

# Lessons Learned from an Integrated Approach for Reaching First-time Young Parents in Nigeria

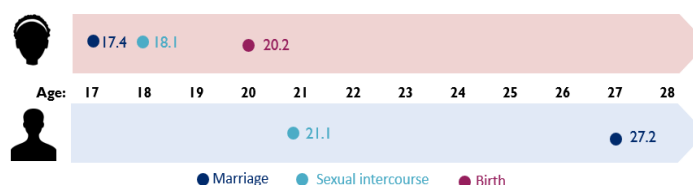
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## Background

About 20% of Nigeria's total population is aged 10–19. Key reproductive life course milestones for this youth population happen in rapid succession (Figure 1). Almost 17% of women aged 15–24 initiated sex by age 15, and 23% of Nigerian women aged 15–19 reported having had at least one child. Levels of adolescent pregnancy reflect the country's fertility rates, ranging from 36% of adolescents in the north to 8% in the south, having begun childbearing before the age of 19.<sup>1</sup>

**Figure 1. Median age at key reproductive life course milestones for Nigerian men and women**



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.

The health consequences of early pregnancy and childbirth are well-documented in lower- and middle-income countries.<sup>2</sup> Young women under age 20 are twice as likely to die in childbirth as women over 20; and women under age 15 are five times as likely to die in childbirth as women under age 20. Children of adolescent mothers have a 34% higher risk of death in the neonatal period, and a 26% higher risk of death by age five.

Yet, adolescents in Nigeria are less likely to use essential health care compared to all women 15–49. In Nigeria, 46% of mothers ages 15–19 did not receive antenatal care (ANC), and only 26% delivered with a skilled provider, compared with 34% and 40% of all women aged 15–49, respectively. Also, 10% of all married/in-union women used a modern method of family planning (FP), while only 1% of married/in-union adolescent girls did.<sup>3</sup>

Despite the need to improve support and health care for pregnant and parenting young people, few programs have considered how to reach first-time young parents' (FTYPs) with an integrated approach that meets the broad range of their health and development needs.

The Maternal and Child Survival Program (MCSP) in Nigeria aims to improve maternal, newborn, and child health outcomes by increasing access to quality lifesaving interventions in Kogi and Ebonyi states. Specifically, MCSP helped to build sustainable capacity and leadership at national, subnational, and facility levels to improve

<sup>1</sup> 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.

<sup>2</sup> World Health Organization (WHO). 2011. *WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes among Adolescents in Developing Countries*. WHO.

<sup>3</sup> 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.

quality of ANC, childbirth, and postnatal care and to strengthen essential health system functions that underpin quality care (including commodities, human resources, and information and referral systems).

In September 2016, MCSP initiated a formative research study in six states of Nigeria. The study found that first-time adolescent mothers (FTAMs) in Nigeria, particularly the youngest and unmarried, have limited decision-making power due to social norms; are often socially isolated, particularly when they are unmarried; face strong stigma from family and community; face significant barriers to health care use because of the costs of accessing facility-based health care and prohibitively high out-of-pocket expenses; and could benefit from meaningful engagement of male partners, who, when present, can play a positive and influential role in supporting FTAMs during pregnancy and the postpartum period.

These findings confirmed the importance of a holistic approach to address the multiple factors that influence FTYP's use of health care. Based on the study findings, in May 2016, MCSP adapted and tested interventions with FTYPs in Kogi and Ebonyi states. This brief describes the interventions implemented in response to the formative research findings and presents preliminary findings from an assessment to document preliminary results and lessons learned.

## Intervention Design

MCSP focused on interventions directly with FTYPs and health providers, with the intention of distilling learnings to inform more a comprehensive approach inclusive of community-level activities in the future. Activities, phased in sequentially, aimed to concurrently strengthen the health facilities' ability to provide adolescent-responsive care in Ebonyi and Kogi states and ensure that FTAMs and their male partners were informed about their health choices and accessed care that responded to their needs.

