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# A TIME OF UNCERTAINTY AND OPPORTUNITY: FINDINGS FROM A FORMATIVE ASSESSMENT OF FIRST- TIME PARENTS IN CROSS RIVER STATE, NIGERIA

**TECHNICAL REPORT**

**OCTOBER 2018**



**E2A PROJECT | 2018**

## **About E2A**

The Evidence to Action Project (E2A) is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive health care needs of girls, women, and underserved communities around the world by increasing support, building evidence, and leading the scale-up of best practices that improve family planning services. A Cooperative Agreement awarded in September 2011, E2A will continue until September 2019. E2A is led by Pathfinder International in partnership with ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.

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## Acronyms

<b>ANC</b>	Antenatal Care
<b>E2A</b>	Evidence to Action Project
<b>CBO</b>	Community-Based Organization
<b>CHEW</b>	Community Health Extension Worker
<b>CHV</b>	Community Health Volunteer
<b>CRS</b>	Cross River State
<b>FGD</b>	Focus Group Discussion
<b>FP</b>	Family Planning
<b>FTM</b>	First-Time Mother
<b>FTP</b>	First-Time Parent
<b>HTSP</b>	Healthy Timing and Spacing of Pregnancies
<b>IDI</b>	In-depth Interview
<b>LARC</b>	Long-Acting Reversible Contraceptive
<b>LGA</b>	Local Government Area
<b>MNCH</b>	Maternal Neonatal and Child Health
<b>SMGL</b>	Saving Mothers, Giving Lives
<b>RH</b>	Reproductive Health

# Executive Summary

## **Background**

Becoming a parent for the first time marks an important milestone in the sexual and reproductive health (RH) lives of women and men around the world. First-time parents (FTPs) in low- and middle-income countries are often young: they may be married or unmarried, and their male partner may be similar in age or much older, or, may not be present. Their experiences during this life stage are shaped by multiple contextual factors that influence their immediate and long-term RH and well-being.

Despite the potential that investing in these young women and their male partners could have on long-term development, few programs have provided FTPs with age appropriate and comprehensive care that encourage the healthy timing and spacing of pregnancies and improve caretaking of infants. In addition, there is also little evidence that demonstrates the needs of FTPs and whether they are being met. This is true of Cross River State (CRS), Nigeria, where most ARH programs, to date, have focused on preventing adolescent pregnancy and reducing HIV transmission—not in reaching adolescent FTPs with RH, family planning, and maternal and newborn health services.

Pathfinder International/Nigeria, through the Evidence to Action (E2A) project, will help fill this programmatic gap. E2A is supporting interventions focused on FTMs, aged 15-24 years, and their husbands/male partners in CRS under the Savings Mothers, Giving Life (SMGL) initiative. Baseline data (discussed below) will shape the interventions which will include promoting the following behaviors:

- healthy timing and spacing of pregnancy
- postpartum family planning
- breastfeeding and child nutrition
- positive parenting
- gender-equitable communication and decision-making

## **The E2A Baseline Study**

The design of the pre-intervention qualitative assessment was guided by E2A's FTP Lifestage Framework, which highlights the key health and social factors that shape the FTP experience, including RH and MNCH needs and vulnerabilities. The framework also incorporates a socio-ecological model of influencers and decision-making that demonstrates the broader context of sexual and reproductive activity at individual, household, community and systems levels, as well as underlying gender and social norms that affect RH choices, decisions and behaviors.

The primary objectives of the assessment were as follows:

- I. To explore knowledge, attitudes, and behaviors among FTMs, their male partners, and other household and community influencers and decision-makers related to health and health-related outcomes of interest, such as experience with ANC and delivery services, child health and breastfeeding, and attitudes towards birth spacing and postpartum contraceptive use;

2. To explore the current experience of facility- and community-based health providers and resource persons in providing services to FTMs and their partners; document the levels of current use of FP/RH and postpartum care services by FTMs at facility level; and
3. To explore acceptability and interest in participating in a program targeting FTMs and their partners on the above outcomes of interest.

The assessment was conducted in communities within the catchment areas of three health facilities in Ikom and Obubra Local Government Areas (LGAs), which were already working with SMGL/FP. Data-collection methods included:

- Focus Group Discussions (FGDs) with married FTMs aged 18-24 years and Community Health Volunteers (CHVs) who provide outreach to all pregnant women on ANC and safe delivery;
- In-depth Interviews (IDIs) with facility-based FP providers; married FTMs aged 18-24 years (both current FP/RH clients of facilities and those who had never used FP/RH care at a facility); unmarried FTMs aged 18-24 years (both FP/RH clients and those who had never used FP/RH care); husbands/partners of FTMs; mothers of unmarried FTMs residing with them; and community leaders.

Recruitment of FTMs, male partners of FTMs, and mothers to unmarried FTMs (who co-reside in the same household) was conducted at households in the designated facility catchment areas. Trained research teams moved from house to house to locate eligible respondents using a pre-determined interval of household selection (based on a quick mapping exercise of the number of residential structures in the target communities). FTMs aged 18-24 years with only one infant less than 12 months of age were the primary target. Additionally, mothers and male partners of FTMs were recruited by inquiring if an FTM with the desired characteristics lived in the residence. FTMs, male partners, and FTM mothers were interviewed in separate households; no more than one respondent was interviewed in each residence. Interviews were conducted primarily in Pidgin, with a few interviews conducted in vernacular languages.

The assessment team maintained detailed field notes and short summaries of field work observations throughout data collection. An analog or digital voice recording device was also used to capture the interviews; recorded interviews were transcribed and translated into English. Field notes and transcripts were coded and a coding template was developed to reflect emerging themes. An analytical summary of themes was conducted, with emerging themes and lines of enquiry extracted, and theoretical constructs developed using NVIVO software. The protocol for this assessment received Institutional Review Board (IRB) approval from the Government of CRS, Nigeria, Health Research Ethics Committee and was exempted from IRB review by PATH's Research Determination Committee. The assessment was conducted from August-September 2017.

The qualitative research methods used during the study have several well-known limitations, such as lack of generalizability of findings, biases introduced by flawed respondent recruitment strategies, moderator biases, non-response of respondents due to sociocultural and power differences, or fear of lack of confidentiality. E2A reduced these limitations through means such as selection of participants at household level, moderation of interviews, and ensuring the full confidentiality of respondents.

A summary of the key study findings follows.

## Objective 1, key findings

To explore knowledge, attitudes, and behaviors among FTMs, their male partners, and other household and community influencers and decision-makers related to health and health-related outcomes of interest, such as experience with ANC and delivery services, child health and breastfeeding, and attitudes towards birth spacing and postpartum contraceptive use.

**Unmarried FTMs tended to be younger than married FTMs, and their male partners were themselves young and first-time fathers.** The assessment provided an important opportunity to learn more about who these FTPs are in terms of their basic socio-demographic characteristics. As most available facility data does not disaggregate recorded information by both age and parity, these findings provide a better sense of the potential participants for FTP programming, and to better understand variations in responses. Table I below provides a summary of FTM and male partner characteristics.

**Table I. Selected demographic characteristics of interview respondents, by respondent type, CRS, Nigeria**

Young First-Time Mothers	Male Partners of FTMs
<ul style="list-style-type: none"><li>• <b>Age:</b> Unmarried FTMs tended to be younger (aged 18-22 years) than married FTMs (generally 20-24 years)</li><li>• <b>Education:</b> Nearly all, regardless of marital status, had completed some or all secondary school</li><li>• <b>Women's occupation:</b> Petty trade/business, hair stylist, housewife, and farming</li><li>• Most respondents had a baby (either male or female) <b>under 6 months of age</b></li></ul>	<ul style="list-style-type: none"><li>• <b>Age:</b> Most are in their mid- to late-20s (overall range 24-35 years old)</li><li>• <b>Education:</b> Nearly all have some secondary or higher</li><li>• <b>Occupation:</b> farming, student, barber, cyclist, business, skilled trade (mason, mechanic)</li><li>• Nearly all are <b>first-time fathers and reported having only one wife/partner</b></li></ul>

**The FTP experience proved to be a time of tremendous uncertainty for young women, their partners and their families.** While it is expected that the FTP lifestage is inherently a time of transition, the assessment highlighted just how challenging the experience can be for many young people and their families. Participants across all respondent categories noted that their pregnancy fundamentally affected many other aspects of their lives – from marital or relationship status, to education, to financial support, to where they live – leaving them uncertain about their immediate and longer-term situation. Some specific and often inter-related points that participants noted included:

- Pregnancies were often unplanned and unexpected, contributing to a sense of disruption and instability: Half of FTMs, regardless of marital status, said their pregnancies were unplanned, fundamentally disrupted existing plans, and raised concerns about their ability to care for and support a child. Both married and unmarried FTMs reported that their education or financial status was negatively affected, which influenced how they felt about their pregnancy. Male partners expressed a similar wish to have completed their education before marrying and having children.

Male partners also reported concerns about their partner's health and pregnancy outcome, especially if the pregnancy was unplanned and their partner was particularly young. Across all participants, financial issues played a critical role in shaping the FTP experience – from family support, to use of health facilities, as well as to where the FTM, partner and child lived.

*People look at you as a spoilt child and will regard you as one who hurried to do what her mates have not done; and when you are pregnant at the early stage, they won't be happy with you. Meanwhile, when the child is born, everyone around will [not] be happy with you. Your family in particular will look at you that you have added another load to the family, because they were struggling to send you to school and you got pregnant and brought it home. If the father of the child isn't ready to take responsibility, they may drop you ... from school, and concentrate on the child. If the family is comfortable, they will say 'let's see how you both can manage', but some privileges you used to have before the child came - you won't have them anymore. Married FTM FGD*

- Pregnancy was a defining moment for their union/relationship status: Across all categories of interviewed FTMs, pregnancy mostly came *before* marriage and influenced whether the relationship resulted in continued partnership, formalized marriage, or separation. Both married and unmarried FTMs expressed uncertainties about their relationships status and partners' commitment. Some male partners reported that there was pressure from the parents of the FTM to take responsibility for the child, which had implications for their relationship.

*...When I was pregnant, my family was in serious conflict with me until my child's father went and told them that he will look for money and come to settle for everything before they calmed down... The man is trying his best, my baby is fine, and I am fine too. Unmarried FTM IDI*

- FTMs and their male partners experienced fluid and complex living arrangements, often related to financial needs or other forms of support. Many FTMs and male partners reported a wide range of living arrangements that often shifted over the course of the FTP experience, regardless of marital status or if their pregnancies were planned or unplanned. FTMs noted that they shared housing or were in temporary living situations due to financial difficulties or need for extra support with child care, especially during the postpartum period. Most FTMs, married and unmarried, received assistance with infant care from the women living with them or nearby, including their mothers, mothers-in-law, or other female relatives. While male partners participating in the study were living together with their partners or wives, several noted reliance on parents and extended family members, especially with those who are not financially independent.
- Many FTMs reported social difficulties from the community related to becoming pregnant before marriage. FTMs noted that being unmarried and pregnant led to social stigma and discrimination, and that as a result, they would isolate themselves and avoid going outside of the home. Critically, FTMs and their mothers noted that this stigma can delay disclosure of the pregnancy and prevent them from seeking health care.

*Those that are married feel happy for being a pride to their family, while those who are not married are*

*regarded as a disappointment to the family. You are looked down on because you are a single girl who is not married but pregnant. Married FTM FGD*

- Male partners had more mixed views about their ability to be good fathers and provide for their families. Many men raised concerns, noting that their youth and financial instability caused them to feel some uncertainty about their futures and their ability to provide for their families now and in the future. At the same time, many men, especially married husbands, were also confident in their ability to build a home together with their wives, despite their young age, and the challenge of obtaining employment.

*How will I manage [to become] head of the family? Because, as of now, I am not yet the head of [anything]. Because if you look now, I am still feeding on somebody. Somebody is feeding me and my wife . . . How will I be strong to feed him [the baby] and feed myself and the mother? Male Partner IDI*

*I had confidence since my wife and I are still young, and we are getting to our expected target. I was thinking I am capable, I was thinking the power was there to handle everything that is coming. Before my wife came, I have been a hardworking guy. I will work harder, because I know that in due time, we will be more than two. Male Partner IDI*

- Older women – the mothers and mothers-in-law of FTMs – provided essential support throughout the FTP experience. Mothers of FTMs, especially those who are unmarried, were heavily involved in ensuring their daughters' health needs throughout pregnancy and delivery were met, caring for their grandchild and providing financial support for the young mother and child. Older women noted that this places a tremendous burden on them, with responsibilities that fall outside their traditional role as mothers and grandmothers. FTMs and male partners frequently recognized the support and guidance provided by older women. FTMs who received extended care from female relatives, especially their own mothers, felt particularly supported with practicing good nutrition and getting rest, potentially decreasing their sense of social isolation during the extended postpartum period. However, mothers of unmarried FTMs often expressed dissatisfaction in the attitude of the baby's father towards their daughter and the extent of financial and other support provided, suggesting underlying tensions within the core group of individuals involved with the young mother caught in the middle.

*If my child gives birth to a baby I don't need to abandon the child but take care of the child and take decisions. I treat my grandchild as my direct child. I care and provide for her. Mother of FTM IDI*

*I am not happy with the way the father of this child is treating everybody. I am not happy with the way he is treating my daughter, because even when I was . . . pregnant, I received a lot of care from my husband and my pregnancy expenses weren't [the responsibility of] my mother, like what is happening to my daughter now. He impregnated my daughter in school. It was so painful. I wanted to do bad to him because of my anger, but people said I shouldn't do it. I do advise him but he doesn't take my advice, he does anything he likes. Mother of FTM IDI*

**FTMs did not make important decisions about their lives and healthcare independently, with parents and/or partners playing critical roles.** A majority of FTMs (both married and unmarried) mentioned that they tend to make day-to-day childcare and feeding decisions, with advice from their mothers, mothers-in-law, or the baby's father. However, more important decisions were often driven by others, especially when financial resources were involved. For married FTMs, male partners and partners' families played a critical role in important decisions, and for unmarried FTMs living with one or both parents, parent(s) were the ones to make key decisions. Male partners generally felt that they made decisions about healthcare, largely driven by their responsibility to pay and assist with their wife/female partner's care, or care of their infants. Conflicts in care and decision-making were reported between FTM mothers and male partners, particularly when the male partner was young and unemployed, with the FTM mother reporting that she made most of the decisions.

**Unmarried and married FTMs differed in their healthcare use, reflecting financial concerns and broader social stigma.** Unmarried FTMs, who reported experiencing more stigma related to their pregnancies than their married counterparts, attended antenatal care (ANC) later in their pregnancies, made fewer visits, and were less likely to deliver at a clinic or hospital than married FTMs. Unmarried FTMs reported not visiting the hospital after a home delivery, while most married FTMs reported visiting the hospital within a few days after a home delivery for medical checks. Cost and proximity to healthcare determined the use of health facilities by all FTMs interviewed. Almost no FTMs mentioned wanting or preferring to deliver at home, but did so due to lack of planning or resources, views echoed by many male partners as well.

*That fateful day, I wasn't at home, I was with one of my friends. I was called that my wife has given birth, she was cooking, and she just gave birth. She was already in labor at home and she could not get to the health center because she couldn't walk to the clinic. It was the way God wanted it to be. God knew that I did not have money to get her to deliver at the hospital, so he made her deliver peacefully. Male Partner ID1*

**While there was broad support for breastfeeding, exclusive breastfeeding was not practiced.** All respondents agreed that breastmilk helps a baby grow and develop, and that it would be taboo not to breastfeed. FTMs had uneven knowledge about the benefits of breastmilk, especially regarding the benefits of colostrum and exclusive breastfeeding. FTMs who accessed facilities for ANC and/or delivers reported receiving information and support with exclusive breastfeeding from providers. However, practice of exclusive breastfeeding was limited, with many FTMs beginning complementary feeding a few weeks after delivery due to views that breastfeeding alone was insufficient nutrition for the baby. Several participants attributed the crying of babies to be an indication of hunger, and therefore initiated water and foods, such as *pap* (cornmeal porridge) or instant custard (commercially made of cornstarch, colors, and flavorings, mixed with water or milk and sugar). This was usually influenced by FTMs' mothers, mothers-in-law, or fathers/male partners.

*I am giving my baby exclusive breastfeeding because we were told in the hospital that it makes the child stronger and it prevents the baby from [getting] sicknesses. Married FTM ID1*

*...if she wants your attention, she will begin to cry and you will feel that the child is crying, let me go and carry*

her. If it is hunger and if you give her breast milk, she will stop. If she continues to cry, you give her pap and she will keep quiet, and if the cry stops, you will know that she was hungry. Male Partner IDI

**Across the board, there was strong understanding and support for spacing the birth of the next child:** Nearly all respondents – across FTMs and male partners - reported that they preferred to wait three to five years before having a second child. Most respondents could easily name several benefits of birth spacing, including improved health of the mother and child, and improved chances of resuming education and being financially prepared for the next pregnancy.

*The benefit for I and his father is that we will be able to make more money before the next child comes, and the first child will be in school. Married FTM IDI*

*“If you look at our economy, it is not good at all, and I want to be financially stable to care for them and look after the baby and the mother properly...and to send her to school from the nursery to secondary and be ready for the next child.” Male partner IDI*

**Despite high acceptance of delaying their next birth, participants did not always see contraception as a safe tool to achieve spacing goals.** Some FTMs and male partners were able to name at least one modern contraceptive method, but most had limited knowledge of how to use any method or how they worked. Myths and misconceptions about contraceptive methods were common, especially fears about causing infertility and ‘spoiling the womb.’ Married FTMs who had never used a method of contraception generally said family planning is safe and beneficial, but unmarried FTMs who had never used contraception were less likely to agree. Several men mentioned that they prefer “the local method” of spacing (i.e., extended postpartum abstinence). While most male partners do not believe that family planning is safe, they said they would approve of their wives/partners using family planning if they wished. Older women – the mothers of FTMs, largely agreed that they would approve of their daughters using FP services, as this would allow them to fully recover from their previous pregnancies and would offer them opportunities to return to school or continue a relationship with the baby’s father.

*No [I have never used a method of family planning]. Some say it’s not good and spoils a woman’s womb, that is why some of us are afraid to use it. Unmarried FTM IDI*

*It affects the womb and sometimes when one later needs babies, the woman will not be able to take-in [get pregnant] again, that means the womb may have been destroyed. Male Partner IDI*

*Yes, I do advise her, she will do FP, we have it in our plans. She came to tell me about what they told them about family planning at the health centre. I advised that the FP is good so that she would not make any mistake and it is left to her to decide if she wants to do it or not. FTM Mother IDI*

**For FTMs, concerns related to financial instability and lack of security influenced FP use and choice of contraceptive method.** In general, respondents who were in more stable unions and less worried for their financial stability seemed less likely to use a contraceptive method. Several unmarried

FTMs who were currently using a method mentioned that they would use FP until they got married or wished to become pregnant again. Married FTMs using contraception mostly relied on condoms, which were often given to their husbands/male partners or to FTMs themselves for free upon discharge after delivery. Unmarried FTMs reported using either an implant or injectable obtained during a specific FP counseling visit to a facility. While men suggested they would support their partners if they wished to use FP, FTMs were less clear on this, even indicating that secret use of FP could occur.

