> <p>If their first born is a girl, what do you think both of them will do? Their desire will be that their next child is a male (chorus answer and laughs). (FTAF, rural)</p> <p>I said that because most men in this environment like to have a male child, unlike when the first child is female, and they try another one, maybe 2 years later, they tried another one and find out its female again. He will still feel he needs a male child and try again. It causes polygamous family most of the time; the man will want to try if another woman will give him a male child. (FTAF, urban)</p>
Sokoto	There are extreme norms around unmarried pregnant girls; they are not acceptable in this state. Gender roles are very defined, and the lines cannot be crossed without social consequences in the family and community.	<p>How do they treat young people who are starting a family but who are not married? We see them as rascals. (FTAM 18–19, urban)</p> <p>(About unwed young parents) 1) For people like us, we are lucky to have been married. We consider such affairs as something extremely wrong. It is something like inability to abstain and lack of good domestic brought up, and it is something that has been destined to happen, and it is inevitable.</p> <p>Let us say something like that has happened. How are you going to describe or value that person? 2) He will be considered as someone who has no good character and is willing to lead girls astray. In fact, he no longer has value in the society. 3) Truly, they have no value in the society and shall be considered as someone who has destroyed his reputation and that of his family. (3 FTAFs, rural)</p> <p>1) There is one man in our area, people calls him wife's slave just because he helps his wife with house chores and not going to chat with friends. 2) Wife's slave, they will call him. 3) Or they think she bewitched him. (3 FTAMs 18–19, urban)</p>

Table 12. Religious beliefs by state

State	Main Themes	Illustrative Quotes
Bauchi	There were not many references to religion. Comments were fatalistic in nature for both FP and MNCH.	<p>Was there a time when you wanted to delay your pregnancy? How dare I stop what God has blessed me with? (FTAM 15–17, rural)</p> <p>If your husband is Musa, what do you think you will do (the pregnant woman is sick and in need of care)? I will tell him that if we have the money, I will go. But if he insists [I cannot go], I will just stay back and submit everything to God. Whatever God does is OK. (FTAM 18–19, urban)</p>

State	Main Themes	Illustrative Quotes
Cross River	There were no comments about religion and culture.	
Ebonyi	There were not many comments around religion. The ones that did pertained to superstition.	
Kogi	Prayer is an important element of care here, but prayer is not part of modern health facilities.	The reason some youth allows their wife to go to the TBAs is because they do receive good care there; they will assist them to pray. It is possible for them to go to the hospital and the child will not survive, but [at] the TBA, they would quickly figure out what they can do to make sure the baby survive. (FTAF, rural)
Ondo	Religious etiology was attributed to maternal illness	<p>Some people, their parents already told them you do not know what I went through before I had my first pregnancy. Your father's relative or your mother's relative are the ones behind the spiritual attack that made me have miscarriage upon miscarriage. This is why I am telling you to go to the TBAs so they can find something to do as regards your pregnancy so you will not have any miscarriage. (FTAM 18–19, rural)</p> <p>I delivered, and God did it at the TBA's. (FTAM 18–19, urban)</p> <p>I do not use any drug. I only use the prayer water given by my pastor. At times, he will tell me to drink it or bathe with it. I will buy the water, and I will hold it while my pastor pray on it. (Older woman, urban)</p> <p>Whether one delivers in the hospital or with a TBA, there are some people in church that the prophet has seen a vision about them that they should not deliver in the hospital, that they should deliver at the TBA. Do you understand? (FTAF, urban)</p> <p>If they go to the hospital and they did not have the power to push out the baby, but if it were to be TBAs, there are some things they will do for the person [to] be able to deliver the baby, but if it were the hospital, they will advise operation.</p> <p>You said there are some things that the TBAs can do for someone—like what? Like they use anointing oil and prayer for someone. (FTAF, urban)</p>
Sokoto	Religion plays a strong role.	<p>We do not drink anything, nor do we go to anyone. God will help us to deliver safely. During delivery, the only thing that we do if we are sure is time for delivery is to render help to the person by giving prayer inside water. God will help for safe delivery...when everything is from God. (Older women, rural)</p> <p>Why do young couples decide to deliver with TBAs? The main reasons are there are shortage of doctors in the hospitals, and female doctors are supposed to attend females, not men. (FTAM 15–17, urban)</p>