Key components of the integrated package that was developed and implemented with the federal and state ministries of health included the following:

- A set of Adolescent Age and Life-Stage Assessment and Counseling Tools were developed and helped health providers to tailor one-on-one counseling based on an adolescent's sex, age and life stage to provide sound, practical and actionable information.
- Whole-site orientations were conducted for 57 staff in five MCSP-supported facilities built capacity for delivering youth-friendly health care, with an emphasis on fostering supportive and nonjudgmental attitudes.
- Our First Baby (OFB), a nine-session, peer group-based discussion approach previously tested by MCSP in Mozambique were adapted to the Nigerian context upon completion of the formative research. The approach builds a sense of social support among group members and provides life stage-tailored information about fertility, pregnancy, delivery, baby care and contraception to FTYPs and incorporates a financial literacy component and linkages to existing mothers' savings and loan groups.
- Facilitators were trained to form and lead OFB discussion group sessions with FTAMs. Facilitators (11 total: six male, five female) were chosen from communities within the catchment areas of the five above-mentioned health facilities. The facilitator selection criteria included personal experience as first-time adolescent mother/parent, literacy in English, commitment to facilitating group discussions, well-respected in the community and under the age of 30. Facilitators participated in a five-day training, after which five health providers trained in adolescent health and MCSP staff supported the facilitators to form and lead OFB discussion groups with FTAMs. A total of 59 FTAMs participated (20 women aged 15–17 years; 39 women age 18–19 years). Male partners were invited to join five of the nine sessions; 10 male partners, ages 15–19, participated in five or less sessions.

To foster a supportive policy environment, MCSP convened bi-annual national adolescent working group meetings and quarterly state-level adolescent health technical working group meetings in both states.

Figure 2 shows the detailed timeline for development, implementation, learning and documentation.

## Method

In July 2018, MCSP documented preliminary findings and lessons learned from activities to increase FTYPs' use of health care in Kogi and Ebonyi states. The documentation aimed to expand the evidence base on essential components for programs with FTYPs in Nigeria and globally. Specific documentation questions included:

- Can an integrated package of health care for FTAMs in Kogi and Ebonyi states be feasibly implemented within a broader reproductive, maternal, newborn and child health (RMNCH) platform?
- How can male partners be engaged? What are implementation experiences, including challenges and successes, with the use of Age and Life-Stage Counseling Tools?

To assess the impact and implementation experiences of this intervention package, MCSP facilitated qualitative group interviews with stakeholders (Table 1). This end-of-program review was determined to be not research by Jhpiego's Institutional Review Board Support Team, and received ethical clearance from Ebonyi and Kogi state ministries of health. All interviews were recorded, and transcripts were analyzed in ATLAS.ti (Version 8) using a codebook.

**Table 1. End-of-project documentation participant summary**

Participant Type	# of Group Interviews	Range in # of Participants, per Interview	Total # of Participants
Young mothers who participated in OFB (18–19 years old)	5	3–5	20
Fathers/husbands/boyfriends who participated in OFB (18–19 years)	4	2–3	10
OFB facilitators	5	2–3	11
Health facility staff: Whole-site orientation participants	5	3–6	21
Health facility staff: Users of Age & Life Stage Assessment and Counseling Tools	5	2–5	17

## Results

### Engagement with First-Time Young Parents: Our First Baby

#### *Our First Baby Reached First-Time Adolescent Mothers with Information and Skills-building*

Respondents noted that the OFB sessions shared useful RMNCH information with FTAMs and created a space for reflection about gender norms. OFB facilitators felt that the sessions contributed to positive health-seeking behaviors among FTAMs and increased their social capital.

*Our First Baby made most of them agree to go to health center for childbirth and encourage other first-time mothers to go for delivery at health center.* – OFB Facilitator, Kogi State

*It was through this program that helped them to create that kind of bond among these first-time mothers. They were able to see that 'yes, I am not the only one that is a first-time mother'... It really helped them a lot.* – OFB Facilitator, Ebonyi State

Several factors contributed to the successful implementation of the approach. Establishing trust and rapport between the OFB facilitator and participants, as well as fluid communication, were identified as facilitating factors. According to facilitators, ensuring confidentiality within the groups was also key for creating a safe space to participate. Additionally, FTAMs highly appreciated the participatory learning style.