*Some [husbands] will support [their wives to use FP], some don't support, some women will hide and do it [FP] without the knowledge of the man. Married FTM FGD*

**Parenting and childcare roles and responsibilities fell along clear gender lines.** In general, FTMs reported having primary responsibility for daily care of the household and child, often with the assistance of other women in the household or extended family. Many men reported caring for and providing support to their wives with a variety of childcare tasks, despite norms-driven negative perceptions that say a man must have been “charmed” or “bewitched” to do so. For most men, however, direct handling of the baby (eg, holding, soothing, playing) only occurred after the infant was a few months old. Men consistently stressed their role as being the provider for the family, and less on daily care of their partners and children. With the range of relationships and living arrangements, FTMs were varied in how they felt about the father’s support and engagement with the child.

*He spends time [with the baby] as he is supposed to do. He will stay with the child for some hours. Right now, I don't have anybody apart from him, so he will help me do anything I need before he goes out. Married FTM IDI*

*My wife does virtually all the activities, I only assist her when the baby cries. Male Partner IDI*

*...the father takes care of the children when they are born, you will buy him medicine, give him treatment, and when a child is not well, he keeps embracing the child so that the child will be happy, and when the woman herself cries about food at home saying there is no food today, the father will go out to buy food - if he is a real father. But if [he] is not a real father, he will just go his way not having time, his own [role] is just to come and see the woman and go back. He does not even have time for the child. Male Partner IDI*

*He doesn't provide enough caring [for the baby]; I want him to be involved more. He should come more often and play with the child and care for him. FTM Mother IDI*

**Across respondents, there was strong interaction with infants and young children, and some understanding of child development in the first year.** All respondents understood that babies communicate from a very early age, even through crying. Both male and female respondents played, sang, and talked to their infants, even before they could talk or sing in return. FTMs and male partners said they occasionally became angry with their babies; few reacted by scolding or physically punishing the infant.

## **Objective 2, key findings**

*To explore the current experience of facility- and community-based health providers and resource persons in providing services to FTMs and their partners; document the levels of current use of FPIRH and postpartum care services by FTMs at facility level.*

The three facilities selected for the study had a range of family planning methods available, including injectables, condoms, implants, and intrauterine devices; however, providers, mostly CHEWs, said stock-outs of drugs and consumables, and limited office space, equipment, and availability of healthcare workers, were major challenges. Providers said they rendered services without upfront payment when needed. Many providers reported that they were not trained in immediate postpartum care. Providers reported that there were no specific differences in how they offered family planning services to married and unmarried FTMs.

However, CBO/Pathfinder staff reported that young first-time mothers require more support and information than those mothers with many children at facility and community level. They acknowledged that adolescents are unique and require specific considerations. Challenges in providing adolescent and youth RH originate mainly from opposition of communities and religious organizations (less so from health providers).

Providers reported outreach services across catchment areas of the three facilities, community meetings where family planning information is given, and weekly or monthly supportive supervision visits. They reported collaboration with Pathfinder and CBO staff, and specific efforts of Community Health Volunteers under SMGL to inform women about the risk of giving birth at home and encourage unregistered pregnant women to enrol in ANC and deliver at the hospital.

## **Objective 3, key findings**

*To explore acceptability and interest in participating in a program targeting FTMs and their partners on the above outcomes of interest.*

Most first-time mothers expressed willingness to participate in a program for FTMs, male partners, and mothers of FTMs. Married FTMs noted that they would be willing only with the permission of their husbands. Married or cohabitating men were also asked about their own interest in participating in the program, as well as approval for their partners or wives to participate. Nearly all men mentioned that they would be eager to participate, and several mentioned the desire to participate in home visits specifically. Mothers of FTMs said participation may be beneficial for their daughters and that they could convince them to participate, especially since they have been the main person supporting their daughters during pregnancy through childbirth and child care. Staff of Pathfinder and CBOs said training CHVs to counsel FTMs to improve breastfeeding and weaning, improve maternal wellbeing, teaching families to play and interact with their children, or for couples to talk more and make decisions together seemed like a good approach that would face few challenges.

## **Program Considerations**

The findings from this formative assessment provide important insights for stakeholders, programmers and communities interested in reaching young FTPs in CRS. The experiences shared by FTMs, their male partners and their mothers point to the complexity of the FTP lifestage and the multiple people and factors that influence how pregnancy, childbirth and child raising occur. Based on the study findings, a program targeting FTMs, their male partners, mothers and mothers-in-law should consider the following points.

***Work with young FTMs to build understanding and skills to address the varied health and gender-related factors that are critical to ensure good outcomes throughout pregnancy, childbirth and the early life of their child.*** Regardless of their individual characteristics and situations, FTMs are generally uninformed and unprepared for the health journey of becoming a mother – especially as so many are coping with unplanned pregnancies and unexpected motherhood. Given the fluid nature of relationships, living situations and support, all FTMs would benefit from programs that build their RH/MCH/FP knowledge and related life skills and access to quality health care. An essential part of this must focus on gender norms and roles, including helping FTMs build the planning, decision-making, communication and negotiation skills they need to take more control of their personal situations and options. With the stigma and isolation that some FTMs experience, there is also great value in creating a safe space where young women can come together to learn and build new connections with others in their same situation.

***Systematically engage the key influencers – the male partners of FTMs and the mothers of FTMs – to build support for FTM action and foster more gender-equitable roles and responsibilities.*** Although male partners and older women may be most influential with different FTMs – male partners within marriage, and mothers for unmarried FTMs – they consistently have a say in critical choices and decisions for all FTMs. Many male partners are themselves young First-Time Fathers also coping with unexpected fatherhood. Older women are taking on roles and tasks as mothers and grandmothers that push beyond traditional practices. As such, these key influencers also need basic RH/MCH/FP information and access to services to support decisions and actions throughout the FTP lifestage. In addition, programs should build understanding of gender norms and power dynamics, as well as encourage influencers to reduce relational barriers to better health and life options for themselves and their partners/daughters.

***Address community norms and attitudes that can lead to isolation and stigmatization of young FTMs.*** Many FTMs reported feeling condemned by their communities for being young, unmarried and pregnant. Given that marital status is so fluid, it is likely that many, if not most, FTMs face the emotional and mental toll of stigma, as well as the very real health consequences of not seeking timely health services for themselves and their child. Programs should build understanding of the FTP lifestage and the complex situations of FTPs in CRS with community leaders and members – especially parents and

gatekeepers responsible for the well-being of adolescents and youth – including support for FTP choice and timely access to AYRH care.

**Tailor RHIMCHIFP information and service delivery to better reach and serve young FTMs and influencers.** Experiences shared by FTMs, male partners and older women indicated several gaps in knowledge and access that increase risks of poor pregnancy, maternal and child health outcomes. Given that so many FTPs are dealing with unplanned pregnancies, it is essential to find health information and service delivery access points that link young mothers to care in a timely manner. The assessment suggested several opportunities to reduce the social, physical and financial barriers that FTPs face:

- Create systems that identify and link young FTMs (especially unmarried FTMs) to a continuum of care that begins with timely ANC and continues through child health services, such as home visits by trained community-based resource persons and community-based health and service outreaches;
- Support financing options that reduce costs for FTPs to travel to and deliver at health facilities; such as delivery vouchers/subsidies and emergency transport systems;
- Expand on positive norms related to breastfeeding to strengthen practice of exclusive breastfeeding, focusing on the nutritional “completeness” of breastmilk for young infants, timing of weaning, and importance of colostrum;
- Build on support for birth spacing to improve acceptance of modern contraceptives as a tool to achieve spacing goals by improving knowledge of contraceptive methods (including side effects), addressing myths and misconceptions; and exploring values related to contraceptive use.

**Promote positive parenting and gender-equitable roles in caring for homes and children.** While both FTMs and male partners valued interacting with their infants and children, caretaking responsibilities fell along clear gender lines, with FTMs or other female relatives responsible for all daily tasks (e.g., feeding, bathing, washing, etc.) and men focusing on the provider role. Programs should work with FTPs to challenge and change gender norms that limit fathers’ engagement with their families and reduce the burden of care placed on FTMs.

**Incorporate program elements (or link to other ongoing programs) that address educational and economic opportunities for FTMs and their families.** Across the board, FTMs, male partners and older women flagged how unexpected parenthood disrupted educational plans and raised financial concerns. Programs that support continued education, vocational/entrepreneurship training and income generating activities would address significant non-health needs of FTPs.

## I. Background

Becoming a parent for the first time marks an important milestone in the lives of women and men around the world. First-time parents (FTPs)—young, first-time mothers (FTMs) and their male partners—experience a time of evolving needs and challenges. Adolescence is already a time of tremendous change and transition in terms of physical, emotional and cognitive change, which is, in turn, made more complex by the challenge of pregnancy, childbirth and parenting. Adolescent and young

parents must seek out new maternal and newborn health (MNH) services, learn how to care for a young child, and adapt to the shifts in lifestyle, responsibilities, social status and personal relationships that come with becoming a mother or father. Their experiences are shaped by multiple contextual factors that directly or indirectly influence their immediate and longer-term options and outcomes, which include their reproductive health.

An important opportunity presents itself to programs interested in improving health outcomes for adolescents. First-time parents have significant needs but are not well-served by programs targeting unmarried youth. A more holistic and integrated response to the complex needs of this population. Investing in the human capital of young women, including their health and the health of their babies, is important for boosting Nigeria's long-term development prosperity. This requires a focus on adolescent and youth reproductive health (AYRH), high-quality antenatal care (ANC) and postnatal care (PNC), safe delivery, maternal and infant nutrition, couple communication, and gender equitable relationships, including for FTMs.

In Cross River State (CRS), Nigeria, very few programs have been implemented to support FTMs and their male partners to access comprehensive RH/FP and MNH information and services for the health timing and spacing of pregnancies (HTSP) and care of infants. Most AYRH programs have focused on preventing first adolescent pregnancy and reducing HIV transmission. Interventions for FTMs that improve the health and mortality rates of mothers and their infants will need to focus on: ANC and safe delivery, exclusive breastfeeding until the infant is aged six months, the importance of immunizations, and guidance on modern FP use. For many young mothers and fathers, it is also important to acquire new skills, adopt healthy behaviors, and access FP/MNH services that will safeguard the health and well-being of their new families and positively influence their future.

### **The 'First-Time Parent' (FTP) Lifestage**

E2A defines the 'FTP lifestage' as one which extends from conception through one year postpartum, lasts roughly 21 months, and occurs only once in a lifetime. Yet in this short span, FTMs deal with a wide range of MNCH and FP/RH issues, from accessing services to navigating new social and gender norms—all of which influence FP-related choice and action.

## I.1 Targeting FTPs through Saving Mothers, Giving Life Program

While there is growing global interest in FTPs as a target group for health interventions, there is limited evidence on the broader health situation of this population and effective programming to meet their multiple needs. Pathfinder International/Nigeria, through the Evidence to Action (E2A) project, will help fill this evidence gap. E2A is supporting an intervention focused on FTMs, aged 15-24 years, and their

### **Saving Mothers, Giving Life (SMGL)**

SMGL aims to accelerate the reduction of maternal and neonatal morbidity and mortality by implementing a model maternal and neonatal health intervention that applies a systems approach to ensure that every pregnant woman has access to clean and safe delivery services.

husbands/male partners in CRS, building on current FP and MNCH program activity under the Savings Mothers, Giving Life (SMGL) initiative. Through SMGL and expanded FP efforts, E2A is already addressing a range of health outcomes relevant for FTPs. Through expanded FP interventions under SMGL, specifically, E2A is supporting women with access to comprehensive FP care, including postpartum services and provision of long-acting reversible contraceptives (LARCs).

Building on SMGL's strong platform of facility- and community-based activity, E2A will design and implement an intervention package that addresses a continuum of health needs and outcomes at the critical FTP lifestage.

Interventions for FTPs CRS will include:

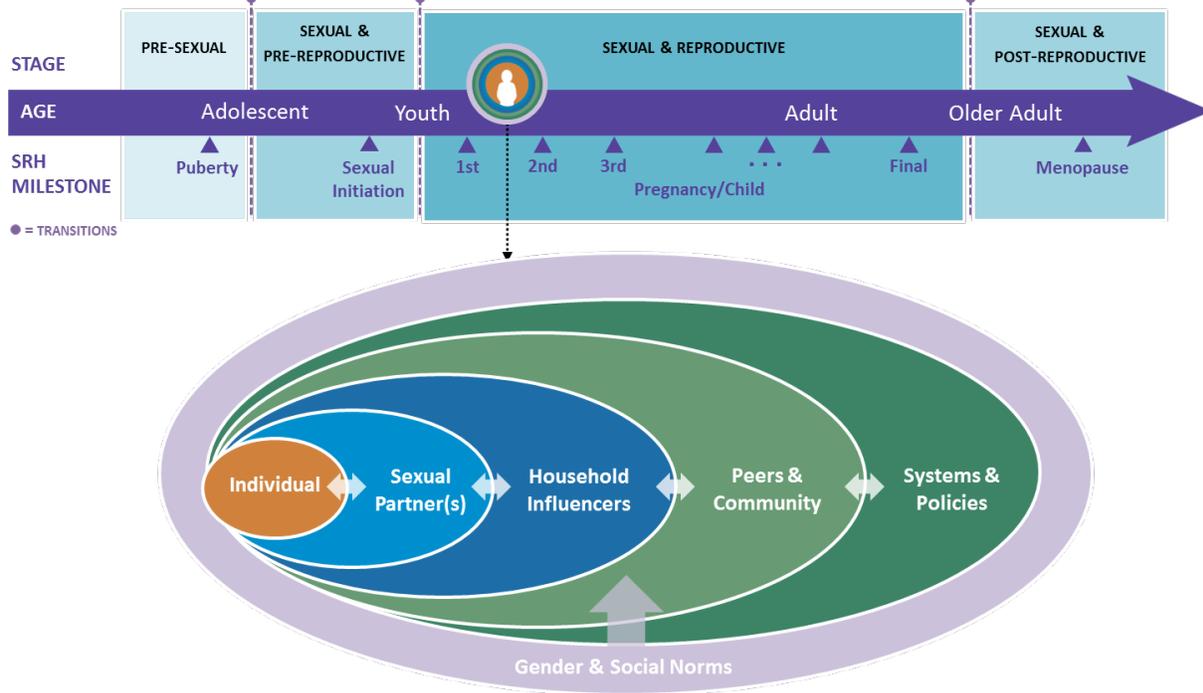
- Healthy timing and spacing of pregnancy (HTSP);
- Postpartum family planning (PPFP);
- Breastfeeding and child nutrition;
- Positive parenting;
- Gender-equitable decision-making and communication.

To inform the interventions for FTPs in CRS, E2A conducted a formative assessment using its FTP Framework (see Figure 1). Drawing from its work with FTPs in multiple settings, the framework combines a lifestage approach and a socio-ecological model of agency and decision-making to identify the key factors and dynamics that shape the FTP experience. The framework outlines different parameters for understanding where an individual or population is in terms of:

- RH markers, risks, and vulnerabilities across a lifetime continuum of transitions and stages in sexual and reproductive activity;
- Socio-ecological factors that define the broader context of sexual and reproductive activity—at individual, household, community, and structural levels;
- Relationships and interactions that influence RH agency, decision-making, and action;
- Gender and social norms that affect RH decisions and behaviors.

The RH Lifestages Framework and the socio-ecological model of decision-making can be used to design and implement context-specific RH interventions tailored to the needs of specific populations, including first-time parents. For this assessment, it was used to identify which respondents to interview and prioritize what information to collect: specific life events, health concerns, and contacts with key influencers that drive access to FP and MNH information and services among FTPs in CRS, Nigeria.

**Figure 1. E2A Sexual and Reproductive Lifesage Framework (FTP Lifesage)**



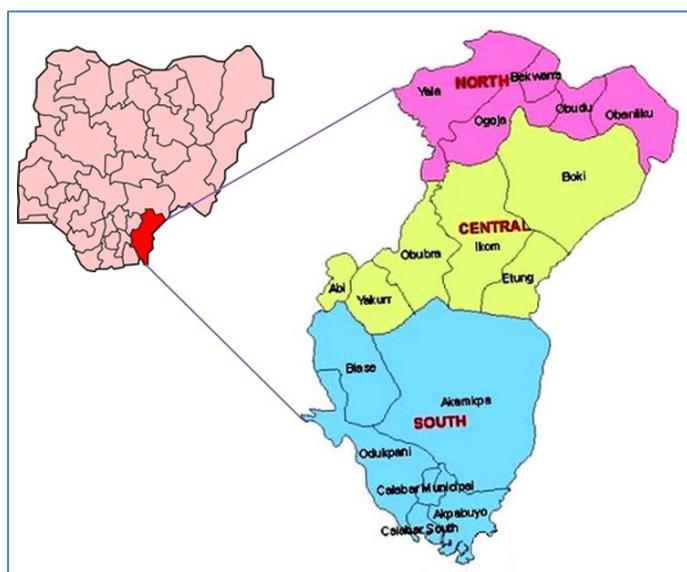
## I.2 First-Time Parents in CRS & Nigeria

Over one-third of Nigeria’s population of 47 million is between 10 and 24 years old<sup>1</sup>, and CRS has a large youth population of about 1.3 million<sup>2</sup> with significant RH needs. In the South-South geopolitical zone of Nigeria, where CRS is located, nearly half (48%, n=123) of all pregnant women aged 15-24 years are expecting their *first* child—a statistic that underscores the need to build evidence-based programs for FTPs during this critical lifesage.<sup>3</sup> The current situation of young women in Nigeria and CRS highlights the vulnerabilities of this population across multiple health indicators.

## Childbearing:

Early childbearing is common throughout Nigeria, including CRS. In CRS, 18 percent of adolescent girls have started childbearing.<sup>3</sup> Available data show that early sexual debut is common, with the median age at sexual debut among adolescent mothers in CRS at 18.8 years.<sup>3</sup> It is not known to what extent early sexual debut in CRS is consensual vs. coerced. However, it is well known that early sexual debut may result in a range of unintended and unwanted outcomes, such as sexually transmitted infections (STIs), unwanted pregnancies, and unsafe abortions.<sup>3</sup>

**Figure 2. Map of Nigeria, showing Cross River State and corresponding LGAs**



The estimated maternal mortality rate (MMR) is 576 per 100,000 live births, while the infant mortality is 69 per 1,000 live births.<sup>3</sup> Globally, adolescent pregnancy is associated with higher morbidity and mortality for both the mother and the child.<sup>4</sup>

These international findings have been confirmed by studies in Nigeria.<sup>4</sup>

In Nigeria, the median birth interval is 31.7 months.<sup>3</sup> Infants born less than two years after a previous birth have high under-five mortality rates (213 deaths per 1,000 live births compared with 103 deaths per 1,000 live births for infants born three years after the previous birth).<sup>3</sup> Nearly one-quarter (23%) of all children are born less than two years after their siblings.<sup>3</sup> Evidence shows that both mothers and babies are also healthier if at least 24 months between last birth and next pregnancy (or even 36 months from one birth to the next). Yet, a literature review by E2A on first-time parent implementation efforts<sup>5</sup> showed that very little programming has been dedicated to adequately spacing second and subsequent pregnancies among young mothers, despite the enormous need.