Table 13. Gender-inequitable roles and norms by state

State	Main Themes	Illustrative Quotes
Bauchi	Only one instance of GBV was mentioned. Gender power here is a mix of male power and in-law power, mostly in rural areas.	<p>(When the girl was quite sick and wanted health care during pregnancy) Honestly, she should have been a little more patient till he comes back. If not and she goes and tells his parents, he will not be happy, and they will start to face domestic violence. The issue of facing domestic violence is not going to end. What she is supposed to do is to go and tell his mother, who will then inform his father, and she waits to see which action they will take. (FTAF, urban)</p> <p>She should ask his permission if she has the money to go hospital for her own and the baby's health. As far as I am concerned, I will not allow my wife to claim that she would deliver only two children for me. She must have to obey my opinion six children in brief. (FTAF, rural)</p> <p>Please can you explain to me some of the reasons why you don't want to go to the government health facility for care? My husband did not allow me.</p> <p>He did not permit you? Yes. (FTAM 18–19, rural)</p> <p>How dare I argue with <i>malam</i> (husband)? He always made the decision. (Older woman, rural)</p> <p>1) His role is to go up and down as became restless now. 2) He will do what he can to see that his wife has a safe delivery. 3) Respondents (all): (Started laughing)... 4) He will pray (laughing). (4 FTAMs 15–17, rural)</p> <p>Because I do not attend hospital, he purchases food that can boost blood in my body. (FTAM 15–17, rural)</p> <p>The role he will play is caring for the mother (i.e., his wife) and the child that they have by giving them food and clothing, and caring for their health. He must play this role. (FTAM 18–19, urban)</p>

State	Main Themes	Illustrative Quotes
Cross River	<p>Respondents made equal numbers of comments about husbands being the decision-makers and that couples decide together. There were also some comments about women taking things into their own hands because their partner would not accept their desire to space pregnancies. There were many comments supporting men making decisions about ANC, FP, and maternal health care for their wives.</p>	<p>The man is the owner of the house, the father or the head, so if I decide to have 10 children, yes, you must keep to it. That is where the marriage is going to scatter because if you do not agree with my own decision, then you are going to park out of the house. If you even need 12 children, if she cannot get, then let them...so it is possible. (FTAF, rural)</p> <p>I go by myself because of too much suffer. (Laugh) I am still talking...I decide on my own because he refuse to accept.</p> <p>So he made the decision for you? I am the one that made the decision on my own because he is not accepting. (Older woman, urban)</p> <p>I will quietly [use FP] after giving birth to two children because there is no how I will stay and see my children crying for food, and there's no food to give the child. After two issue, I will quickly go for FP and seal it up, take the injection and hustle, work for my children and their school fees. I will not let [my husband] know. [He] will be there thinking of another pregnancy, and it will not come. (FTAM 15–17, urban)</p> <p>By right, that is the husband's right because, by that stage, the wife cannot do anything. You need to assist your wife. But is not because your husband is helping you, you need to leave everything for him, so... (FTAM 18–19, urban)</p>
Ebonyi	<p>Gender power is about male decision-making and the relative powerlessness of girls and women.</p>	<p>Many [men] do not take responsibility for being the father—they deny it. [The father] was my senior prefect. He asked me for friendship, and I accepted. Then I got pregnant. When I told him, he did not accept it. So my grandparents, they did everything they could, and he [the man] ran away. (FTAM 15–17, rural)</p> <p>The man can decide because if the woman does not have a job, the man can decide for you. If not, you will not eat for the day. (FTAM 15–17, rural)</p> <p>Any reasonable man would like to make the decision: “Here is where my wife will give birth.” (FTAM 18–19, rural)</p> <p>I told my husband that I am tired of bearing children, but he told me that he is the only one that has the right to say when I will stop having children because the children are the people he has. He also said that the number of children he wants is what I will give birth to. (Older woman, rural)</p>