**Figure 2. Timeline for development, implementation and documentation of the FTYP intervention**



*[We explained] that whatever we discussed here remains here and no one will take your issues outside. So, that now motivated them to come, and after the first time they found it interesting.* – OFB Facilitator, Kogi State

Annexing the OFB groups into existing savings and loans groups was also well received and viewed as a promising practice for future projects. Facilitators and FTAMs spoke of funds being used for emergency and social needs (i.e., school fees and child needs); this was seen as fostering group cohesion and collective efficacy.

*The mothers' saving [group] really helped us a lot. It was easy for us that a pregnant woman could get the money to use in the hospital.* – FTAM, Ebonyi State

Most respondents felt that all nine OFB sessions were relevant and interesting. FTAMs especially appreciated the sessions on fetal development during pregnancy and ANC, FP and sexually transmitted infections (STIs), gender-based violence and gender.

Although the OFB approach reached the targeted number of FTAMs, respondents noted that social stigma against unmarried adolescent mothers may have limited participation.

*The ladies believed that when somebody has done what is unethical and unsocial to the communities - by getting pregnant before time - they will receive negative talk from the community.* – OFB Facilitator, Kogi State

*We have so many young adolescents who are pregnant and in houses, in hideouts, because they feel they could not walk in the streets ... So, one of the challenges we had was identifying them, since they could not even come out.* – OFB Facilitator, Ebonyi State

## **Our First Baby Facilitators Received Training and Support**

OFB facilitators were central to the success of the approach and respondents generally agreed that they were effective in their role. Facilitators felt most at ease leading sessions on topics of which either they themselves had prior knowledge and experience or of which participants had prior knowledge. However, some facilitators felt the OFB facilitators initial training did not adequately cover all required content. This contributed to feeling ill-prepared to lead sessions that involved technical health information on FP and on STIs. Some facilitators lacked confidence in answering questions that were raised during these sessions. Respondents also mentioned that it was a challenge to manage sessions that challenged norms about FP and norms that defied traditional gender roles. Having trained adolescent health providers and/or MCSP staff co-facilitate the more technical or sensitive discussions helped overcome this challenge. OFB facilitators greatly appreciated this support.

*The sexually transmitted infections session was a bit difficult because of the technicalities. Though we were trained, it was difficult because of the questions that were thrown to us.* – OFB Facilitator, Ebonyi State

*Then spacing children, some of them [OFB group members] believe that you are meant to give birth to all your children at once; that you don't need to give two years... But our visitor [health provider]... was there and she tried to explain to them why you need to space your children.* – OFB Facilitator, Ebonyi State

## **Male Partners Engaged**

The program achieved varying levels of participation among FTAMs' male partners across the different implementation sites. Among the fathers who participated in OFB sessions, the primary motivation to participate was a desire to become better fathers and to improve their ability to ensure the well-being of their family. This aligns with findings from other research.<sup>4,5</sup>

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<sup>4</sup> Mathur S, et al. 2016. Fatherhood, marriage and HIV risk among young men in rural Uganda. *Cult Health Sex.* 18(5): 538-52.

<sup>5</sup> Chili S, Maharaj P. 2015. 'Becoming a father': perspectives and experiences of young men in Durban, South Africa. *South African Review of Sociology* 46(3): 28-44.

*As a man it, it broadens my knowledge in the sense that I know how to help my wife if she has another pregnancy. How to take good care of her and how to contribute to her well-being.... the joy of a man is seeing your family being happy.*  
– Father, Kogi State

Male participants highly valued sessions about becoming a father for the first time and caring for women during pregnancy. Facilitators observed that OFB sessions helped male partners learn how to better care for their children, while also fostering more gender equitable attitudes and positive attitudes about contraception.