## Marriage:

In CRS, FTMs range in age and many FTMs are unmarried. Often unmarried FTMs are single parents; however, in some cases, unmarried FTMs remain in a relationship with the father of their child. Among married FTMs, many are relatively close in age their husbands. However, there are also some couples who differ significantly in age gaps (at least 10 years' age difference). Overall, unmarried FTMs have a lower socio-economic status than married FTMs, especially unmarried adolescent FTMs.

### **Access to and use of RH and FP care:**

Contraceptive prevalence rates among adolescents and young women in Nigeria remain low. Only 1.2 percent of married adolescent girls (15-19) and 6.2 percent of married young women (20-24) currently use a modern method of contraception, much lower than the contraceptive prevalence among older married women (11.4 percent). For unmarried sexually active adolescents and young women, 49.7 percent and 63.5 percent, respectively, currently use a modern method of contraception.<sup>3</sup> Unmet need for contraceptives among adolescents and young women (15-24 years) is also important to note: 15.1 percent of married young women and 24.4 percent of sexually active unmarried young women in Nigeria have an unmet need for contraception.<sup>3</sup>

Married adolescents and young FTMs are less likely to currently use contraception than those who have three or more children.<sup>7</sup> The limited use of RH/FP care among FTMs, including contraceptive services, is partly because they do not typically have control over decision-making about their RH. Often, key influencers, such as parents, in-laws, husbands or male partners, or perhaps older co-wives, drive household decision-making as well as health care spending, including RH and contraceptive use. In addition, young people themselves have their own biases and misinformation about the risks and potential side effects of contraception. Fertility is highly valued in Nigeria, and youth, adults and service providers often fear that use of any method of family planning may result in infertility, permanent damage to reproductive organs, infections, or cancer. It is also perceived that these side effects may become more prevalent with use of long-term contraception, such as the IUD or implant.<sup>8</sup>

Young women who desire to use family planning methods also face barriers on the supply side – through non-availability of a trained provider, contraceptive method stockouts, geographical distance, or through individual health care provider biases of who should or should not obtain family planning services. Providers often contribute to barriers to contraceptive use through restricting access to methods based on their own personal biases about who should or shouldn't use certain contraceptive methods. Providers often decide which contraceptive method to offer on the basis of his/her own cultural and social norms, or on the basis of his/her observations about a client's personal characteristics, such as: age, parity, and marital status.<sup>9</sup>

In addition, unmarried FTMs often face additional stigma and discrimination at community or even household level, which further prevents them from accessing RH information and care. Unequal power dynamics and gender inequalities place young women and girls in Nigeria at particular risk of gender-based violence and HIV, and early or closely spaced pregnancies and child-bearing—in turn, increasing their risk of maternal and infant mortalities and morbidities.<sup>10</sup> Furthermore, FTMs can quickly become

**Figure 3. Cross River State Indicators, 2013 Nigeria DHS**

**Number of youth, 10-24 years:** 1.3 million

**Sexually active adolescent girls 15-19 currently using a modern FP method (both married and unmarried):** 27%

**Adolescent girls 15-19 who have begun childbearing:** 18%

**Received ANC from a skilled provider during their most recent pregnancy:** 73% of women

**Delivery at health facility by a skilled attendant:** 40% of births in last five years

**Infant mortality:** 67 deaths per 1,000 live births

isolated, with household responsibilities and limitations on their mobility, keeping them at home and away from health information and services and supportive social networks, affecting their mental health and sense of well-being as new mothers.

### **Access to and use of RH and MNH services:**

FTMs in Nigeria often lack sufficient and accurate information about their RH and MNH. Young mothers are also less likely to access maternal healthcare, specifically antenatal (ANC) and postnatal care (PNC), as well as skilled birth attendance.<sup>11</sup> According to the 2013 National Demographic and Health Survey, 61 percent of all women aged 15-49 years who had a birth in the last five years received ANC from a skilled provider during their most recent pregnancy; however, only 48 percent of mothers under 20 years of age received ANC from a skilled provider. Timing of initiation of ANC (during the first, second, or third trimester), however, was found to be significantly related to mother's level of education, socio-economic status, and urban/rural residence (age was not significantly related to timing of ANC among those who sought ANC services).

Only 40 percent of births to women in the last five years in CRS were delivered in a health facility and by a skilled birth attendant. Most common reasons for not delivering in a facility included “cost too much” (33%); “child born suddenly before reaching facility” (28%); “not necessary” (14%); and “too far/no transportation” (13%).<sup>3</sup>

Home-based postpartum care (*omugwo* in Igbo language) for the mother and baby is traditionally practiced in CRS.<sup>12</sup> Immediately after birth, a nursing mother and her baby are cared for by a close family member, usually her mother, and typically for a period of 1-3 months. The main reason is to support postpartum mothers to recover from birth and to teach the new mother about infant care. In addition, a special kind of diet, which includes soupy, spicy, high-protein stews with lots of vegetables, are given to the mothers to enhance production of breast milk for the baby and to help with the mother's recovery. The mother is given time and space to rest and regain her strength.

Other well-known traditional postpartum practices beneficial for health include extended postpartum abstinence while breastfeeding. In many parts of Africa, particularly West Africa, cultural norms traditionally prohibit sexual intercourse for breastfeeding mothers.<sup>13</sup> In an environment where polygamy is common and contraceptive use is low, this practice serves to improve healthy timing and spacing of pregnancies, therefore reducing a woman's lifetime fertility and risk of maternal mortality, improving the health of infants as well.

However, traditional postpartum care and abstinence may not be practiced as frequently or intensively today in many societies throughout Africa, including Nigeria, due to modernization and demographic and socioeconomic changes (e.g., women's education, availability of modern contraception, urbanization, and migration).<sup>31</sup>

In Nigeria, while some breastfeeding is nearly universal (98 percent), only 17 percent of mothers exclusively breastfeed their babies (0-6 months).<sup>3</sup> Maternal nutrition during breastfeeding and exclusive breastfeeding for the infant, at least up to six months, is critical for infant and maternal health.

## II. Objectives of Assessment

It is envisioned that the results of this assessment will be used to inform the content and structure of interventions to reach FTMs with critical MNH and FP/RH information and services in CRS, Nigeria, and ultimately across the country. The design of the assessment was guided by the following primary objectives:

1. To explore knowledge, attitudes, and behaviors among FTMs, their male partners, and other household and community influencers and decision-makers related to health and health-related outcomes of interest, such as experience with ANC and delivery services, child health and breastfeeding, and attitudes towards birth spacing and postpartum contraceptive use;
2. To explore the current experience of facility- and community-based health providers and resource persons in providing services to FTMs and their partners; document the levels of current use of FP/RH and postpartum care services by FTMs at facility level; and
3. To explore acceptability and interest in participating in a program targeting FTMs and their partners on the above outcomes of interest.

## III. Assessment Methods

### 3.1 Overview

This study is a pre-intervention qualitative assessment conducted in two selected LGAs where SMGL/FP activities are being implemented in CRS, Nigeria, to strengthen MNH interventions and expand contraceptive method choice (with a focus on LARCs). The findings and programmatic recommendations will be used to design initial FTP interventions in CRS and inform potential efforts to integrate FTP-specific elements within the broader scope of MNH and FP/RH programs across the state.

### 3.2 Research Design

The research was qualitative, with data collected through focus group discussions (FGDs) and in-depth interviews (IDIs). The study sites were communities within three facility catchment areas in Ikom and Obubra, two Local Government Areas (LGAs), already working with E2A and Pathfinder/Nigeria through SMGL/FP activities. The study was conducted between August and November 2017. The qualitative assessment provided information on experiences and acceptability of postpartum FP and breastfeeding practices, a deeper understanding of roles and responsibilities for child care at the household level, reflection on parenting roles, couples' communication, and other gender-related areas. In-depth discussions also helped to understand the acceptability of conducting interventions tailored to FTMs and their male partners within the communities.

### 3.3 Data Collection

Data-collection methods at facility and community level included: Review of FP/RH and MNH-related health service statistics at three facilities.

- IDIs with facility-based FP providers; married FTMs aged 18-24 years (both current FP/RH clients of facilities and those who had never used FP/RH care at a facility); unmarried FTMs aged 18-24 years (both FP/RH clients and those who had never used FP/RH care); husbands/partners of FTMs; mothers of unmarried FTMs residing with them; and community leaders.
- FGDs with Community Health Volunteers (CHVs) and married FTMs aged 18-24 years.

### 3.4 Sampling

Three facilities were purposively selected within the two LGAs: the Comprehensive Health Center and Emangabe Primary Health Center in Ikom, and Ochung Primary Health Center in Obubra. Respondents were recruited for interviews from the corresponding communities in the designated catchment areas of each facility.

In all, a total of 8 FGDs, each with 6-10 participants, involving approximately 55 individuals, were interviewed. Approximately 85 participants were also interviewed individually through IDIs (see **Table 2**).

**Table 2. Participant category and target sample sizes for IDIs and FGDs**

Participant category	Type of interview	Target number of interviews
Facility-based family planning (FP) providers	IDI	6 (3 facilities; 2 per facility)
Married* first-time mothers (FTMs), aged 18-24 years, who have only one child aged 12 months or younger, and are facility FP clients since the birth of their child	IDI	9 (3 per facility catchment area)
Married FTMs, aged 18-24 years, who have only one child aged 12 months or younger, and who have not used FP since the birth of their child	IDI	9 (3 per facility catchment area)
Unmarried FTMs, aged 18-24 years, who have only one child aged 12 months or younger, and are facility FP clients since the birth of their child	IDI	9 (3 per facility catchment area)
Unmarried FTMs, aged 18-24 years, who have only one child aged 12 months or younger, and who have not used FP since the birth of their child	IDI	9 (3 per facility/ catchment area)
Community leaders who also serve as members of Ward Development Committees (WDCs) in charge of ensuring better community linkages to the target facilities	IDI	6 (2 per facility catchment area) were targeted; 4 interviews completed
Key community-based organization (CBO) staff/Pathfinder staff	IDI	3 (2 CBO; 1 Pathfinder staff)
Married FTMs, aged 18-24 years who have only one child aged 12 months or younger	FGD	6 (2 per facility catchment area)
CBO Community Health Volunteers (CHVs)	FGD	2 (only 12 CHVs are active and attached to the program, and nine CHVs were interviewed in the two FGDs)
Husbands/partners of married FTMs under 25 years with one child aged 12 months or younger	IDI	18 (6 per catchment area)
Mothers who live with an unmarried FTM who is under 25 years with one child aged 12 months or younger	IDI	18 (6 per facility/ catchment area)

\*For the purposes of this research, “married” is defined as officially married, or living with a partner (regardless of whether he is the father or not).

### **3.5 Training and Piloting**

The staff of Research and Communication Services (RCS) conducted a five-day intensive training of the field research team in Ikom, CRS. E2A and Pathfinder/Nigeria staff led presentations. The training covered fundamental topics, such as the methodology (to ensure efficient identification, recruitment and screening of potential participants); qualitative research techniques in conducting IDIs and FGDs; note-taking techniques; and the content and meaning of questions included in all interview guides to be used in the study. The training also aimed to ensure that the data collection team had thorough and in-depth knowledge of the E2A-led study and its goals, including roles and responsibilities of the data collection team and research ethics.

E2A piloted the data collection tools in one non-investigational community in Ikom, CRS, with all team members to check suitability, reliability, coherence, and clarity of the tools and to test the recruitment procedures. A feedback session was held and corrections were made to ensure that the tools were clear, areas for noting responses were not confusing, the necessary data were captured, and questions were understandable and relevant to the context.

### **3.6 Data Collection Procedures**

Recruitment of FTMs, male partners of FTMs, and mothers to unmarried FTMs (who co-reside in the same household) was conducted at households in the designated facility catchment areas. Trained research teams moved from house to house to locate eligible respondents using a pre-determined interval of household selection (based on a quick mapping exercise of the number of residential structures in the target communities). FTMs aged 18-24 years with only one infant less than 12 months of age were the primary target. Additionally, mothers and male partners of FTMs were recruited by inquiring if an FTM with the desired characteristics lived in the residence. FTMs, male partners, and FTM mothers were interviewed in separate households; no more than one respondent was interviewed in each residence. At the end of each IDI and FGD, the interviewer quickly checked the guide and responses for completeness before ending the interview. In addition, interviews were recorded to reduce loss of vital data obtained from IDIs and FGDs. Below is a detailed description of recruitment by category of respondent type for this study.

#### ***Recruitment of FTMs:***

FTMs were recruited at the household level. Households and dwellings around the study facilities were assigned to trained research teams to conduct a mapping. Researchers moved from house to house to identify eligible respondents who were willing and available to participate in the study. On arrival at a house, the recruitment team used simple balloting to select one FTM in a given household if there were more than one who met the inclusion criteria, and then invited her to participate in the study, or made an appointment to return and discuss her availability or interest in participating. An appointment was made for two members of the interviewing team to perform an interview later that day or week.

### ***Recruitment of FTM mothers and partners:***

Male partners of FTMs and mothers of unmarried FTMs were also recruited. To ensure good representation of different members of the community and avoid selection bias, FTMs, their partners, and mothers were recruited from different households. Partners and mothers of FTMs were recruited by first identifying the existence of an FTM in that household who met the criteria and then enquiring if an FTM, mother, or partner lived there. An appointment was made for two members of the interviewing team to perform an interview later that day or week.

### ***Recruitment of facility-based FP providers, community leaders, and community-based organization (CBO)/Pathfinder volunteers and staff:***

FP providers that currently offered services at one of the three study facilities in Ikom and Obubra LGAs were interviewed as part of the study. Recruitment of facility-based FP providers was conducted with the support of the Pathfinder/E2A staff that provided entry and introductions for the research team.

Key Pathfinder/E2A staff, community leaders, and staff of the CBO based in Ikom (Greater Hands Foundation), implementing activities through the SMGL Project, were also recruited to be part of the study. Community leaders who also served as members of Ward Development Committees (WDCs) in charge of the target facilities were identified with assistance from staff from the local CBO. Participants were selected based on their confidence and ability to provide critical insights.

Pathfinder and CBO staff and volunteers who are part of the implementation of the SMGL/FP project were also interviewed. CHVs working with the local CBO, as well as key informants from the local CBO and Pathfinder/Nigeria office in CRS, were also recruited for interviews based on their roles in their respective organizations.

## **3.7 Data Analysis**

Detailed field notes and short summaries of field work observations of each interview and FGD were typed in Microsoft Word for coding after completing field work. An analog or digital voice recording device was also used to capture the interviews. Field notes and transcripts were coded daily by research assistants, and double checked by a senior researcher. The Jefferson Transcription System was adapted for use in transcription analysis (transcripts were designed not only to capture **what** was said, but also the **way** in which it was said). A coding template was developed from initial scripts extracted, with this further refined to reflect emerging themes. The descriptions of the observations and informal conversations were grouped into themes. An analytical summary of themes was conducted, with emerging themes and lines of enquiry extracted, and theoretical constructs developed. The NVIVO software was used in the analysis, with the Jefferson Transcription System employed, only retained in the original data.

### **3.8 Ethical Considerations**

The protocol for this assessment received Institutional Review Board (IRB) approval from the Government of CRS, Nigeria, Health Research Ethics Committee (CRS-HREC) on July 13, 2017, to conduct the assessment (ref: CRSMOH/RP/REC/2017/513) and was exempted from IRB review by PATH's Research Determination Committee on May 8, 2017. This study was carefully designed to address ethical principles, including respect for persons, beneficence, and justice. Efforts were made to protect individual autonomy, minimize harm, maximize benefits, and equitably distribute risks and benefits. All study team members were given ethics and data confidentiality training so that they fully understood the concepts of informed consent and confidentiality. Participants were provided with the summary of the study and the implication of their participation, following which a consent process was administered at the scheduled appointment before the interview. Permission to both interview and record was also sought by the interviewers. Participation in the research was voluntary and participants had the right to withdraw from the study at any time, without any sanction. A signed consent (thumbprint) form was collected, and a copy was left with participants. All participants were aged 18 and above years, hence there was no need to consider parental/guardian consent.

### **3.9 Limitations**

The qualitative research methods used in this assessment have several well-known limitations. Participants selected using purposive sampling may not be representative of the perceptions and views of all community members or other respondents. To address this risk, the project team ensured that participants represented the target LGAs, coming from a variety of community settings, using a multi-stage recruitment strategy which included an element of randomness (or lack of bias) at the lowest level of selection.

This assessment excluded young women aged 18-24 years who may have previously given birth, but whose child had passed away, because we were interested in current parenting and child care practices and experiences among FTMs of this age group. If they had been included, these women surely may have had different experiences with health services, including child birth and delivery care, postpartum care, breastfeeding, or other child care behaviors. Thus, it should be noted that this assessment is not a comprehensive research study on the experiences of all FTMs, but rather a pre-program assessment of those currently parenting an infant.

Further, this study did not attempt to interview FTMs under 18 years of age due to the difficulties in obtaining written parental consent, and the possible risk of harm associated with trying to obtain parental, spousal, or other family consent. In addition, we sought to increase the validity and credibility of these results by not including a sub-population which may have felt obliged to give consent due to age and power differences between interviewers, consenting family members, and FTMs themselves. This means that responses and experiences from minor FTMs, which may have contributed a unique and perhaps different perspective on the outcomes of this study were not included. However, we did include a number of 18- and 19-year-old FTMs with infants up to one year old, which means that they were younger adolescents when they began their relationships and became pregnant. It is likely that the age group selected (18-24 years) represents the views of the typical younger FTM in CRS, Nigeria.

Finally, this study could not explore, in exhaustive detail, changes in residential arrangements (such as temporary or permanent moves to their parental homes), as well as the circumstances, availability, and conditions given by FTMs and their male partners to engage with various health services and behaviors of interest, such as FP and exclusive breastfeeding. The data gathered represent a brief overview of each health area of interest from a variety of perspectives (FTMs, male partners, etc.), and give enough information to design a short program for FTMs and their partners on these topics.

## **IV. Assessment Results**

### **4.1 Objective 1: Assess knowledge, attitudes and behaviors among FTMs, their male partners, and other household and community influencers and decision-makers related to health and health-related outcomes of interest.**

#### ***4.1.1 Background Characteristics***

Table 3 below summarizes the various respondents interviewed as part of this study, types and numbers of interviews conducted, and relevant background characteristics of respondents. It should be noted that most FTMs interviewed in this assessment had some level of secondary school education, earned money through farming or petty business, and had a relatively young (less than six months) infant. Male partners of FTMs were also young, with most in their mid- to late twenties, and nearly all reporting to be first-time fathers. FTM mothers were relatively young themselves, aged 35-45 years. Facility-based service providers were mostly female CHEWs in their 40s, and community volunteers were mostly females in their 20s, with a secondary level of education.