State	Main Themes	Illustrative Quotes
Kogi	As in other states, there were various mentions of gender power: a husband being able to marry another wife if he is dissatisfied with his current one or because he wants more children, and needing to do what the husband says. The expectations around husbands to care for wives and children could include cooking and taking on other roles traditionally assigned to women to help them during pregnancy. This went across groups.	<p>Since I got pregnant, my husband changed. If I ask him for money, he did not used to give it to me. If I ask him for food money, he did not used to give it to me. At times, he will give me 150 naira (42 cents), and at times 200 naira (56 cents) to eat, and that will not be enough for me to use. (FTAM 18–19, rural)</p> <p>The person that is responsible for my child too did not help me. (FTAM 18–19, rural)</p>
Ondo	Many people reported that the husbands decide what care their wives will access. This occurs in several comments, but especially in partner comments. Some GBV was mentioned in connection to pregnancy.	<p><i>In addition, in our community, do both couples decide together that its time, or it's just one of them that will decide that it's time?</i> Husband.</p> <p><i>It is the husband?</i> It is one of them, but it is the husband's family. It is them that will say it is time to impregnate the wife. (FTAM18–19, rural)</p> <p>1) But if she refuses (to have more children), then he can get another wife to give him the remaining eight children. 2) It is the man that should initiate the plan. (2 FTAFs, rural)</p> <p><i>Who makes the final decision?</i> 1) Husband. 2) It is the husband. 3) It is the husband; whatever he says is the final say. 4) The husband. Whatever he says is the final say. (4 FTAMs 15–17, urban)</p> <p>Husband's house is a learning ground. They said we should submit to our husbands, and we should not be arrogant. (FTAM 15–17, rural)</p>

State	Main Themes	Illustrative Quotes
		Those ones will know how to behave in the husband's house, how they will give birth, how they will take care of the house very well. The so-called husband house that everyone is talking about, the husband's house is a place to learn because anything we do in our own house cannot be done in the husband's house. They say if someone is going to her husband's house, one is going there to learn, and what one gets to learn there is different from what someone has been learning from her parents' house. (FTAM 18–19, rural)
Sokoto	Gender power themes were more prominent here than in other states. Men's decision-making power in the household pertaining to health care is clear. Again, it is expected that it is the man's job to take care of his wife. In this instance, it, so when she experiences danger signs in pregnancy and labor he should take her to the health facility. Most women reported that their husband helped a lot, even with chores.	<p>What determines with whom and where to deliver? (Respondents in total) Husband. (FTAM 15–17, urban)</p> <p>Sincerely am of the opinion not to allow my wife go to hospital because male doctors look after them. I do not subscribe to that. (FTAF, urban)</p> <p>What do you think Onyinye should do? If you were in Tunde's shoes, what will you do? 1) She will not be happy because she knew she will be treated better in the hospital than home. 2) To me, when my wife is about to deliver, I prefer she to stay at home because all my parents delivered at home. 3) On my own side, she should abide by her husband instruction. Maybe he has no money. (3 FTAFs, rural)</p> <p>1) I think she should obey her husband's instructions. 2) I concur with what the first speaker has just said. There is need for her to accept the decision made by her husband (2 FTAFs, rural)</p> <p>I concur with what the first speaker has just said. There is need for her to accept the decision made by her husband. (FTAM 18–19, rural)</p> <p>If I were Musa and I have a vehicle, I will quickly take her to the health facility for proper checkup by health workers. In addition, if I do not have a vehicle, I will find a friend who has and ask him to take her. Still, if I do not have a friend who has a vehicle, I will try to find any of my relatives who have a vehicle and ask him to take her to the health facility. I will not relent and allow anything to happen to her because what happened to her has also happened to me because I adore her so much. (FTAF, rural)</p> <p>1) He plays a major role by providing all that is required. 2) He will be there in case they need anything. 3) It is paramount the husband stays close, especially when they encounter problem especially with first birth. (3 FTAMs 15–17, urban)</p> <p>1) He should look after the child when delivers and then buy clothes for him. 2) First thing was to look after the health of his wife, then the baby's, and later provide nutritional food for the health of the family. (FTAF, urban)</p> <p>If a child is grown and well trained, he has the full responsibility of taking care of his child. (Older woman, rural)</p> <p>Did your partner or spouse support you during your current or last pregnancy (before delivery)? To be candid, he has tried his best from every aspect, like house chores, purchase of prescribed drugs, taking me to hospital—he does it all. (FTAM 15–17, urban)</p>