*I really understand that if you are married, it is not as if the whole work is for the wife, the husband too needs to help the wife in taking the activities at home, and... once she is pregnant, you just have to do at least more than half of the activities from your wife... so that it will not cause problems to her pregnancy, I think the program really encouraged us for something of such and I really appreciate it.* – Father, Kogi State

FTAMs whose partners joined OFB sessions were generally happy with the gender-synchronized approach. Bringing male partners together with their wives and other FTAMs was perceived to create solidarity between young men and women. However, some FTAMs felt uncomfortable or shy with unknown men in the group.

*Whenever they [young father] attend this program, it kind of opens their eyes more to understand that they are part of the child's life. And they should not leave the whole responsibility for the mother.* – FTAM, Kogi State

*I'm very happy attending the meeting on how to share ideas together, join hand together to work together, to make things easy, and decision-making together, honestly, I enjoyed it.* – Father, Kogi State

*I feel like... I may be a little bit shy to speak my mind. The first time we started the program, we were all ladies. And when they told us that... maybe our husband or boyfriend will come... and... he will participate in the program, maybe some people will feel shy to express their feelings or the challenges they are facing.* – Mother, Kogi State

Qualitative group interview respondents cited logistical and socio-cultural barriers to male participation in OFB sessions. Logistical challenges included inconvenient times of meetings (both in terms of the time of day and the season of the year) and insufficient incentives for participation. Socio-cultural barriers included concerns about being perceived as ‘unmanly’ by other community members for participating in activities that are generally considered to be for women.

*Participant: Me I feel happy but not that happy [being in the same group with my partner in the meetings], because as a young man, when you sit together with them [young women], some of those people will say ‘Oh, this is a small guy.’ So, by that time you will be ashamed of yourself.* – Father, Ebonyi State

Respondents noted that unmarried young fathers may have feared being stigmatized for being ‘irresponsible,’ thereby limiting their participation. However, some of the unmarried young fathers who participated in the sessions noted that they appreciated coming together with peers in similar situations as themselves.

*The challenge for the guys is they think we want to have them embarrassed... because some of them got their spouse pregnant out of wedlock so they felt shy.* – OFB Facilitator, Kogi State

*For me, I really enjoy the group because I thought that [pregnancy] is the end for me. I thought I'm the only one to make that kind of mistake. But when this group came... I met one or two people that this thing is happening to. That means I'm not the only one.* – Father, Kogi State

## Client-centered Health Care for First-time Young Parents

### Use of the Age & Life Stage Counseling Tools

Nearly all health facility staff interviewed indicated using both the counseling cards and the flipcharts regularly with adolescents, often at least a couple times per week. One site indicated relying more on the flipchart because the pictures were more interesting to adolescents. Health facility staff reported using the tools as intended—in other words, using the age, marital status and health priorities of the adolescent to



support appropriate topic and module selection. One interviewee believed that the tools served as a “standard operating procedure.”

*It is too easy. Why it is easy is that you will not think what to ask to the adolescent or what to say, it is just like [a] [standard operating procedure] to us. – Health facility staff, Ebonyi*

Most health facility respondents noted that they were satisfied with the tools’ content, format and pictures; content was relevant and easy to reference. However, a few respondents cited difficulty with using the tools to tailor counseling based on age and life stage because of the time required to engage adolescents in detailed counseling sessions.

*Why I am saying cumbersome is just that there are some people that will not have enough time... that it requires for you... [to] give the adolescent the education that they need in the assessment tools. – Health facility staff, Ebonyi*

### **Improvement in Quality of Care for First-time Adolescent Mothers**

Overall, health facility staff revealed that the Age and Life-Stage Counseling Tools improved their capacity to effectively counsel adolescents, which in turn, contributed to client satisfaction among adolescents.