**Table 3. Background characteristics by respondent type**

Respondent Type	Characteristics
<p><b>First-Time Mothers:</b></p> <ul style="list-style-type: none"> <li>• 18 IDIs with currently married FTMs</li> <li>• 18 IDIs with currently unmarried FTMs</li> <li>• 6 FGDs with currently married FTMs</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Age:</b> Unmarried FTMs tended to be younger (aged 18-22 years) than married FTMs (generally 20-24 years)</li> <li>• <b>Education:</b> Nearly all women, regardless of marital status, had completed some or all secondary school</li> <li>• <b>Occupation:</b> Women earned money through petty trade/business, work as a hair stylist, and through farming</li> <li>• <b>Age of baby:</b> Most respondents had a baby (either male or female) under 6 months of age</li> </ul>
<p><b>Male partners of FTMs:</b></p> <ul style="list-style-type: none"> <li>• 18 IDIs with men who were either married or co-residing with an FTM, regardless of number of children or other wives</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Age:</b> 24-35 years old, with most in their mid to late 20s</li> <li>• <b>Education:</b> nearly all had some secondary or higher education</li> <li>• <b>Occupation:</b> Most reported working as a farmer, barber, cyclist transport, businessman, or in a skilled trade (mason, mechanic). A few reported that they were still students in school.</li> <li>• <b>Number of wives/children:</b> Nearly all were first-time fathers and reported having only one wife/partner. Many fathers said they don't have another child, although some reported having another child with another woman.</li> </ul>
<p><b>Mothers of unmarried FTMs:</b></p> <ul style="list-style-type: none"> <li>• 18 IDIs with mothers of unmarried FTMs who still lived at home and had only one infant who was 12 months or younger</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Age:</b> Nearly all mothers of FTMs were aged 35-45 years old</li> <li>• <b>Age/sex of grandchild:</b> Their grandchildren were evenly distributed from age 1-12 months, with seven who had a male grandchild, and 11 who had a female.</li> <li>• <b>Education of daughters:</b> Most (all but two) reported that their daughters had either a secondary or tertiary level of education</li> <li>• <b>Occupation of daughters:</b> Nearly all daughters were either unemployed or farmers.</li> </ul>
<p><b>Facility providers:</b></p> <ul style="list-style-type: none"> <li>• 6 IDIs with facility-based providers, two from each of the three selected facilities, with experience providing FP services.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Age/sex:</b> Most providers were female in their 40s (33 – 48 years).</li> <li>• <b>Health worker designation:</b> Four providers interviewed were Community Health Extension Workers (CHEWs). The team also interviewed two Community Health Officers (CHOs).</li> <li>• <b>Professional experience:</b> Providers were typically based at the facility 5-10 years (one had served for 17 years)</li> </ul>
<p><b>Community health volunteers:</b></p> <ul style="list-style-type: none"> <li>• 2 FGDs, one with three CHVs and one with six CHVs working in the two LGAs.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Age/sex:</b> Most CHVs were female, in their twenties.</li> <li>• <b>Education:</b> Most had completed secondary school (Senior Secondary Certificate of Education; SSCE). Two CHVs had diplomas in community health.</li> <li>• <b>Professional experience:</b> Most CHVs had been working as a CHV for two to three years. One CHV was a 41-year-old male who had been serving for at least nine years.</li> </ul>
<p><b>Community leaders/CBO staff:</b></p> <ul style="list-style-type: none"> <li>• 4 IDIs with members of Ward Development Committees as community leaders</li> <li>• 2 IDIs with local CBO staff serving communities located in the Ikom/Obubra SMGL cluster</li> <li>• 1 IDI with Pathfinder staff located in the CRS, Calabar office.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Age/sex:</b> All WDC respondents were male, aged 41-65 and</li> <li>• <b>Professional experience:</b> All WDC respondents had served on their respective WDCs for two to four years. All CBO/NGO staff were directly involved in managing field activities in the SMGL program in CRS.</li> </ul>

#### 4.1.2 Relationships/marriage and pregnancy

Nearly all respondents were asked about their experiences with young relationships and marriage, adolescent pregnancy, being a young mother, supporting a young mother, or providing services in the community or at a facility to young mothers. These and other results in this assessment are presented by respondent type, with major sub-themes presented within respondent type.

##### **FTMs:**

For most FTMs, pregnancy was a defining moment for union status. Across all categories of FTMs, pregnancy mostly came *before* marriage, and resulted either in continued partnership, formalized marriage, or separation among young women who considered themselves both unmarried and in union. About half of married and unmarried FTMs reported being worried about their pregnancy as it was unplanned and unexpected. Some FTMs reported uncertainties, worries, and social difficulties about their marriages and husbands' commitment to the marriage. There appears to be little variation in the views of married and unmarried FTMs; both expressed uncertainties and worries about their marital status, with some stating that they were a second or third wife, or they believed their husbands having might have another wife.

*I don't know, he said he doesn't have another wife. Unmarried FTM IDI*

*No other wives, but I don't know if he has girlfriends, am not sure of that. Married FTM IDI*

*My husband abandoned me because I had twins. I take care of my children alone without his care...I heard he has impregnated another woman. Married FTM IDI*

Many FTMs also reported social difficulties from the community related to becoming pregnant before marriage. This particularly led to social stigma and discrimination, which made them stay indoors, preventing them from seeking needed health care and using health facilities.

*R1. Yes, some of the girls are treated with disdain, they talk bad against them.*

*R2. A lot of people condemn first time mothers that are pregnant without being married. Married FTM FGD*

*Those that are married feel happy for being a pride to their family, while those who are not married are regarded as a disappointment to the family. You are looked down on because you are a single girl who is not married but pregnant. Married FTM FGD*

In many instances, FTMs reported that their families regarded the baby as an added liability. When there are no resources to take care of the FTM and her child or the baby's father is not taking any responsibility, a young mother loses privileges in her house or she is even forced to drop out of school with tuition fees diverted to nurturing the new mother and child.

*I am not generalizing it, just based on my family's opinion. Like in my family, the mother not the father is regarded as one who can't train her child. People look at you as a spoiled child and will regard you as one who hurried to do what her mates have not done; and when you are pregnant at the early stage, they won't be happy with you. Meanwhile, when the child is born everyone around will be happy with you. Your family in particular will look at you that you have added another load to the family, because they were struggling to send you to school and you got pregnant and brought it home. If the father of the child isn't ready to take responsibility, they may drop you off from school, and concentrate on*

*the child. If the family is comfortable, they will say let's see how you both can manage, but some privileges you used to have before the child came - you won't have them anymore.* Married FTM FGD

FTMs whose education and future plans were interrupted had regrets, but the arrival of the baby forced them to move forward and focus on raising and caring for their children. Some FTMs, especially those who were younger, with less education, or who remained unmarried after the delivery regretted having their children, especially due to lack of funds to meet their children's basic needs. Others did not mention any regrets and expressed happiness over their first child's birth, although they noted concern about the limited social and personal activities they could perform now.

*I feel bad because the father is not always around and sometimes when there is no food at home. When I think about all these things it makes it look like I'm not ready to take care of the baby.* Unmarried FTM IDI

*I was happy that I delivered successfully even when I know that my usual daily activity will be limited.* Married FTM IDI

Several FTMs mentioned disappointment and negative consequences related to the father's disappointment over the sex of the baby or having twins<sup>a</sup>, although this was relatively rare.

*You know some families that need, for instance, they already have girls and then they are looking for a boy, then give birth to a girl again, will be very upset and disappointed and some men will not even come check their wife at the hospital...* Married FTM IDI

*I was disappointed because my baby's father was looking for a boy and that made them send me to my mother because I put to birth baby girl* Unmarried FTM IDI

*I felt bad because it has caused a problem. My baby's father abandoned us because I delivered a baby girl.* Unmarried FTM IDI

*My husband abandoned me because I had twins. I take care of my children alone without his care.* Married FTM IDI

Other challenges and worries were related to the fact that the pregnancy was unexpected, marriage unplanned, and lack of support from the FTMs' male partners, for both themselves and their babies. For example, across married and unmarried FTMs (who had used or not used FP/RH facility-based services), many of the respondents reported they are currently happy about their pregnancy, but were not initially, particularly those who felt it would affect their education. These FTMs (both married and unmarried) reported that their education or financial status was negatively affected, which made them relatively unhappy about their pregnancy.

*I did not expect the pregnancy.* Unmarried FTM IDI

*When you are pregnant you don't say it is a mistake. God knows why that pregnancy is there because you will always meet with your man. So, you should always expect it and when it comes take it in good faith.* Married FTM IDI

*I feel fine now but was not happy for like three months because it affected my education.* Married FTM IDI

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<sup>a</sup>Traditions of ritual infanticide exist among a number of communities in Nigeria (as well as in other countries) in response to births of twins or children with deformities or abnormalities (cleft palate, enlarged heads, etc.). Twins, triplets and other multiple-birth babies are perceived by some communities to be "evil", having bad spirits that will inflict misfortune upon their communities, and may be killed soon after birth to prevent this "misfortune" from occurring or spreading. Aside from spiritual beliefs, twin babies obviously require more care and resources, and thus may be undesirable from a social or economic viewpoint.

*First time I was not happy because of my future. I was about [to receive] admission into the university of Calabar. I was planning so many things but when I became pregnant my parents were very angry with me and saying all sorts of things. It was the father of my child that stood by me and told my parent that after I give birth to the child that I will go back to school. That was when my parents then welcomed the idea and we all became happy about it. Unmarried FTM IDI*

Despite these various challenges, half of the women interviewed felt that their pregnancies were positive and happy experiences, regardless of whether they were married or unmarried, and whether the child was expected or unexpected. In some cases, women who did not expect to become pregnant felt affirmed and supported by the fathers of their young infants, and thus, very happy with their status as new mothers.

*...When I was pregnant, my family was in serious conflict with me until my child's father went and told them that he will look for money and come to settle for everything before they calmed down... The man is trying his best, my baby is fine, and I am fine too. Unmarried FTM IDI*

*I am 100% satisfied and happy and I also certify that I have gotten enough help from him. Unmarried FTM IDI*

*Whatever I want, he gives me. He supports my education, food, and helps me with the farm work. Married FTM IDI*

### **Male partners:**

Male partners were asked about the characteristics and behaviors of an ideal husband in their communities, as well as their experiences trying to provide for a new family. Most respondents mentioned that an ideal husband is a good provider for the needs of their families and someone who makes mature decisions and ensures that their family receives the medical care that they need. A few mentioned the quality of the relationship they would ideally like to have with their wife and family.

*I will say I will be very humble to my wife and train my children how to be humble to others and make the family very sweet. Male Partner IDI*

*An ideal husband is someone that is industrious, must perform traditional rites, must take responsibility of his children, teach his children Ikom language. Male Partner IDI*

Most fathers interviewed agree that a father has responsibilities for the children, wife, and the family, especially meeting basic daily needs. Fathers reported being worried about their wife's pregnancy if the pregnancy was unplanned, and some reported that there was pressure from the wife's parents (to marry or otherwise take responsibility for the child), coupled with the fact that their wives were FTMs and relatively young.

*When she was pregnant, her parents were all over me, they put fear in me. As a man, that didn't make me afraid [of taking on these new responsibilities] or think of aborting the baby. Male Partner IDI*

Many fathers had regrets and wished they had completed their education before marrying and having children.

*I would have wished to finish school before having my baby to keep money to care for my baby. I wished, I had finished my NYSC before having my baby. Male Partner IDI*

Many partners (especially married husbands) expressed confidence in their ability to build a home together with their wives, while also reporting uncertainty about the future due to their young age and financial instability. As reported, fathers encounter several challenges, notably financial, in the role as providers for their families and children, but still maintained a desire to have plans to secure their children's future.

*Some of the challenges is when there is no work and her food is finished. I find it difficult to get her food. Male Partner IDI*

*My aspiration is how to save good money, to secure a better future for him, I had a plan of saving #5000.00 every month for him, then let him know when he is grown up. Male Partner IDI*

Men as partners discussed their stresses and struggles to meet personal needs and those of their wives and children as well as their optimism in the future for doing so. Many husbands expressed confidence in their ability to build a home together with their wives in the future, despite their young age, and the challenge of obtaining employment.

*I had confidence since my wife and I are still young, and we are getting to our expected target. I was thinking I am capable, I was thinking the power was there to handle everything that is coming. Before my wife came, I have been a hardworking guy. I will work harder, because I know that in due time, we will be more than two. Male Partner IDI*

### **Mothers of unmarried FTMs:**

Many FTM mothers agreed that their unmarried daughters faced humiliation after getting pregnant. Many mothers reported that they were unaware their daughters were pregnant until they began showing their pregnancy. While marriage before the pregnancy is the "ideal," most admitted that pregnancy before marriage was common, with the average age of marriage around 20 years.

*Yes, they mock her for being pregnant without being married. FTM mother IDI*

*Most of them are aware that they are pregnant, because of the numerous boyfriends (lovers) they have. Example is my daughter: she was three months pregnant, but she was not aware. It was when I noticed and I ran a test to confirm. FTM mother IDI*

FTM mothers were recruited and interviewed specifically because they are supporting their unmarried daughter and infant grandchild. Therefore, it is perhaps unsurprising that many mothers of unmarried FTMs (still living at home) expressed dissatisfaction in the attitude of the baby's father towards their daughter and overall support for the child. They complained of his failure to provide basic needs for the baby, and in fact, tried to persuade their daughters to abort the pregnancy. Many believed if the father of the baby had been more responsive, their difficulties would have been minimal.

*He asked my daughter to abort the baby and she didn't. So because of that he did not send money to support taking care of the child. He does not provide financial support; he does not spend time with the baby. He does not call, even after delivery at the hospital he did not come to the hospital. I paid #10,000. FTM mother IDI*

*He doesn't come at all, it's only when the child was three months old that he brought custard for me, but since then he hasn't come. If he does come, he will play with the child or carry the child. Like I told you I am the person looking after the child which also includes his expenses. FTM mother IDI*

*I am not happy with the way the father of this child is treating everybody. I am not happy with the way he is treating my daughter, because even when I was...pregnant, I received a lot of care from my husband and my pregnancy expenses weren't [the responsibility of] my mother, like what is happening to my daughter now. He impregnated my daughter in school. It was so painful. I wanted to do bad to him because of my anger, but people said I shouldn't do it. I do advise him but he doesn't take my advice, he does anything he likes. FTM mother IDI*

Domestic violence can affect a mother's mental and physical health, often causing symptoms of depression. Mothers of unmarried FTMs reported that domestic violence is a concern in their communities, noting that this was an issue especially among men who smoke tobacco and drink alcohol. However, respondents believed that domestic violence occurrences are on the decline due to changes in social norms, increased awareness, and enforcement of laws. They reported that churches and community elders have also been helpful in resolving domestic conflicts.

*Some men - after drinking and smoking - they come back and beat their wives. I have seen many families like that. FTM mother IDI*

*It affects the mother's mind. They keep thinking too much and it can affect the mother's mind. FTM mother IDI*

*I call my church members to help settle the quarrel. If I call the community, they will ask for [palm] wine but the church will settle it for free. FTM mother IDI*

### **Service providers:**

Service providers across the three facility study sites mentioned that it is common in their practice to attend to pregnant adolescent clients, even very young adolescents.

*In this community, since they don't marry, you see them start having children from 18 years. I have conducted delivery on a 13-year old. Service Provider IDI*

Facility-based service providers also perceived that peer pressure among adolescents and young women may contribute to adolescent pregnancy and child-bearing.

*Let me set this scenario where I live. There is a lady, a 16-year-old, who, without getting married, put to the bed [gave birth to a baby]. Her friend saw that she put to bed and said she wanted to have a baby, too. After a short time, we saw her pregnant and nursing a baby too. It's as if they are into competition. Service Provider IDI*

When asked about polygamy, most service providers responded that it was common for young women to be a second or third wife.

*Polygamy is very, very common in this area, with adolescents being second or third wife. Service Provider IDI*

Service providers (as well as other respondents) often described polygamy as young men having multiple sexual partners and the consequences of those multiple relationships (rather than in the traditional sense of formalized marriage to two or more wives in succession over a number of years). For example, several service providers recalled stories of young men having multiple partners and supporting two pregnant partners at the same time.

*It [polygamy] is common even when married. A young man got involved with two girls and then one stayed with the young man and the other stayed with the parent. Service Provider IDI*

There were some concerns related to domestic violence among the three study sites, although service providers admitted that these issues were usually handled at home as a familial issue. Service providers reported intervening in a few instances. However, all agreed that there were no resources offering counseling or social protection to the abused partner at community level.

*A man threatened to send the wife packing because she came for FP and we intervened. The man even threatened to come here with a machete, so I quickly intervened and called the two of them [to talk], he now told me that the wife did not inform him that she is coming for FP. Health Provider IDI*

*If we have anyone like that we go close to them and counsel and there will be peace. Health Provider IDI*

### **CHVs/community leaders/CBO staff:**

Community Health Volunteers (CHVs), Ward Development Committee members (WDCs; community leaders), and CBO staff generally believe that an ideal wife is submissive to the husband, while as a mother, she combines that with care for her children and management and provision of her home. Few distinguished the role of wife from mother. In most cases, respondents had the same or a combined description of an ideal wife and mother, expressing support for traditional gender norms.

*An ideal wife is well behaved, doesn't complain too much, makes sure she knows what is missing in a family and when it needs a replacement. She should be able to take care of the home when the husband is not around, take care of the children, take care of visitors. In short, [she] should be able to manage the home. CHV FGD*

*An ideal mother is a mother a woman who is caring, has a baby, and takes care of the baby... breastfeeds the baby, and takes care of the husband too...and the household. CHV FGD*

*She has to show good example to her children, also care for them, make provision necessary for the children's upkeep. [She] should also play a role of a mother, on how she cares for the children because, most times mothers are closer to their children than fathers, so they are the one to care for the children, give them petting words [affection, praise, encouragement] and plan something good for them in the future. Community Leader/WDC member IDI*

CHVs, members of the WDCs, and CBO staff believe that early marriage among adolescents is a common, but less than ideal, occurrence. Early marriages (before 20 years) and teenage pregnancies (both within and outside of marriage) thus appear to be somewhat of a norm in these settings, albeit a negative one as perceived by older adults. In explaining the reasons adolescent girls in their community become pregnant, most blamed either the parents or the adolescents themselves (or both), lamenting the lack of responsibility among both parents and youth as the cause of adolescent pregnancy. To a certain extent, most community volunteers (CHVs, WDC members, and CBO staff) blamed youth for being irresponsible, immature, or “disobedient”:

*It is because most women have children at their early age, they get pregnant, they are not married, and some women have children from different man, and may not be married again but have children already. CHV FGD*

*[Adolescent pregnancy] is very common. Like I earlier said, most children don't even listen to their parents. Even when their parents try to put them right, they don't listen. They go outside and get pregnant at that early age before someone will come to marry them. Community Leader/WDC member IDI*

*She is a problem to the society, because the pregnancy comes accidentally, and the condition pushes them into psychological unbalance. They become a laughing stock to friends. They aren't mature enough to deliver a baby safely. The situation would not be their problem alone, but also affect others. CBO staff IDI*

*[Adolescent pregnancy and marriage] is a problem because the adolescent is not matured age-wise and mentally to be able to live with a man. Sometimes they misbehave and have been returned back to their parents. CBO staff IDI*

Community volunteers and leaders also believe that parents abdicate their responsibilities by neglecting their adolescent children and failing to supervise and guide them properly, by allowing them to attend parties or even have boyfriends or girlfriends.