State	Main Themes	Illustrative Quotes
		<p><i>Musa now assists his wife with her household chores, and his friends are making fun of him. Do things like this happen in your community?</i> As his wife, I will ask him to stop it and let it be.</p> <p><i>What will people in the community say about it?</i> People will tag him. In addition, because of that, I as his wife will take over my chores because I do not like people thinking of him in that way. (FTAM 18–19, rural)</p>

Table 14. People who pose barriers to care use by state

State	Main Themes	Illustrative Quotes
Bauchi	Partners do not give their permission because of financial constraints and the costs of services.	<p>I would like to go to the hospital, but my husband is totally against that, even if I requested for that, he does not like it. That is why I do not bother myself anymore. (FTAM 15–17, rural)</p> <p>I do not want her to deliver at a health facility. We are talking about remaining 2 weeks or so for her to deliver. I will continue to inform her to stay at home since I do not want her to deliver at a health facility. She will not go to the hospital because it is not my opinion to deliver at the hospital.</p> <p><i>With the sickness?</i> The sickness is just labor she started. She will continue to take herbs until she delivers. I just do not want her to go to the hospital. (FTAF, urban)</p>
Cross River	Older female relatives were mentioned as barriers, primarily in the context that they would recommend a TBA—this is where they delivered, and this was normal.	<p>My mother, she will not know the drugs to give to me, but, OK, doctor might give me something, and she there, she will say, “Do not take it. Take this way.” I do not really like it because I am not very used to that native way. (FTAM 18–19, urban)</p> <p>It was my mother that took me there (to the TBA), and then I discovered the woman was kind, and we do not pay money there.</p> <p><i>So your mother first took you there? Why?</i> Because she does not collect money and she is kind. (FTAM 18–19, rural)</p> <p>There are some mothers that will prefer the traditional way. They will start telling you this—and your friends too that have gone through it, they will start putting fears in you. They will start telling you how they will tear you, how they will do this if you go to hospital. (FTAM 18–19, urban)</p> <p>Sometimes I have noticed some family member of mine that prefers to deliver with traditional attendants or traditional way. They see the hospital as something that is not part of their life, so they still do it. (FTAF, rural)</p>
Ebonyi	Older female relatives pose a barrier to health services.	<p><i>Why did you go or what motivated/encouraged you to stay at home to receive services from your mom?</i> Because my belief is that I will be so shamed, and there is no help that will come from the hospital. (FTAM 15–17, urban)</p>
Kogi	People were not mentioned as barriers.	<p>There are some men who do not patronize hospitals. He thinks she will encounter problems when she was taken there. (FTAM 15–17, urban)</p> <p>When my wife is about to deliver, I prefer she to stay at home. I love my wife to deliver at home. (FTAF, urban)</p>

State	Main Themes	Illustrative Quotes
Ondo	Most often, other relatives and mothers-in-law decide where the FTAM will give birth. All respondents said that partners did not take interest enough to help decide.	<p>Some people may have money, but if they tell her, for instance, that her mother-in-law used TBA for all her child deliveries, they will make it a must for her to use TBA too. (FTAM 15–17, urban)</p> <p>Because my husband and I have never had a baby before, I had no choice but the follow my mother in-law's advice. (FTAM 18–19, urban)</p>
Sokoto	The woman herself was considered a barrier in Sokoto. Reasons included that the women were unaware, were not trying to go, or did not want to go. They did not ask their husbands if they could go and did not like medical interventions.	<p><i>Can you tell me why you don't go for ANC?</i> My husband has not granted me the permission.</p> <p><i>Why don't you ask for the permission?</i> Because I heard him saying he does not want me to go for ANC. (FTAM 18–19, rural)</p>