*She opened up and told [me] what her problem is, saying the breast is becoming increasing that she doesn’t know what is happening to her. And we took her through the counseling tool on puberty and gave her sex education and everything she needed to know. She left happy. She has been referring her friends to come around. – Health facility staff, Kogi*

Interviewer: *Why do you like using the tools?*

Participant: *Because all what we have to tell our clients is there. It’s a real guideline. – Health facility staff, Ebonyi*

Regarding the whole-site orientations, respondents were keen to mention how they had become more attuned to youth needs in clinical settings. Providers mentioned that there were positive changes in how staff received adolescent patients. Interpersonal skills—listening, privacy, a nonjudgmental approach and friendliness—were described as having improved.

*I want to use myself as an example: I have two teens – one is 17 and one is 14. At times I have tried to use the same approach, but it didn’t work, they are not the same. So, from the training, I learned that you don’t have to use the same approach, what works for A may not work for B, so I try to find what works for them. – Health facility staff, Ebonyi*

*I was once a teenager myself. I passed through teenage life, so when I see adolescent behavior, I should not judge them; rather I should encourage them and talk to them. – Health facility staff, Ebonyi*

Respondents also noted several challenges that should be addressed to further improve access to youth-friendly RMNCH and FP care. For example, concern was raised that many adolescents are not aware of the adolescent-friendly health facility in the area. Others noted how social stigma against young mothers continues to be a barrier for FTAMs to access care.

*Most of the time the problem we are facing with [adolescent mothers] is just that some of them don’t like to stay too long in the facility. Because coming to the antenatal [care visit]... some may be thinking [that] I don’t know who knows me, who may just say, ‘Ahbb! Why are you here?’ – Health facility staff, Ebonyi*

### **Expansion of Health Providers as Change Agents beyond the Health Facility**

Health providers applied the knowledge and skills gained from the training beyond the health facility setting. For example, in addition to using the Age and Life-Stage Counseling Tools as intended, respondents shared some unintended applications of the tools, including using the tools while informally counseling adolescents at home. Another respondent shared that adolescent clients took interest in the flipbook when left on a clinic table or in a waiting area.

*I have four adolescents in my house now; I normally refer to this book when I am giving them any adolescent counseling.*  
– Health facility staff, Ebonyi

*Or even at home. There are some mothers now that approach me. They are bringing adolescents for me to talk to. They may not like to come to the facility; it means I will use [the tools] in the house.* – Health facility staff, Ebonyi

Whole-site orientation participants also felt encouraged to integrate their learnings in their personal lives. As parents, relatives, caretakers and more, health facility staff are influencers on youth beyond the clinic.

*So, it's helping us not only within the hospital sector, even within our homes it is helping us.* – Health facility staff, Kogi

*I learned that you should be a friend with them. I am organizing a kind of training for teenagers in my neighborhood. Be a friend with them so that they can open up to you.* – Health facility staff, Ebonyi

## Recommendations

The findings suggest that an integrated package of interventions can improve both demand for and supply of RMNCH care to FTAMs. This end-of-program review offers the following recommendations for future programs with FTAMs.

### Strengthen Synergies within a Multi-component Approach for FTAMs

The knowledge and skills that FTYPs gained through the OFB sessions helped increase FTAMs' engagement with RMNCH issues via multiple channels. The whole-site orientation and the Age and Life-Stage Counseling Tools improved providers' capacity to tailor care to the specific needs of different groups of young clients, thus improving access to quality youth-friendly care. Although data collected during implementation did not track the actual interaction between the community-based OFB approach and the uptake of facility-based care, our interpretation of the data suggests a synergistic relation between the OFB discussion groups and facility-based interventions. Synergies between these components could be strengthened through the following:

- Building skills and developmental assets (e.g., communication, decision-making and conflict resolution skills) into interventions that engage FTAMs (such as OFB);
- Ensuring that approaches (such as OFB) that reach FTAMs directly are paired with health care strengthening efforts and interventions that increase community support for the FTAMs' health, rights and well-being;
- Building the evidence base through evaluating linkages between adolescent health care strengthening interventions and gender-synchronized interventions that reach FTAMs in community settings; and
- Monitoring FTYP demand and utilization of health care in the context of larger-scale programs.