*In some homes, parents are unable to take care of their children very well or handle them very well. They allow them to go out for parties, burials and so many other places. With that, children get pregnant because you don't know where they are going, and the kind of behavior they are exhibiting. You don't guide them. Community Leader/WDC member IDI*

Some also mentioned other reasons for early pregnancy, such as the lack of access to school and vocational training, household poverty, and peer pressure (girls wishing to become pregnant like their friends).

*A lot of issues are responsible [for adolescent pregnancy] like peer influence...some friends think because their friends are pregnant they too must be pregnant. Poverty is also having a lot of influence because her parent could not provide all her needs, so whoever offers the needs becomes her 'predator' [taking advantage of her]. Also, some families do not see teenage pregnancy as being wrong. CBO staff IDI*

Consequently, while families do not typically live in multigenerational households (with their parents or parents-in-law) in Ikom or Obubra, many adolescent mothers, for financial reasons, have no other choice but to reside with their own parents or other family members, and depend on them for their sustenance. Respondents generally reported that it is not typical for adult children to continue living with their parents, but in the absence of needed support, it is a common practice for adolescents to do so, usually while engaging in informal employment, like farming and petty trading, to assist their households and meet some of their own financial needs. Respondents described how this arrangement may become economically and socially burdensome or disruptive for both the FTM and her parent(s).

*The boy's parent supports and provides for them while she lives with them and assists them in farming, Pathfinder IDI*

*They live at the mercy of people in their environment. Some of them are malnourished except for those from a capable home. CBO staff IDI*

*They live with their parents most times. Sometimes they try to live on their own, [but] they don't find it easy. Even living with their parents, they don't find it easy, as they fight with their parent and they are not ready to follow their parents [guidance, wishes, or instruction] because they are already grown-ups. CHV FGD*

According to CHVs, CBO staff, and WDC members, domestic violence is a concern in these settings, particularly due to abuse from husbands and some parents. In such instances, many felt that domestic violence can be reduced through a woman's submission or change in her behavior, clearly holding the adolescent girl responsible for her abuse. Both WDC members and CHVs noted they have been involved in settling domestic disputes in the community. CBO staff also mentioned that domestic violence is common in these communities, although solutions are limited to advice and counselling, similarly focused on a woman's behavior to prevent domestic violence.

*We are concerned about it, you see we can hardly check people's temperament, people are violent and unforgiving, and the people want to show their strength, which does not help anybody. CHV FGD*

*It arises between husband and wife having a fight or quarrel, oftentimes when it happens before now, the community fines the couple or ask them to leave the community, but it is rare nowadays for fear of leaving the community. CHV FGD*

*I'm saying this from experience; one man who was living in our house was quarrelling with his wife. I came out of my room to go and separate them and the man told me that anytime they are quarrelling in their room - even fighting - I should not come out. But I can't stay quiet as a community leader. Community Leader/WDC member IDI*

*It is very prevalent in our community. That is why we are working hard to sensitize the men on behavioral change. The women sometimes complain to us on how they are raped and maltreated by the men. I advise them to dress modestly to avoid sexual harassment from men. CBO IDI*

*There are things that happen at homes that are not normal. For example; crisis and problems that happen within homes. Sometimes, while we are trying to talk to the partners in the community, we notice some reactions which let us know that they aren't in good terms with another. So when we probe, they do reveal some of their problems to us. We counsel both partners. In fact, we don't ask to know deeply about their misunderstanding because that will make them feel that we have known everything about them. We tell them what is right without blaming any of the parties. CBO IDI*

### **4.1.3 Residential arrangements**

#### **FTMs:**

As mentioned previously, pregnancies were often unplanned and unexpected among FTMs, and thus many FTMs stay with their parents or other extended families to receive support. Alternatively, parents sometimes instruct FTMs to leave the family home and move in with their partner or partner's family. In addition, many women who have just delivered may stay on an extended basis (often several months) with their own mothers during the immediate postpartum period to receive support in caring for their newborns.

*I live with the mother to the boy who impregnated me. I just decided to come and stay with her. Unmarried FTM IDI*

*My child's father was asking that I move from my sister's place and live with him, but my parents refused and said if he insists, I should hand over his baby to him until he comes and marries me fully before I can move in and stay with him. Unmarried FTM IDI*

FTMs noted fluid and complex living arrangements, in terms of shared housing or temporary living situations due to financial difficulties or need for extra support, especially during the postpartum period. Thus, place of residence among FTMs appears to be shared between their parents and spouses. Most unmarried FTMs were residing with their parents or in-laws.

*For married young mothers, what is their typical residential arrangement?*

*R1- Like me, I was staying with my mother.*

*R2- It is not all that are in their husband's house, some are in their parent's house.*

*R3- The fact that I have given birth for him does not mean he is my husband, until he pays my bride price, that is when I will live with him and call him my husband.*

*R5- For me, if the man has not paid my bride price, I can [still] live with him.*

R4- I live with my parents and he lives with his parents.

R5- Many of them stay in their parent's house...only few live with their husband

R6- People that live with their husband are more than those living with parents. But [living with a husband's parents] is common because when the man can't afford your bill, he asks you to stay with his parent.

R1- ...if the parent of the man is not around, [she can stay with] any other person that is related to the man. (Married FTM FGD)

### **Male partners:**

As noted previously, male partners participating in the study were living together with their partners or wives (with some level of experience caring for a newborn and living with a postpartum wife). In Ikom and Obubra, many male partners reported that it is not common for couples to live with parents or extended family, except for financial reasons or relocation during the postpartum period (when a new mother or her mother/mother-in-law relocates to receive/provide help and support caring for herself and her newborn). As previously mentioned, this is common for adolescent FTMs and their male partners who may not be financially independent, and still rely on parents or extended family for support.

*I don't live here, I live far from here, since my wife just gave birth, she was discharged to my mother's house. Male Partner IDI*

### **Service providers/CHVs/community leaders/CBO staff:**

Facility-based providers, CHVs, community leaders (WDC members), and CBO staff agreed that it is very common for young or adolescent mothers to live with their own mothers or in-laws, as most men are either unemployed or living on a very low budget, and the young women cannot support themselves. They reported that unmarried adolescents tend to live with their parents, while in most instances, married adolescents live with their in-laws or partners (if he has income to support her).

*They start by dating boyfriends and eventually become pregnant and their parents will ask them to move and live with the person who impregnated them. Sometimes the boy is not a mature male...so the pregnant adolescent will end up living with the boyfriend's parent. CBO staff IDI*

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*A typical adolescent woman as I may know in this locality: they still don't have a home of themselves, they live with their parents, some live with a single parent. As I said earlier, it is not really marriage, they only cohabit. Marriage has to do with performing all the necessary rites at their home, but this one they have not done anything and they stay with a young man that will make them a mother. Some stay with their boyfriends and still visit their parents while some live with their parents and visit the boyfriends. They still go back to their parent to get meals and some rely on their parents for their care. Sometimes it is the parents that still pay their facility bill even while staying with the boyfriend. To me, it is not comfortable because the husband is supposed to carry [out] their responsibilities. Both of them should work hand in hand to bring up their home, but in this case, the parents are still involved in their marriage, so I don't consider it as normal. Service Provider IDI*

*You see somebody having three children and those three children all having their own babies and staying in the same room with their mother. If you are married you should go and stay with your husband. Service Provider IDI*

*They live with their parents most times. Sometimes they try to live on their own, they don't find it easy, even living with their parents they don't find it easy, as they fight with their parent and they are not ready to follow their parents because they are already grown-ups. CHV FGD*

#### **4.1.4 Maternal support, nutrition, rest, and well-being**

We enquired about maternal support, nutrition, rest and well-being among FTMs to learn more about their postpartum and newborn care practices and influence of family members during this critical time. The mother or older female relative to the postpartum woman traditionally offers postpartum care. For the first few weeks or months after delivery, support offered by these female relatives includes instruction in baby care and breastfeeding, nutritional support, and rest and emotional support. Considering factors such as physical and emotional health and needs of a new mother are important to designing an effective program for FTMs.

#### **FTMs:**

Both married and unmarried FTMs expressed some mild health challenges, mostly headaches, back and body aches, some fever, and general weakness. Most, however, reported that they were feeling fine and had no health concerns.

*I have been feeling headache sometimes...feverish and pains on my waist region. Married FTM IDI*

*I am feeling headache...sometimes my ribs chest pains me and cold. Married FTM IDI*

*I have no strength. As the baby feeds on me, the weaker I become. Married FTM IDI*

Most FTMs, both married and unmarried, received considerable assistance from their mothers or mothers-in-law with baby care (depending on with whom they lived). Some also received support from other female relatives living with them or nearby. Nearly all FTMs (either married or unmarried) mentioned that they had help from a female relative to care for the baby. Only one or two FTMs mentioned that they had no help from relatives and were struggling as a result.

*They [my family] helped me, when I gave birth. My mother came and stayed with me and helped me with my farm work before I became strong. Married FTM IDI*

*As a first-time mother, it was not easy at all and having the child in the first place and how to bathe the child, then how I will take care of the child because they are delicate...seeking advice from elderly ones on how to take better care of the baby. At least, I went through it for 2 weeks from my sister-in-law. She taught me how to bathe the child, if the child is having catarrh [excessive mucus], what to do and what to give the child. If the child is having cold, and how to take care of the child and handle the child. Married FTM IDI*

*[My family] cares for the baby when am busy...I get support from my mother...she assists me in all aspects that are concerned with caring for the baby. Unmarried FTM IDI*

*Yes, I'm dissatisfied. I think I work too much...I feed the baby, cook, and many other things, so I don't have rest. Married FTM IDI*

However, most married FTMs reported that their husbands offer only limited assistance with daily child care, even when the husbands are not at work. Some did report that their husband or partner helped with chores or spent time with the baby.

*He just holds the child and checks how he is doing. Married FTM IDI*

*Yes, yesterday when I was busy the father cooked and gave him food. Married FTM IDI*

*My husband helps me with everything. If I want him to help me hold the child, he will. Married FTM IDI*

*He spends time [with the baby] as he is supposed to do. He will stay with the child for some hours. Right now, I don't have anybody apart from him, so he will help me do anything I need before he goes out. Married FTM IDI*

Others reported that while they would appreciate the help at times, it is not a social norm for a husband to help with household chores. Men who provide such assistance in the house would be considered “bewitched” or “charmed” in some families.

*Are there any social taboos or expectations which prevent a husband from taking care of their children? What will their family or close friends think if he helps care for a child?*

*R1- Some of his friends will call him a fool.*

*R2- Men are not supposed to fetch firewood.*

*R4- Some feel it is juju [magic].*

*R5- Some say he has been charmed. Married FTM FGD*

Most married and unmarried FTMs noted the importance of resting, as this helped them to gradually regain fitness after delivery and obviously improved their health over time. FTMs reported getting enough rest and employing various strategies to do so (e.g., sleep while the baby sleeps).

*Yes, it helps improve good health. Married FTM IDI*

*It is important because whenever you rest you bath and sleep, wakeup and eat. I am ok because any thing I want is available. Married FTM IDI*

*I rest very well at night because my baby sleeps very well and does not disturb or cry. Unmarried FTM IDI.*

*I do rest whenever I have nothing to do. Married FTM IDI*

*When, I just newly put to bed, I rested well, in fact since I was 4 months pregnant. Presently I rest anytime I wish to rest. Married FTM IDI*

There appears to be some dietary perceptions related to maternal nutrition and breast milk production, as most married FTMs reported they were advised to be on heavy meals and to drink liquids, including soup, hot water, tea, and fresh (not yet alcoholic) palm wine regularly. Mothers were also advised by their families that breast milk production can be increased by eating specific foods (rice, beans, peanuts). They had limited information or guidance on maternal nutrition from healthcare workers. Some received only very generic advice.

*I should eat better food like yam, fufu, garri, beans and rice. Married FTM IDI*

*They said we should eat heavy food like akpu. Married FTM IDI*

*We should drink palm wine to increase the quantity of breast milk. Married FTM IDI*

*Yes, I was advised to drink palm wine. Married FTM IDI*

*No one had ever advised me on my diet. I was only advised to eat properly. Unmarried FTM IDI*

Most FTMs mentioned that they avoided sugary foods, sodas, and some even fruits, believing that maternal consumption of sugary food will cause gastrointestinal distress (*jeri jeri*) to the baby.

*While I was on exclusive [breastfeeding] they [health care providers] said we should not drink coke because it causes jeri jeri. Married FTM IDI*

FTMs were also asked briefly about symptoms of postpartum depression (loss of appetite, feelings of worthlessness, intense sadness, or distress). Six out of the 36 FTMs interviewed agreed that they felt some of these symptoms, although it is not clear to what extent they felt this way. They attributed these feelings to the initial unexpectedness of their pregnancy, combined with their difficult financial situation, social isolation, or abandonment/disinterest on the part of the baby's father.

*Yes, I feel sad whenever I remember I cannot afford the needs of my daughter. I regret having a baby now. Even now I feel sad. Married FTM IDI*

*It happened [these feelings] to my cousin sister after she gave birth. Anytime she sees her baby, she will be angry...until she heard a message on the radio...that was when she started liking her baby. Married FTM FGD*

Overall, when asked what additional support FTMs needed from their partner or the baby's father, they wished for more financial support, more help looking after the baby (e.g., carrying the baby while they do chores) and with labor-intensive activities of farm work.

*I will like him to do some more, because sometimes he will complain that he is tired, and that I should come and take the child from him. I will like him to handle the child some more and give him the things he needs. Married FTM IDI*

*He should assist me at the farm and looking after the baby. Married FTM IDI*

### **Male partners:**

Nearly all male partners of FTMs reported that their wives or partners were currently in good health, and suffered only minor health problems, such as a cough, back aches, and rashes.

*They [the mother and the baby] are okay, they do attend hospitals. In terms of their health, they are okay. Well, she used to tell me that sometimes she has pain in her back. Male Partner IDI*

As with FTMs, most male partners reported that the FTM does most of the baby care, with the help of his or her female relatives. A few men mentioned that they regularly assist in child care and household chores.

*When it is duties like washing and cooking, I do all these activities. But the feeding and changing of nappies, the mother does all of that. Male Partner IDI*

*The time the mother of the child wasn't strong, when she was not healthy [enough] to do all those things, then your mother, your grandmother, your elder sister, or your brother's wife will take care of those things. Male Partner IDI*

*My wife does virtually all the activities, I only assist her when the baby cries. Male Partner IDI*

Most partners agreed that good nutrition and rest is important for women during pregnancy and after child birth. Many male partners noted that their wives/partners had enough time to rest during the day and at night, and that they also try to guide their wives/partners (within their resources) about what they should eat to ensure that they are in a good state of health.

*Sometimes, I tell her to avoid sweet things like Fanta [orange soda], sometimes she wants to drink Star [beer], which add in tormenting the baby, so I told her to avoid these sweet [drinks] and alcohol to help the baby in breastfeeding. Male Partner ID1*

*Yes, it [rest] is good, so she gains her strength back. She rests in the night and in the day. She rests at intervals of 2-3 hours after working, and she has enough rest when she is not working. Male Partner ID1*

*[My role in ensuring my wife eats well is] to give her money to buy fruits, vegetables, and all she likes to eat. I force her to eat well. But everything is money, when I have [it], I buy all of these things. Male Partner ID1*

Nearly all fathers agreed that some women in their community may experience feelings of sadness and distress after birth, suggesting that postpartum depression may occur among some women in these communities. Most mentioned that having these feelings might be a result of having an unwanted pregnancy that interrupted her schooling, and/or is not accepted by the father of the child.

*Yes, it is common. Like an unwanted pregnancy, if the father runs, then some [mothers] wish the child were dead and she is not happy. Male Partner ID1*

*Like all these women that carry an unwanted pregnancy. They are not always happy with the baby. And when they see their mates achieving things, they feel angry with their baby for hindering them of such achievement. They are not always happy with the baby, and it is in this community too. Male Partner ID1*

*Yes, I have seen such, where the mother maltreats the child and I jokingly ask her, 'if you don't like the child, then why did you give birth to her?' And she shares her predicament, that she didn't plan to give birth to a child now, but since she took in [got pregnant] she has no choice but to accept the baby, because she can't reject it. Some women got pregnant mistakenly. It is common in some parts of this community. Male Partner ID1*

### **Mothers to unmarried FTMs:**

Mothers of unmarried FTMs (who still live with their natal families) reported some of the health challenges their daughters faced post-delivery. These were mostly minor health issues, which resolved over time. Some major health issues required seeing a healthcare worker, but in many instances, mothers resorted to local herbs.

*We used some traditional leaves or herbs for treatment. Some other times like last week when she fell sick, we went to a (CHEMIST) pharmacy. FTM mother ID1*

FTM mothers were heavily involved in supporting their daughters, especially immediately postpartum. They serve multiple roles, including teaching the new mother skills in caring for the baby, performing tasks to care for her daughter, and continuing with her income-generation activities (farming, business, etc.)

*Very early in the morning, I will boil water and give the mother to go and take her bath and treat herself. After that, I will go to the kitchen and cook food, something that I know that she will be able to eat when she comes back from the maternity, like tea or any other thing. I will come back and warm water then I will bathe my child, or I will tell the mother 'I hope you've seen how I am bathing the child, since you have not given birth before, come and feel the type of*

water I am bathing the child with'. She will come and feel it. I will tell her that you have the type of water we use to bath newly born baby. She will say yes. I will tell her that whenever I am not around, don't use water that is hotter than this because if you use water that is hotter than this, the child will fall sick. This occur because the child's skin is not yet strong. That is how I use to do...During our time, there was no pampers. I showed her that method and told her that you will take napkin towel and fold it in a neat way and put it on the child. Then, we use pins that will be able to hold him firmly on his waist, after which you will wear pant for him, apply powder on his body. When you want to bath him, you put small towel in the hot water and press his navel. The main problem of a child is his navel. You press the navel...continuously so that it will die inside and the wound will heal inside, you will tie it so that air will not pass through it. That is what I use to tell her. FTM mother IDI

FTM mothers held various beliefs on what foods should be given to a mother that just delivered. They believed that mothers should be given a mix of solids and liquids, which can help the mother recuperate quickly. Hot soup is believed to help in the healing process, while fresh (not yet alcoholic) palm wine was mentioned as helpful in increasing the flow of breast milk. Taking care of a mother and her child could be expensive, according to the mothers, but they have been able to manage from proceeds of their farm and petty trading.

*Like the very day she gave birth, we bought her small stout [250 ml bottle of stout beer]. In this town, when someone gives birth, you cook hot soup and drink. The reason we gave her small stout is to remove the remaining blood. We gave her hot soup and hot water so as to heal the wound inside her womb. We don't have another food in this town than pounded yam. The palm wine is given to increase the breast milk but she doesn't drink palm wine, so she was not given [it].* FTM mother IDI

All mothers agreed that rest is very important for new mothers to recuperate from pregnancy and delivery. They mentioned that they play an important role in ensuring that their daughter has enough rest and relaxation.

*Yes [her rest is important], so that she will gain back her health and everything...because her health is very important.* FTM mother IDI

*Yes, rest is good for new mothers because they don't have the strength to work, and they need rest to regain their lost strength. My daughter rests well and I know, because I am the one that tells her to rest.* FTM mother IDI

While mothers agree rest is good for the body, they, however, think their daughters are not getting much rest due to the lack of support from their male partners (or baby's father). They think their daughters worry too much about their relationships, future, and finances, with this affecting their overall well-being. However, on most occasions, mothers play an important role in helping their daughters to get through these difficulties.

*After they gave birth with nobody to support them financially, it makes some of them sad. It [post-partum sadness] is common in our community.* FTM mother IDI

*Yes, if you give birth and you don't have anyone to help you, you will suffer and be wondering who is going to feed you and take care of the baby, who will be there for you.* FTM mother IDI

*Yes, mothers pet their daughters to help them cope and resolve the feelings.* FTM mother IDI

#### 4.1.5 Healthcare decision-making

##### **FTMs:**

Both married and unmarried FTMs were asked about decisions to seek healthcare generally. A majority of FTMs (both married and unmarried) mentioned that they tend to make day-to-day childcare and feeding decisions (breastfeeding, etc.), with advice from their mothers, mothers-in-law, or the baby's father. However, decisions about healthcare (especially delivery and child healthcare) are often decided by cost and access. It is expected that a male partner or parent will accompany the FTM to a chemist, clinic, or hospital if in need of medical care. FTMs report that they do not make decisions about healthcare themselves independently. Most unmarried FTMs who live with their parents reported relying on their parents to make decisions about their own healthcare, while married FTMs reported relying on their male partners and partners' families for financial support (regardless of residential arrangement). Perceptions about male partners' approval of FP use varied (elaborated further in next section).

Most married FTMs reported being financially supported by their husbands, although there appears to be some degree of self and parental care. Most unmarried FTMs are catered to by their parents or in-laws. Conflicts in care and decision-making were reported between FTM mothers and male partners, particularly when the male partner was young and unemployed, with the FTM mother reporting that she made most of the decisions.

##### **Male partners:**

Most male partners reported that they usually made the decisions about healthcare, which seemed largely driven by their responsibility to pay and assist the woman in navigating her care or the baby's care.

*I make the decision most times because I will be the one to take them to the hospital with his mother. Male Partner ID1*

*It is my responsibility to see that my wife and my child are ok. Male Partner ID1*

##### **Mothers of unmarried FTMs:**

Most mothers affirmed making necessary decisions about the nutrition and health of their grandchild as both her daughter and the baby's father are, in her opinion, too young to make some vital decisions.

*I make all the decisions about feeding and the baby's medication because the father is still a young boy. FTM Mother ID1*

*I am an experienced grandmother. I also make decision on his health and what to use because of my past experience as a mother too. Like the new paracetamol, they call it CMP during our own time for headache, so I know about all these things and I make the decisions. FTM Mother ID1*

FTM mothers also noted they have been advising their daughters on child care and important health decisions, like FP. They also noted that as an ideal mother, they need to support their daughters through

her difficult moments.

*I advise here not to get pregnant, so she can continue with her studies. This farm work is no gain at all. FTM Mother IDI*

*An ideal mother cares for her child...I care for the baby and ensure he feeds well and if the child's temperature is high, I take her to the children's hospital for proper care. I make sure the mother and child eat well, bathe, and are in good health. FTM Mother IDI*

#### **4.1.6 Views about ANC**

Seeking ANC and delivery services are important behaviors in understanding women's acceptance of their pregnancies and learning more about their access to health services over the course of their lives. Neither ANC services nor labor and delivery services are completely free for all pregnant women in the public sector in Cross River State. ANC clients must pay transport, registration, laboratory fees, as well as any required drugs, while maternity clients must pay for a variety of costs related to surgical or vaginal delivery, even in the public sector. FTMs were asked whether they sought ANC during their pregnancy and in which month they made their first visit. In addition, FTMs were asked where they received care, what cadre of service provider attended to them, and how many visits they made. Overall, ANC visits were only made at facility level; no FTMs reported receiving ANC by an independent provider outside of a facility.

However, substantial variation in ANC attendance existed between unmarried and married FTMs. Unmarried FTMs reported attending ANC much later (in the sixth or seventh month of their pregnancy), and therefore made fewer visits (three to four) during pregnancy than married FTMs. Married FTMs, however, generally reported attending ANC between the third and fifth month of pregnancy, and typically made five to six visits over the course of their pregnancies. It should be noted that unmarried FTMs were younger than married FTMs in this assessment. In addition, a few FTMs mentioned financial challenges and access to care related to seeking ANC at a late stage of the pregnancy. Thus, unmarried FTMs perhaps were less empowered and received less financial support than FTMs living with a partner, so age differences and financial constraints may explain this variation. "Expectedness" of the pregnancy, however, was not a factor: unmarried women who reported expecting or planning their pregnancy typically attended ANC in the sixth month or later, and most of the married women who reported having had an unexpected pregnancy made their first ANC visit during the first or second trimester.

#### **Male partners:**

Male partners generally reported that to prepare for their wife's delivery, they saved during the pregnancy, registered their wives in ANC, and bought the needed baby items prior to delivery and after delivery. Male partners were not asked questions about whether their partners attended ANC, the month they started, where they attended services, or how many visits they made, as these details are not usually well recalled or known by male partners. However, most husbands reported during

interviews that they were somewhat anxious about their wife's pregnancy and thus ensured that their wife was registered to deliver in a health facility.

*I started by buying baby items before the arrival of the baby, so that the baby can have what [they need] to use and wear at birth, and also so that when the baby will arrive, I am not broke... Male Partner IDI*

*I was worried [about her delivery]. How she will deliver the baby, because she was not yet 20 years, when she got pregnant? Male Partner IDI*

*When I went to register her at the hospital when she was pregnant, the nurse advised me, saying any time she is ready to deliver, I should not let her labor for even 10 minutes [at home]. We should take her to hospital so that she and the baby will be safe, and I want them to be safe, that is why I then took them to hospital. Male Partner IDI*

### **Mothers to unmarried FTMs:**

Most FTM mothers (mothers to unmarried FTMs who lived at home) noted that their daughters attended ANC, and could generally report the month they started, where they attended services, and how many visits they made. Some explained that they took a more proactive position and registered their daughter for antenatal care; others mentioned that the baby's father or their daughter herself was responsible for ensuring adequate prenatal care.

*...when my daughter came home with pregnancy and wanted to abort it, I didn't support the idea, and I registered her for antenatal until she gave birth in the hospital, and I ensured that after giving birth, she doesn't go around with multiple men to avoid another pregnancy. FTM Mother IDI*

*R- Once it is time for her to go [for antenatal care], especially when they will be administered some medication, I make sure she attends, because it's her first pregnancy.*

*Q- Do you remember how many times you asked her to go for antenatal [care]?*

*R- No, but I ensure she goes. FTM Mother IDI*

*I don't know who they see [for prenatal care] because I didn't usually follow them to the hospital. She goes to the hospital with her husband. I didn't ask them. FTM Mother IDI*

As for timing of care, most FTM mothers reported that their daughter received care between the third and sixth month of pregnancy. A few mothers explained that they started late, as their daughter "hid" the pregnancy from them or kept their pregnancy status private for as long as possible.

*No. She was pregnant and hid it from me. I kept confronting her telling her she was pregnant, but she denied it. I told her to meet us at the health center, but she refused. On the day she was due, it started disturbing her, so we went to the hospital where she delivered. She hid that's why she did not go to clinic for antenatal. FTM Mother IDI*

*I didn't know how many months her pregnancy was because neither did she knew when she was pregnant...and I discovered it when the pregnancy has gone far. FTM Mother IDI*

A few mothers mentioned that while the pregnancy was known to them, there was a financial conflict, either related to who should pay for care, or availability of funds that led to a delay in beginning ANC.

*[She waited to get antenatal care until the fourth month of pregnancy because] there was still an argument with the man responsible for the pregnancy, which was the reason for the delay. FTM Mother IDI*

R- When she was pregnant I registered her at the children's clinic.

Q- In which month of pregnancy?

R- It was 6 months.

Q- Why did she wait to visit until 6 months?

R- There was no money. FTM Mother IDI

#### **4.1.7 Views about delivery and postpartum care**

##### **FTMs:**

Most married FTMs reported giving birth at a health facility, including local health centers; however, about half of unmarried FTMs delivered at home with nurses, traditional birth attendants, or their own. Nurses mostly managed facility-based deliveries, supported by doctors (occasionally), and with the typical length of hospital stay ranging from one to three days (most staying 24 hours or less). Reasons for delivering in a facility included the fact that they are safe, the baby is well taken care of, and the facilities are better equipped to manage emergencies. Both married and unmarried FTMs generally reported that, overall, they received good care at the health facilities.

*Because I know when I go to the hospital, I will deliver safely and be strong, and if any bad thing happens to me, they will take care of me, that was why I went there. Married FTM IDI*

*I stayed for 24 hours because something can sometimes happen to the babies. Married FTM IDI*

*It was really necessary to deliver in the hospital in case of emergency, because I believe that is where the baby can be taken care of. Married FTM IDI*

*They received us well, they told us how we will take care of our children, how we should keep our house clean so that the child can grow well. They conducted checkups for malaria. They treated us very well. Unmarried FTM IDI*

Healthcare costs and accessibility (lack of transport, services closed or on strike) determined the use of health facilities among all FTMs; almost no FTMs mentioned wanting or preferring to deliver at home. However, many FTMs, especially unmarried FTMs, delivered at home or with a traditional birth attendant

*[I delivered at home] because of the cost of delivery in the hospital. Married FTM IDI*

*I did not choose to deliver at home, the labour started suddenly and there was no motorcycle to take me to the hospital. Unmarried FTM IDI*

*I gave birth in a chemist, as at the time I was to give birth, the hospital was not open. Married FTM IDI*

*Because the labour started while I was in the farm. I then returned back home from the farm at around 7pm and I moved to the hospital, but I met nobody at the hospital, the workers had all closed from work and the place was locked. It was on a Saturday, so I went back home and delivered my baby. Married FTM IDI*

Unmarried FTMs generally reported not visiting the hospital after a home delivery, while most married FTMs reported they visited the hospital soon (within a few days) after a home delivery for further medical checks.

*Yes, I went to the hospital four days after my child delivery for check-up. Married FTM IDI*

*No, I did not take him to the hospital. I was asked to wait until my baby's navel (umbilical stump) was healed before I could take him to the hospital. Unmarried FTM IDI*

Most married FTMs reported that their husbands were expected and indeed provided the necessary financial support post-delivery, with food, the child's clothes, as well as paying necessary hospital or delivery fees. Parents and relatives of the baby's father supported unmarried FTMs.

*Yes, it was my sister-in-law who paid for the bills. Married FTM IDI*

*Yes, he paid after I delivered, and he invited a female drug-dealer/chemist. Married FTM IDI*

*Yes, he paid all the bills and bought all he was asked to buy. Married FTM IDI*

Attending the delivery was not an option as fathers were not allowed in the delivery wards. In addition, some women reported that their husbands were uncomfortable being nearby during delivery.

*You know men are afraid so he gave me money and my friend accompany me to the facility. He came after I have given birth. Married FTM IDI*

About one-quarter of unmarried FTMs and half of married FTMs reported that their partners or husbands supported them during and after delivery by cooking food, washing clothes, or fetching water and firewood.

*He assisted me to take my bath, washed my clothes for love sake and finally helped in placing my leg in good position since I had stitches in my stomach. Unmarried FTM IDI*

*Yes [he helped me in other ways]. He boiled water for me to take my bath, and for the child. He washed my clothes that time when my mum did not come. He cooked for me when I was in the hospital. He cleaned and arranged the house in case visitors come. Unmarried FTM IDI*

*The nurses asked him to go and buy something and he rushed and got it. We earlier forgot to bring a wrapper, so he went back home and got it. He prepared tea and brought it in a vacuum flask. Married FTM IDI*

It is possible that unmarried FTMs were less likely to deliver in a facility due to the poor treatment they might receive from nurses who would perhaps scold or abuse them for becoming pregnant before marriage while providing care to them. However, when married and unmarried FTMs were questioned about their own care and general treatment of pregnant and laboring FTMs by healthcare providers in local facilities, nearly all agreed that they had received very good care, and generally felt that all women were treated well in their facilities.

*Q- Are young mothers generally received well by staff in government hospitals when they come for antenatal care, delivery services, or for postnatal care?*

*R- Yes, they received us well. When we arrive, we will be asked to sit down after which they will attend to us.*

*Q- Are young single mothers like you given the same treatment as married women?*

R- Yes, we are given the same treatment. Unmarried FTM IDI

Only a few mentioned that nurses provide poor care to pregnant young women. Several mentioned that this treatment was understandable, as it was a result of mothers themselves being disrespectful to or noncompliant with the nurses.

*They receive mothers well, although there are some nurses who are very harsh and unfriendly to mothers. When we encounter such nurses, we tend to move on with the friendly ones...even after postnatal they treated us well.* Unmarried FTM IDI

*I don't know [if women are treated well at the facility]. Just that there are some women who always talk to the nurse anyhow [carelessly], but I don't know if it is because they are pregnant.* Unmarried FTM IDI

*Yes, when we go to the hospital, they treat our children well and take care of us too. But sometimes, some young mothers prove stubborn to the nurses and refuse to follow the nurse's advice. That's why sometimes the nurses become harsh.* Married FTM IDI

### **Male partners:**

Most male partners and husbands reported taking their wives to the hospital during pregnancy. Nearly half of male partners and husbands reported that their wives had delivered at home, although only two mentioned that the home delivery was planned:

*The reason is because, as a first-time parent, I allowed her to go and stay in her mother's house because, as a first-time parent to be, you have no experience and we need help in the delivery of the baby, and I don't know anything about it. That is why I said she should go and stay with her mother that has the experience.* Male Partner IDI

*She was at home and the labor was not complicated, so there was no need to taking her to the hospital.* Male Partner IDI

Some male partners and husbands reported they would have preferred hospital delivery, but due to certain limitations, including finances and access to a hospital, their wives delivered at home or in the church.

*That fateful day, I wasn't at home, I was with one of my friends. I was called that my wife has given birth, she was cooking, and she just gave birth. She was already in labor at home and she could not get to the health center because she couldn't walk to the clinic. It was the way God wanted it to be. God knew that I did not have money to get her to deliver at the hospital, so he made her deliver peacefully.* Male Partner IDI

Male partners whose wives had had an unexpected home delivery still tried to ensure that their wives received follow-up medical care.

*Yes, as she has given birth, I warmed water for her and I kept it at the bathroom for her. I brought someone to come inject her after delivery. A chemist friend came to inject her.* Male Partner IDI

*After she gave birth, the first month I made sure she got medical attention to ensure she is okay.* Male Partner IDI

After delivery, husbands reported they supported their wives, although ability to offer care depended on what they could afford and healthcare services available. Many complained of adverse events post-delivery that required emergency care, including fainting spells, anemia, malaria, and respiratory

infections, reflecting the nature of care received during pregnancy and delivery. Most of these conditions were handled in the hospital as they were completely beyond what could be handled at home.

*One day she fell down...that's when the doctor told me it's a lack of blood. Male Partner IDI*

*Recently she was ill, and I asked her to go for a check-up and it was discovered she had malaria, which was as a result of the stress. She was treated, and she is okay now. Male Partner IDI*

*She bled during the childbirth, she is now well because she had medical care. Male Partner IDI*

*When she delivered she was weak, she fainted, and I consulted the doctor immediately, and she was given drips and she is ok now. Male Partner IDI*

About half of the male partners interviewed mentioned that they provided help and support (other than financial) to their wives after the delivery of their baby.

*Actually, I helped her with Lucozade Boost for her to drink and be strong; I helped in massaging her with warm water and making tea for her to drink. Male Partner IDI*

*I helped in her in carrying the baby for her to have a bath and I also washed some of her materials that were soaked. Male Partner IDI*

*I didn't allow her to stress herself in the kitchen or any activity; I assisted her do the little chores. Male Partner IDI*

They also reported being supported by their parents and in-laws to care for their wives and babies.

*My family brings food items to the house. Financially they have been supporting. Male Partner IDI*

*My mum bought clothes and paid hospital bills. Male Partner IDI*

### **Mothers to unmarried FTMs:**

Most mothers reported that they assisted their daughter financially to deliver at a facility, despite the financial constraints. None of the respondents reported preferring that their daughters deliver their babies at home. Some delivered at home due to financial challenges or difficulties accessing a facility in time for the delivery.

*It was an emergency. She was bleeding and thought that she had had a miscarriage, so we rushed her to the health center and they said they won't assist her because she didn't register, that we should go to the General hospital. I dashed out to get a bike and come and take her, only to come back and she has already put to bed [delivered]. FTM Mother IDI*

*She gave birth at home because of the bill, so I helped with the delivery. FTM Mother IDI*

FTM mothers reported that deliveries at health centers were assisted by nurses. Mothers also reported that their daughters spent one to three days in the hospital and were treated well by the nurses.

*They treat them well, they check their body to know how their babies are lying in the womb. FTM Mother IDI*

*They received her with a warm reception before and after the birth of her baby, and she still got a good reception during the post-natal care. FTM Mother IDI*

In addition, most mothers reported that the baby's father had provided some support to the baby, either by paying hospital bills or offering baby care items, such as a baby bathing tub, lotion, and clothing.

*The father brought the baby bathing tub set, baby carrier, shawl... He does bring money for food for his son, and he does complain he doesn't have money yet because his farm has not yielded [cash crops].* FTM Mother IDI

However, FTM mothers played an important role in helping their daughters after delivery, providing for their basic needs and assisting their daughters with infant care. They were often the only source of support a young unmarried FTM living at home received. About one-third of mothers interviewed mentioned that they did not receive any support from the baby's father for their daughter.

*I went to the market to buy things for a nursing mother like tea, bread so she can take it early in the morning, so her body will get better.* FTM Mother IDI

*He asked my daughter (Confidence) to abort the baby and she didn't, so as a result of that, he doesn't have money to support in taking care of the child. He does not provide financial support; he does not spend time with the baby. He does not call, even after delivery at the hospital, he did not come to the hospital. I paid #10,000.* FTM Mother IDI

#### **4.1.8 Views about breastfeeding and infant feeding**

##### **FTMs:**

FTMs that received ANC through a health facility also learned about the importance of exclusive breastfeeding from attending health talks during ANC. Many FTMs reported that they initiated breastfeeding within one to two hours of delivery, guiding themselves or assisted by mothers or mothers-in-law. For those FTMs who delivered at a facility, both married and unmarried FTMs stated that they were assisted by a healthcare worker at the place of delivery.

*I didn't waste time. I don't think it took up to an hour before I gave breast milk to him.* Married FTM IDI

*After I delivered, I had a bath, it was about 30 minutes before I breastfed her.* Married FTM IDI

*It was the nurse that assisted me with breastfeeding my child after delivery.* Married FTM IDI

*It was my mother-in-law that helped with breastfeeding.* Married FTM IDI

*No one else [assisted me]. I put the breast in the baby's mouth.* Married FTM IDI

FTMs who delivered in a facility reported giving colostrum to their baby after being advised by nurses or other health workers to do so. FTMs specifically noted that nurses were very helpful immediately postpartum with initiating breastfeeding. However, some FTMs were advised to taste their own milk first or not to give their babies colostrum.