### Create Safe and Inclusive Community Environments for FTAMs

Aligned with previously published data,<sup>6</sup> trust and confidentiality emerged as a cornerstone of success in tailoring health care for adolescents and youth. Supported health providers and OFB facilitators instilled trust and confidentiality by creating an inclusive environment at health facilities and in OFB meeting sites and treating adolescents in a respectful and nonjudgmental manner, regardless of their personal circumstances. The findings suggest that efforts to establish an inclusive and nonjudgmental environment in the wider community would further strengthen the interventions' reach and effects. For example, stigma against unmarried young parents was identified as a barrier for recruitment and participation of male and female FTYPs in the OFB sessions and use of RMNCH and FP care. Tackling these barriers will require addressing the underlying gender and social norms that drive stigma and discrimination against adolescent parents. The findings also suggest that working with health providers as community champions for rights-based adolescent and youth health may hold potential to complement broader social norm change efforts. Specific recommendations include:

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<sup>6</sup> WHO. 2018. WHO recommendations on adolescent sexual and reproductive health and rights. Geneva: World Health Organization.

- Investing in community engagement efforts to transform social and gender norms, particularly those that stigmatize unmarried FTAMs and discourage use of care, to create a more supportive and safe environment for FTAMs to access RMNCH and FP information and care.
- Ensure linkages between social and normative change interventions, service-delivery strengthening interventions and peer group interventions with FTAMs.
- Further exploration of the potential role of health providers to influence social norms and health practices through their household and community influence.

## Explore New Approaches to Train and Support Young People and Health Providers as Change Agents

The findings emphasized the need to sustain technical support to OFB facilitators, particularly for FP and STIs. Respondents identified that a promising practice was to include health providers as session co-facilitators. Further, the qualitative data indicated that facilitators had difficulty discussing topics that challenged social and gender norms. This may be because the facilitators were examining their own attitudes and values for the first time while being responsible for guiding other young people to explore norms and values in a nonjudgmental, inclusive manner. This complex role requires specific skills and support that may need to be incorporated into the OFB facilitator training. These challenges could be addressed through:

- Integrating a clear and central focus on social and gender norm transformative skills within the aims and pedagogical approaches to the training;
- Moving away from a one-time training toward an approach with an initial training, followed by sustained opportunities for discussion and reflection on social and gender norms over time; and
- Building health provider co-facilitation of at least one session into the OFB model.

## Refine Strategies to Reach Male Partners

Findings suggest a need to refine strategies for reaching out to and attracting male partners to participate in OFB sessions. In addition to adjusting the time of year and time of day of OFB meetings, respondents suggested reframing the activity to be more inclusive of men. The male partners who participated in the OFB sessions valued the opportunity to build skills and become good fathers. When describing the intervention in communities, it could be beneficial to emphasize how the OFB approach helps men pursue their stated aspirations of becoming good fathers. Findings also highlight the need to assuage men's concerns about being considered weak by other community members for participating in what is considered to be a woman's activity. These findings further indicate the importance of considering notions of masculinity, as well as gender and social norms, to strengthen efforts to reach male partners. These findings could be addressed through the following actions:

- Reframing content of OFB to speak to the aspirations of male partners, as well as young mothers.
- Adapting communication about the OFB approach within communities to highlight that it is an approach for young women, their partners, and young couples, rather than primarily for young women.
- Exploring feasible and acceptable formats for engaging male partners in diverse settings. In Ebonyi and Kogi states, engaging male partners in an activity designed for girls and women was challenging. Programs need to explore ways to promote the content for male partners to align with men's interest and provide male partners a space to navigate complex challenges and emotions around fatherhood. In addition, in some settings, separate groups for married/in-union and single FTAMs may be appropriate to avoid isolating FTAMs who do not have male partners.

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