*[After delivery] it took up to two hours before my breast milk came out for her to suck. I gave [the colostrum] to my baby because it's very good.* Unmarried FTM IDI

*I asked the nurse, if it was safe to give the child [the colostrum], and the nurse said it has to be tasted [to determine] if it is okay before it can be given, and I tasted it, it was okay. They even taught me how to do it and I gave it to my child. I did not throw it away.* Married FTM IDI

No, I pressed it out, and some yellowish ones came after. Married FTM IDI

Most FTMs reported giving both breast milk and water to the baby after delivery. Some FTMs reported giving water and infant formulas to babies after delivery due to poor or delayed milk flow. Giving water was interpreted as a part of “exclusive” breastfeeding.

Breastmilk first and water after. Married FTM IDI

I gave water two hours after delivery. I stayed for two days before breast milk came out, hence I gave her water for two days before breast milk. Married FTM IDI

A few FTMs appeared to understand the concept of exclusive breastfeeding, as they noted that they intended to give their babies breastmilk only for six months.

For now, I don't give any other thing apart from breast milk, until he is 6 months before I will start giving him another food. Married FTM IDI

I am giving my baby exclusive breastfeeding because we were told in the hospital that it makes the child stronger and it prevents the baby from [getting] sicknesses. Married FTM IDI

All FTMs agreed that breastmilk helps a baby grow and develop and are aware that it would be a taboo in their community not to breastfeed. However, many felt they had to stop exclusive breastfeeding and begin complimentary feeding a few weeks after delivery because their babies were always crying, which they interpreted as being hungry. For many, exclusive breastfeeding was a challenge, as they believe this was not enough food to satisfy the baby's hunger.

It depends on the baby...not all babies accept exclusive, some babies cry until another food is given to them before they stop crying. Married FTM FGD

A baby needs more than breastmilk because breastmilk is not sufficient. [Feeding] only breastmilk makes the baby cry always because it is not sufficient for satisfaction. Married FTM IDI

I initially intended giving him breast milk exclusively for six months, but the baby always cried too much, then I introduced custard to him. Now, he does not cry like that anymore. Unmarried FTM IDI

Yes, the breast milk is not enough for the baby and she cries. After a week, I was advised to give NAN milk [infant formula] due to inadequate flow of breast milk. Married FTM IDI

I have message for mothers that are [exclusively] breastfeeding for six months. It is not good because your baby is not eating well. It is dirty, mothers that do exclusive breastfeeding. Clean mothers give their babies other food like water in a clean cup or feeding bottle and other nutritious foods. Married FTM IDI

A few FTMs who exclusively breastfed complained that when the baby gets used to breastmilk only, it becomes very difficult to introduce soft meals after six months. This and other beliefs generally appear to be a major barrier to practicing exclusive breastfeeding.

When I gave birth to him, I was giving him exclusive breastfeeding, that is 6 months breast milk, that is also called baby friendly. I tried all kinds of food after the 6 months, but he didn't eat any [food] except breast milk and water up till date. Married FTM IDI

Both married and unmarried FTMs reported that breastfeeding fosters emotional bonding between a mother and child. None reported major challenges with breastfeeding, aside from minor issues such as

delayed flow, regurgitation, and nipple biting, but they said these issues can be resolved with help from their own mothers, nurses, and other experienced helpers.

*I feel tickled and happy at the same time when breastfeeding. For the first few months when the baby sucks, it is always sweet. Unmarried FTM IDI*

*Anytime my baby is sucking the breast, she will be looking at my face, and that time she is looking at me she wouldn't allow anyone to carry her from me. She cries should anyone carry her. Married FTM IDI*

*She bites me with her gums. Married FTM IDI*

*No problem at all. The last month my child had cough and regurgitated after breastfeeding. I took her for treatment and the doctor prescribe drugs for her which I duly followed. Married FTM IDI*

### **Male partners:**

Most babies were breastfed after delivery, but not immediately in many cases, due to the mother's state of recovery and poor flow of breastmilk. Some said they particularly emphasized exclusive breastfeeding, as advised by medical providers or their own mothers or mothers-in-law.

*I gave that order that she should undergo exclusive breastfeeding. Male Partner IDI*

Most noted they had to introduce soft foods when they observed that breastmilk was no longer satisfying their babies. Fathers seemed to initiate feeding particularly in response to the infant crying, which some found nearly intolerable.

*Before I advised for the child to be fed pap [corn meal porridge], after she sucks breast milk she still cried because she wasn't satisfied. But [when] she was given pap, she doesn't cry after taking pap. Male Partner IDI*

*...if she wants your attention, she will begin to cry and you will feel that the child is crying, let me go and carry her. If it is hunger and if you give her breast milk, she will stop. If she continues to cry, you give her pap and she will keep quiet, and if the cry stops, you will know that she was hungry. Male Partner IDI*

### **Mothers to unmarried FTMs:**

FTM mothers generally reported that breastmilk is the first food given after delivery, assisted by nurses at the health facility (for those who delivered in a facility). After returning home, or for FTMs who delivered at home, mothers mentioned that they themselves assisted their daughters with learning how to breastfeed. Some mothers mentioned that either glucose or boiled water was the child's first feed.

*Glucose was the first meal the children [twins] had, they refused breast milk afterwards and were fed with NAN [baby formula]. FTM Mother IDI*

*When she newly delivered, first I let her rest. Later that evening, I boiled water, put it in the flask, then later gave it to the baby. FTM Mother IDI*

*The first time, I boiled hot water and gave the baby before the first breast milk. FTM Mother IDI*

Most mothers reported that their daughters gave colostrum to their babies, although some had the misconception that this milk is too "bitter" to be given to babies or is not good for the baby.

*When she gave birth, her breast milk didn't come out early so we got her palm wine so that the breast milk can come out. The breast milk came out later but was bitter, so she threw some of it away and started giving the baby the whitish milk that it was sweet. So she threw it [the colostrum] away. FTM Mother IDI*

*I press it [the colostrum] and threw it away. I was scared because it may affect the child. FTM Mother IDI*

*After she gave birth, for the first breast milk, I boiled water and gave the mother. She pressed out the first breast milk and washed the breast well before she started breastfeeding. FTM Mother IDI*

However, nearly all FTM mothers agree that breastmilk helps a baby's development and the baby to stay strong and healthy.

*The breastmilk helps the baby to be alright. Yes, it helps the child to develop. What God made is much better than what we buy in stores. FTM Mother IDI*

*The breastmilk helps the baby to be alright. Yes, it helps the child to develop. What God made is much better than what we buy in stores. FTM Mother IDI*

FTM mothers were asked why some women may choose not to breastfeed. Many mothers could not respond to this question, as they mentioned that all women are expected to breastfeed, and if they do not, they are intentionally hurting the child and breaking a taboo. However, some gave reasons, including: the mother is too sick to breastfeed (or has HIV); a mother may think it takes too much time; a mother does not know how to care for her child; or that a mother does not want her breasts to change shape or appearance (fall flat).

*Some of them feel that sitting down at a place to breastfeed will take their time, so they give the baby baby-foods, bathe them, and allow them to sleep so they can quickly go out. FTM Mother IDI*

*Except the mother is not well. If she is alright she will breastfeed her baby. In our place here, every mother breastfeeds; but in the city/town, there are women that don't breastfeed. FTM Mother IDI*

There are varying views on what soft foods should be given to the baby and at what age. Most mothers reported that infants should not start eating solid foods until after six months, and that exclusive breastfeeding is important. However, about half of the FTM mothers interviewed reported they either gave their grandchild water or started introducing other foods before six months, because the child cried and was not satisfied drinking breastmilk alone, or they had nothing else to feed the child while caring for the child when their daughter was out of the house.

*I give the baby custard, especial when the mother goes out to farm and leaves the child at home. FTM Mother IDI*

*Because like my baby, she always wants to [put] in her mouth anything we eat. Whatsoever we are eating, she will want to eat it too. So at four months we started introducing fufu with okra soup containing enough crayfish. FTM Mother IDI*

*When the baby was more than two months, we started feeding him with blended boiled egg because he was always crying too much. Then we later started feeding him with akamu [corn meal]. FTM Mother IDI*

#### 4.1.9 Parenting and child development

##### FTMs:

According to married FTMs (through FGDs), an ideal mother meets the basic needs of her child in terms of feeding, keeps the child bathed and clean, ensures that the baby receives all immunizations and needed health care, and “trains” (parenting through affirmation and correction) the child well, so that the child knows “right” and “wrong” behaviors. Some mothers mentioned that an ideal mother respects herself, and maintains composure and discretion when talking with neighbors (not gossiping or fighting), or offers to care for other children living in the compound.

*For me, you [must] start from birth to correct the child [and you must find the right balance between ignoring bad behavior or spoiling the child and being too strict] ...even as small as s/he is, you correct the child. Secondly, all of the baby items should be neat at all time, so the child won't fall sick all of the time; thirdly, take the child for immunization, [and don't wait until] you have money. Just be sure that at your own level [of household income], take care of the child with your own money. Don't look at the way others are living or compare yourself with others...provide for the child as God has given you at your level. Be sure you keep the child clean. Attend to the child. Don't give your child to others to take [babysit] with the excuse that he or she is a neighbor, always take the child [with you] wherever you are going. Married FTM FGD*

*...The [ideal] mother will provide whatsoever the child needs to eat, wash your child's clothes when they are dirty, change the nappies when wet, bath the child in the morning, afternoon or evening, give food and play with your child, play with other people in the yard and people will know that you are a good mother. Married FTM FGD*

*You can also take care of other people children. = When you are a [good] mother, you will take other people babies like yours and take care of them. Married FTM FGD*

Most respondents did not have any sex preference for their first baby. About one-third of FTMs wanted a baby girl, so that she could be trained at an older age to do household chores and care for her siblings. A smaller number of FTMs wanted a male child, which reflects the intrinsic sociocultural values in the society, husbands' preference for a son, or reincarnation of an important male ancestor.

*I had been praying to deliver a boy because my mother delivered only female children. Married FTM IDI*

*My husband informed me he has preference for a male child although he will appreciate any sex I delivered. Married FTM, used facility. Married FTM IDI*

*I was hoping to have a male, reason being that the grandfather died in January and the child was born in January. It's reincarnation. Unmarried FTM IDI*

Generally, many reported that their babies are well, but with occasional fever, colds, and gastrointestinal symptoms. Some FTMs (both married and unmarried) reported that they had a well-established system of communicating with the father to ensure that the baby's health and other needs are accommodated.

*At the moment my baby is weak, stooling and doesn't sleep at night. Unmarried FTM IDI*

*Yes, he was passing greenish feces and I have taken him to the hospital. I was told it was heat rashes, that I should buy anti-fungals, but the more I use the anti-fungal, the more the rashes. So, I was advised to give him native herbs and that is what I have been giving him. Married FTM IDI*

*She is doing fine she just has little fever, and cold. Married FTM IDI*

*My baby's health is fine apart from Jeri Jeri. Married FTM IDI*

*... So we do talk about our baby or sometimes he calls on phone if it is urgent. If it isn't urgent he keeps it until when he comes, and we talk about it. Sometimes when he comes home and I am not around he will not even remember asking after me but the first thing that he will ask after is the child. Unmarried FTM IDI*

Both married and unmarried FTMs reported they must plan daily activities alternating between child care and household chores. Most reported being assisted by their mothers, sisters, and in-laws. During basic care of the child, most FTMs reported that they take the lead in deciding how to provide daily care for the baby (washing, feeding, etc.), but are supported primarily by their mothers and other close female relatives.

*If am cooking or washing, I tie him on my back. If there are more jobs to do, I share it amongst the days in the week. Married FTM IDI*

*I wait for him to sleep, I do my chores quickly before he wakes up. I would have done 1 or 2 things. Unmarried FTM IDI*

*My mother in-law and sister in-law helps in cooking: I do the feeding with the help of my mother in-law and sister in-law: Some people are also involved in bathing as well as her father: changing nappies is me: washing the child's clothes is done by me: my sister in-law, brother in-law and I, attend to the child when she cries. Married FTM IDI*

*I do the cooking: feeding, bathing, changing nappies, washing the child's clothes and attend to the child when he cries. Unmarried FTM IDI*

*My grandmother assists me in taking care of the children. Married FTM IDI*

*Yes [I get help from my family members in taking care of the baby]; my sister-in-law and my sister. Married FTM IDI*

*My mother does the cooking. I do the feeding, bathing, and changing of nappies. My younger sister and mum does the washing of clothes and attend to the baby when she cries. Unmarried FTM IDI*

Most married and unmarried FTMs reported some sociocultural care-giving practices in their family, which include massaging the baby's body while bathing, shaping the head and buttocks, straightening and turning the hands and feet, among others, which they often learn from older relatives, including mothers, siblings and in-laws. They also mentioned a practice of throwing an infant up in the air to make him/her strong, brave, and to improve reflex responses.

*When you give birth, they will come and see and dance, they will press the child's head, press his tummy and massage the leg- that will make the baby very strong. Unmarried FTM IDI*

*We used to massage the baby's legs, hands and head, also they will deepen their finger into the baby's cheeks to bring out dimples whenever the baby smiles/laugh. Married FTM IDI*

*Like me, when I gave birth, my madam came and showed me how to bath a child. She taught me how to massage and turn the legs of the child. She said if I want to give the child food I should throw the child up and shake her. Married FTM IDI*

*Yes, we do throw babies up when giving them a bath...it makes the child to get familiar with the air, especially the height. Married FTM IDI*

*We play with the child in the morning by throwing him up and catching him, so he grows to be strong. Married FTM IDI*

Many FTMs reported that babies mostly communicate their needs when they cry (particularly when they are hungry), and they have been able to master communication about their specific needs over time. However, for married FTMs (used facility), they take extra care by checking at the hospital if crying become frequent.

*She will be struggling to come down from your body, so when she starts doing that I will know and I will let her understand that there is pampers on her body, but if she is not on pampers, then I will sit her down for her to urinate. If she is hungry she will cry. If she want to defecate, she will be making some funny sound and I will know. Unmarried FTM IDI*

*He cries when he needs breast, when he cries much I know he needs breast, then I will attend to him. Married FTM IDI*

*When he wants to stool he will start crying, he cries when he wants breast. When he cries too much I know that he is not feeling fine and I will take him to the hospital. Married FTM IDI*

Occasionally, FTMs get angry with their babies when they cry too much, refuse to eat, bite while breastfeeding, dirty themselves, or spoil valued items accidentally (e.g., pouring out cooking oil, breaking the cord on a fan, etc.). However, most responded that they did not act out on their anger, since the infant is too small and should not be corrected. While some reported receiving and following advice from their mothers or other relatives to be patient with the infant, others could or did not wish to contain their anger, and resorted to verbal, or in some cases, physical punishment.

*When I'm angry with her, my mother told me not to get angry with her because she's a baby. Married FTM IDI*

*I get angry with her whenever she spoils [something] or disobeys me. [When I am angry], I get her beaten up. Unmarried FTM IDI*

*Yes, when she refuses to eat and I have to force her or beat her before she eats...that's what makes me angry. Married FTM FGD*

*There was a day she cried non-stop. With all I did to pet [soothe] her she refused [to stop], so I dropped her on the bed and said, 'if you like, continue crying'. Married FTM FGD*

Most FTMs said they often laugh, smile, play, and sing together with their babies, as they find this very fulfilling, and important for language development and social bonding between babies and their mothers. FTMs reported sometimes talking to their infant in their local dialect.

*Sometimes she laughs when one talks and plays with her, sometimes when she cries and I talk to her in my dialect she stops crying. Married FTM IDI*

*He is a comedian. I can just stand and he will be dancing for me. The way he grabs things from me amazes me, I will just laugh. Married FTM IDI*

*When she laughs, I will laugh with her, I speak our dialect to her, she makes sounds, and I respond. Married FTM IDI*

Many FTMs did not observe any challenges with their baby's growth and development, as they noted their babies passed through stages of development, starting with social smiles, neck control, sitting, crawling, and some reported their babies can now walk. Some FTMs noted their babies are learning fast as they can now make some social gestures including waving to people and copying what they do. This, as reported, has been pleasing to them.

*I am satisfied with the level of her learning. She can sit. Sometimes, I shift her toys for her to crawl well. Unmarried FTM IDI*

*She has learned how to welcome people by waving her hands, she has learned how to step down off my lap to pee or defecate. Married FTM IDI*

*She shouts hallelujah after me, and when I chase birds she does the same. Married FTM IDI*

### **Male partners:**

Male partners were asked to describe the characteristics of an ideal father. Men mostly talked about being breadwinners and providers of their families, but some gave definitions which were more holistic, including not only financial support for basic familial needs, but also emotional support, moral and religious guidance, and support for their children's education. Several mentioned that an ideal father taught his children his customs and traditions, as well as vernacular language.

*...the father takes care of the children when they are born, you will buy him medicine, give him treatment, and when a child is not well, he keeps embracing the child so that the child will be happy, and when the woman herself cries about food at home saying there is no food today, the father will go out to buy food - if he is a real father. But if [he] is not a real father, he will just go his way not having time, his own [role] is just to come and see the woman and go back. He does not even have time for the child. Male Partner IDI*

*An ideal husband is someone that is industrious, must perform traditional right, must take responsibility of his children, teach your children Ikom Language. Male Partner IDI*

*An ideal father is a father who has the zeal of parental care for the children, always thinking about his children and taking care of them. Male Partner IDI*

Most male partners preferred a male child, although some mentioned that they would not be concerned about the sex of the child. They also mentioned ancestral reincarnation as a strong motivation for preferences about the child's sex, indicating that some respondents had strong sociocultural reasons for their sex preference.

*Actually, I was hoping for a baby boy. I was praying over it and God gave me a baby boy. Male Partner IDI*

*I was hoping it would be a boy, because my father died I thought he would be the one to come back, but it is my grandmother that came back [he had a baby girl]. Male Partner IDI*

Many male partners believed the state of a child and their general health is reflective of the type of care the baby receives. Good meals and immunization are thought to be vital for a baby. Some have attributed the poor state of their children to the care they receive from their mothers.

#### **More male involvement:**

- Carrying older baby (over 3 months)
- Playing with baby
- Talking/singing to baby
- Cooking for baby/mother
- Washing clothes
- Making decisions about medical care

#### **Less male involvement:**

- Bathing
- Changing diapers
- Feeding
- Carrying newborn baby (under 3 months)
- Tending to a crying baby

*The child that undergoes a proper home training, e.g., good feeding, bathing, and normal correction to encourage a child's good health. Normally [an unhealthy child is a] child whose parents are financially not stable. They only provide food from hand to mouth without medical care. Male Partner IDI*

*Healthiness is based on the food the child eats...[you] give them food like Nunu [canned or powdered milk] and custards. Male Partner IDI*

*The cause is because of how the mother took care of them...not giving them better food. Male Partner IDI*

Men were asked about any cultural child care practices. They reported similar practices as FTMs, including infant massage and body shaping, throwing the baby in the air, and use of traditional herbs.

*We massage the baby's body and hands, the head and the nose. For nose, we use cold water and help shape the nose. Most of these practices are done as soon the baby is born. Male Partner IDI*

*My mother sometimes throws my baby up and massages him believing that such practices gives the baby strength. Male Partner IDI*

*There are some leaves they call OFARIWA, traditionally when the baby is sick you press out the liquid and rub it over the baby's body, and when the child can't defecate, you give the baby kernel oil within some time the baby will defecate. Male Partner IDI*

*Culturally a new baby kernel oil is used as cream for the baby and we rub white chalk all over the child's body. And we tie palm leaves at the door, so anyone passing by will know that there is a new baby in the house. And then people will come to support the family, some with yam, starch, garri etc. We [massage, and] turn his hand backward, bend and stretch the legs, massage the head and buttocks. Male Partner IDI*

Male partners said they spent varying amounts of time carrying and looking after the baby while their wives/partners did other household chores. Some, for example, did not wish to be bothered to hold their children, while others mentioned that they are proud to look after their infants. However, for most men, holding the baby would take place after the infant is a few months old. Most fathers expressed that they were unwilling to carry their newborns, but a few were willing do so only with extra support.

*Of course, an ideal man will assist his wife when he is home and not busy, so she can continue with house chores freely. Like for today the baby has been with me. Male Partner IDI*

*During his tender age, I didn't accept to carry my baby because I felt uncomfortable to do so. Male Partner IDI*

*In my own case, at first, I was scared because it was like the baby will fall from my hand because of the size and tender skin. Male Partner IDI*

Male partners reported communicating and playing with their babies, mostly through touches and smiles, which the child also responds to with similar gestures. They reported that their babies have mastered how to make gestures to seek their attention, which they now understand due to the time they have spent playing with their babies. All fathers, except for one, reported talking with their infant, either as play, or in teaching the baby their vernacular language, some mentioning the importance of doing so.

*She screams I get close to her and carry her. She will raise her two hands for someone to carry her. Male Partner IDI*

*She looks at me when I talk. She smiles and laughs. Male Partner IDI*

*Yes. I do talk to her so that she grows fast and healthy, and so that she can start schooling. Male Partner IDI*

*I do talk to him so that he can understand my dialect. Male Partner IDI*

Although they play with their babies, some male partners recalled times situations, albeit insignificant, when they were angry at them. While many of the men had little patience for a crying baby, none of the male respondents reported physically punishing the child. Most reported that in response to becoming angry, they either soothed the child, gave the child to the mother, or, in a few cases, shouted at or scolded the child.

*I shout at him probably when he cries for a long time or unnecessarily and he stop crying or I pet him. Male Partner IDI*

*Yes [I have been angry with my child], when I try to give him breastmilk and he is crying. I will be angry and say ah-ah...what is making you vexed [angry]? Male Partner IDI*

*I have been angry with my child because at times the fan in my room doesn't function well. Sometimes she will go there to draw the rope of the fan out [break the fan's cord] and I will be a little bit angry with her. As I just noticed that she has spoiled the fan, I blamed the mother and just went out and left them, that was what made me angry and...say, I won't buy the fan again, the child will buy it when she grows up. Male Partner IDI*

*She got me angry today. I kept palm oil and she poured it [out]. I quarreled [scolded] her and then she began to cry, and I picked her up and told her to stop crying. Male Partner IDI*

As reported, fathers encounter several challenges, notably financial, in the care of their children. Many reported their worries about securing their children's future, and at the same time, expressed confidence in their ability to build a home together with their wives. They reported uncertainty about the future due to their young age and financial instability, as well as their hopes and aspirations for their children.

*Some of the challenges is when there is no work and her food is finished I find it difficult to get her food. Male Partner IDI*

*The confidence I have is with my wife. I believe with love and understanding we can build up our home. Male Partner IDI*

*Something was worrying me, I was thinking how I will start life, how the child will grow, how I will feed him, how we will be managing to eat food. You know sometime when you sit when you are hungry, you will remember what to do. When you are hungry, you will think how your wife and children will cope especially the baby that's the baby grows, how I will cope? Male Partner IDI*

*My aspiration is how to save good money, to secure a better future for him, I had a plan of saving #5000.00 every month for him, then let him know when he is grown up. Male Partner IDI*

### **Mothers of unmarried FTMs:**

FTM mothers were also asked about their perceptions of an ideal mother. While FTMs and young male partners said ideal mothers were ones who properly fed, bathed, and trained an infant or young child, mothers tended to focus on how to be an ideal mother to adolescent and young adult children. They mentioned providing financial support for children through farming or other income-generating activities, helping a child to navigate peer pressure and choices about friends, and being a good neighbor and member of the community.

*Mothers are to take care of children to pay their fees and build them morally. Also, teach them the norms and values of the society [in order to contribute to] the community. More so, make them live up to expectations. FTM Mother IDI*

*[A mother's] duty is to advise them, either male or female [children] on going out, not getting into trouble, and not following bad friends, because they will put you in trouble, and I won't have anything to say. I advise them because I have no one to back me up. And mind who you mingle with...No matter the number of children, I don't allow my children to fight or do bad things. FTM Mother IDI*

*An ideal mother is a mother that, when you get up in the morning, you tell your children how to take care of their family. 1. Instruct them on how to do their morning chores, tell them not to [engage in gossiping]. 2. Get up in the morning after morning chores and go to the farm and mind your own business 3. Don't take things belonging to other people. FTM Mother IDI*

Regarding sex preference, many reported that their grandchild's *father* preferred a male child, due to the sociocultural importance attached to a male child. However, most mothers mentioned that first-time mothers usually do not have any preference for sex of their first child, though many women would wish to have a girl as their first baby in order to help with chores over time. A few FTM mothers mentioned that sex preference of the mother who already has children depends on the sex of her older children, as having a balance of boys and girls is important.

*They [fathers] prefer a male child. They always want a male child. FTM Mother IDI*

*In this community, when a woman keeps giving birth to male children, she will start to complain that she needs a female child, likewise when a woman gives birth to a female child continuously, she will say that she needs a male child. FTM Mother IDI*

As mentioned previously, FTM mothers were deeply involved in supporting their daughters, serving multiple roles, including giving advice to the new mother on how to care for the baby, performing most of the childcare tasks, and continuing with her business and income-generation activities (farming, business, etc.).

*I farm so that when my grandchild grows, I send the child to school. FTM Mother IDI*

*If my child gives birth to a baby I don't need to abandon the child but take care of the child and take decisions. I treat my grandchild as my direct child. I care and provide for her. FTM Mother IDI*

*Yes, I advise her on how to carry the baby, breastfeed, and also teach the baby how to sit. FTM Mother IDI*

*Right from when she was pregnant, I guided her to make her understand that, when you give birth to a child, you have to take care of the child. You breastfeed her exclusively for six months. FTM Mother IDI*

They observed that child development has been progressing in a satisfactory way, with the child touching, giggling, crying, and making visual contacts. Communication between mother and child was observed to be positive. FTM mothers reported playing an important role in teaching their daughters how to be patient with an infant, even when the baby is crying inconsolably, biting during breastfeeding, or refusing to eat.

*This my small boy (8 months old) if he wants something, he comes and taps me and points [at] what he wants. If he is hungry he goes and brings a plate, letting me know he is hungry. FTM Mother IDI*

*There will be behavioral change, he will yield to advice [obey] even when he doesn't talk. Like when a child is born you will observe that there are changes and growth. You will start seeing from her mouth, the child is standing up and walking, she plays well and learns. FTM Mother IDI*

...Except when holding your child, he/she may defecate on you before you can be angry, ordinarily it's not ideal to be angry with your child because he doesn't know anything. FTM Mother IDI

FTM mothers were asked about their views on the child's father and the role he plays in parenting his infant. Mothers were recruited specifically because they are supporting their unmarried daughter and infant grandchild. Given that this arrangement is not the ideal social norm (to be an unmarried single mother still living at home with parents), it is perhaps unsurprising that mothers had mixed opinions regarding the child care and parenting role played by the child's father. Half of the respondents reported that they were unhappy with the father's level of involvement in the day-to-day care of the child. These FTM mothers decried the lack of support from the fathers, implying that they have to assume all duties including feeding, washing clothes, and attending to babies when they cry. The other half of respondents were very pleased with the time and attention that the baby's father gave to their grandchild.

*The child's father doesn't support in caring for the child at all.* FTM Mother IDI

*He doesn't provide enough caring [for the baby]; I want him to be involved more. He should come more often and play with the child and care for him.* FTM Mother IDI

*[He spends time with the child] almost every day because he has love for the child.* FTM Mother IDI

*He always spends quality time with his child any time he comes around.* FTM Mother IDI

#### **4.1.10 Views on birth spacing and FP**

##### **FTMs:**

Because birthspacing and FP are key components of the planned FTP intervention (and given that this study was designed as a pre-intervention assessment), it was deemed important to have a thorough understanding of birth spacing, attitudes about FP, and ever use of FP among FTMs, male partners, and other influencers. This study specifically recruited both currently married and unmarried FTMs for interviews who: (1) had ever used facility-based FP services; and (2) had never used FP services.

Nearly all FTMs (both married and unmarried) unequivocally reported that they preferred to wait three to five years before having a second child in order to return to school or to stabilize their uncertain or strained financial situation.

*I want to finish school and marry before I will get another child.* Unmarried FTM/never used FP/IDI

*I would love to wait for a very long time, so that I can complete my education.* Married FTM/never used FP/IDI

*I will like my son to reach five years before I get pregnant again.* Married FTM/used FP/IDI

Most married and unmarried FTMs interviewed could easily name several benefits of spacing, including improved health of the mother and child, and improved chances of being financially prepared for the next pregnancy. According to interviews with FTMs (regardless of marital status or experience using FP), the primary benefits of spacing specifically included:

- The mother can rest and become stronger so she can work and give more attention and care to the baby.

- The child will grow well and be healthy, strong, and smart.
- The first child will be old enough to help care for subsequent children and do household chores when the next baby is born.
- The husband/family will have time to recover financially and prepare for the next child.

*Yes. It helps improve the health of the mother and children. Married FTM/never used FP/IDI*

*Child spacing is good so that the baby will grow properly without sickness. If a woman gets pregnant too early it will affect the baby. The baby will stool [have diarrhea] and people will gossip about you. Married FTM/never used FP/IDI*

*So that my child will be grown before I give birth to another child [and can help a mother around the house after the next baby is born]. Married FTM/used FP/IDI*

*I do not want to get pregnant soon so that my baby will not be dull, but I want him to be sharp and healthy. Unmarried FTM/never used FP/IDI*

*The benefit for I and his father is that we will be able to make more money before the next child comes, and the first child will be in school. Married FTM/used FP/IDI*

Unmarried FTMs also specifically noted that birth spacing and FP prevents unwanted pregnancies and subsequent induced abortion.

*The benefit [of birth spacing] is that the mother will save her time, she will not be stressed and be pregnant all the time, and she will not be patronizing abortion [getting abortions]. And it helps to make the baby look good. Unmarried FTM/used FP/IDI*

*Because if one has given birth it won't be difficult for the next baby to come in. Because if you just gave birth to a child, you should be expecting that any mistake the thing will enter [it will be easy to get pregnant again]...So it's very good. Prevention is better than cure. Unmarried FTM/used FP/IDI*

During the FGDs, married FTMs were asked if husbands in their community generally approved of their wives using FP. Some reported that they believed some male partners would approve of FP, but some would not. Women gave various reasons why men may not be supportive of their wives using FP.

*Some [husbands] will support [their wives to use FP], some don't support, some women will hide and do it [FP] without the knowledge of the man. Married FTM FGD*

*R1. Some may think that the wife will go to another place.  
R2. Some men want to have many children. Married FTM FGD*

*My oga [husband] didn't allow me, he said [if] we do it [use contraception], he will not be able to give birth again. Married FTM FGD*

Among women who had never used a modern method of FP (obtained from a health facility), married FTMs were more likely to believe that FP is safe and beneficial for young postpartum mothers to space their children than unmarried FTMs. When asked about the suitability of different FP methods for young mothers, most believed that there are some FP methods better suited to specific women, but were generally unable or unwilling to make a recommendation about specific methods. Instead, they reported that women should consult a nurse or visit a facility to confirm.

*I don't know which one is good, whether it's the one on the hand [arm], or the one fixed in the private parts, or tablets. Unmarried FTM/never used FP/IDI*

*All the methods are good depending on the individual adaptation to such methods. Unmarried FTM/ used FP/IDI*

Only about half of FTMs who had never used a modern contraceptive method could name at least one modern contraceptive/ FP method. Most did not know how any of the methods are used. Some FTMs were not sure whether contraceptive/ FP was safe, and were concerned that use of FP might “spoil the womb.”

*No [I don't think using FP method is safe for new mothers], because it affects the womb. It is because ladies now can't abstain from sex, that is why. Unmarried FTM/never used FP/IDI*

*No [I have never used a method of family planning]. Some say it's not good and spoils a woman's womb, that is why some of us are afraid to use it. Unmarried FTM/never used FP/IDI*

*Yes, [using the IUD] can stop one from being pregnant again. It could damage one's womb; it could create a hole. Unmarried FTM/used FP/IDI*

Ever users of modern FP (who were also mostly current users), were also asked about their experiences obtaining and using contraceptive methods. FTMs using FP often explained that FP was introduced to them during ANC, and that they had accessed FP in the facility where they delivered.

*Yes, when we went for antenatal, they talked to us about family planning and the methods. Married FTM/used FP/IDI*

Pills, injections, implants were all reportedly available, and the use of condoms was explained in pictures. Married FTMs using FP mostly relied on condoms, which were often given to their husbands/male partners or to FTMs themselves for free upon discharge after delivery. Unmarried FTMs reported using either an implant or injectable obtained during a specific FP counseling visit to a facility. A few of the unmarried FTMs reported previous use of injectables before pregnancy, but were unhappy with the side effects (spotting), and reported discontinuation. Several unmarried FP users who were currently using a method mentioned that they would use FP until they got married or wished to become pregnant again.

*[I will stop using this family planning method] when I have finally settled down in my husband's house. Unmarried FTM/used FP/IDI*

*[I plan to use family planning] until I am ready to give birth. Unmarried FTM/used FP/IDI*

All FTMs who had ever used FP obtained from a facility reported being satisfied with wait time, provider treatment, counseling received, and the cost of service (condoms and injectables were free, but several women reported paying 1000-1500 Naira for an implant). Most FTMs who had ever used FP were satisfied with their methods, though a few implant/injectable users were unhappy about side effects associated with the implant or injectable (bleeding, pain during insertion).

*When my menstruation came I over-bled...so I stopped the family planning. Unmarried FTM/used FP/IDI*

*Sometimes the injection gives some people problems. Sometimes it makes you bleed before you experience your menstrual cycle. Unmarried FTM/used FP/IDI*

Additionally, some intrauterine device (IUD) users complained that their IUDs were uncomfortable. Aside from the inconvenience of having an object inserted into the vagina, they also noted that they experienced spotting and bleeding, due to an incompatibility with their blood types (some mentioned a belief that the choice of FP method must be compatible with one's blood type). They also believed that the IUD may affect breastmilk production, with the baby losing weight as a result.

*Inside the private part, they will put the rubber inside one's private part. Why would they insert something into somebody's private part? That is the one that is not good. Unmarried FTM/used FP/IDI*

*I do not know which family planning method suit with their system but I will advise them to go and test their blood in the hospital so that the nurses can tell them the method that is the best for them because the method I use may not work for them. Unmarried FTM/never used FP/IDI*

*The FP method called "Combination 3" is good, depending on your blood. Unmarried FTM/never used FP/IDI*

*It [the injectable or implant] will disturb you when it doesn't match with your blood. It makes someone bleed. If you are breastfeeding it will make the baby lose weight. Married FTM/FGD*

### **Male partners:**

Many male partners agreed that birth spacing has huge benefits. In fact, most believed that they needed to space their next pregnancies by about three to four years or more.

*As for me, giving birth after the baby is four years is okay for the baby to grow well, and also the father to get money to take care of the next baby. Male Partner IDI*

*Personally, I will say a period of three years. [This timing] is important because I believe that at three [years], my child will be strong enough. Male Partner IDI*

Taboos against sexual intercourse immediately after birth and the practice of abstinence from sexual intercourse until an infant is fully weaned from breastfeeding is a deeply-rooted practice in cultures of different communities in Nigeria and throughout West Africa.<sup>29</sup> After birth, traditionally a woman in a polygamous household was expected to stay away from her husband, with the aim of breastfeeding her child for as long as two to three years without intercourse to prevent pregnancy and improve the health of mother and child through birth spacing. The introduction of modern contraceptive methods and monogamous marital settings has led to changes in these sociocultural practices and traditional observance of extended postpartum abstinence. Several men in this study, however, referred to a modified form of this practice, and mentioned that they prefer "the local method" (extended postpartum abstinence combined with condoms) of spacing.

*[The "local method" of spacing is that] the man won't [have] sex [with] his partner for three years or will use a condom. Male Partner IDI*

*Q- Do you think first-time mothers who just have given birth need to do anything to space the next pregnancy?*

*R- Is not necessary you do anything, it's just self-control. If you want to sleep with your wife, you use protective materials [condom]. Male Partner IDI*

When asked about using modern contraception as a method for delaying the next pregnancy, male partners generally could not name a modern FP method and reported that women should consult a nurse or visit a facility to determine what method to use. A few men mentioned that it is only appropriate for women who have finished childbearing or for women in school so that they can "concentrate on their studies."

*FP is for those people who have given birth. It is better if you have children before you do it. Male Partner IDI  
In my community it [FP] is mostly done by those in school so that they will concentrate in their studies. Male Partner IDI*

Male partners had varying views on the safety of immediate postpartum FP for FTMs, suggesting it may be harmful to the mother's health. A few mentioned that use of FP might cause infertility or somehow "spoil the womb."

Q- *Do you think FTMs can [use FP] to space their births?*

R- *No.*

Q- *Why do you think so?*

R- *Because when they do that, sometimes it will block their system and seize everything in the woman.*

Q- *What do they do?*

R- *They take injection or drugs.*

Q- *Can you recommend injection and pills?*

R- *I will tell the person that...I don't like it because it causes dirt in a woman's womb; sometimes, the bad blood that would have come out will refuse to come and brings sickness. Male Partner IDI*

*It affects the womb and sometimes when one later needs babies, the woman will not be able to take-in [get pregnant] again, that means the womb may have been destroyed. Male Partner IDI*

As mentioned above, most male partners do **not** believe that FP is safe. Despite this apprehension about the safety of FP, most would approve of their wives/partners using FP if they wanted to do so.

*I approve, I was the person that took her to the hospital. Male Partner IDI*

*I have approved it already...by 1<sup>st</sup> week of next month, we will do family planning. Male Partner IDI*

### **Mothers of unmarried FTMs:**

Most FTM mothers reported that it is not very common for young mothers to become pregnant again a few months after their first birth, but that it can and does happen. Mothers to unmarried FTMs who still live at home are disproportionately burdened in caring for both their adolescent daughters and infant grandchildren, and providing financially for their upkeep and welfare. Thus it is not surprising that they overwhelmingly believe that there are huge benefits to birth spacing. Many believe two to four years between pregnancies is ideal and good for mother and child.

*A woman should wait for two years after [giving birth to] a child before having another, so that the previous child would have been strong enough before the new one comes. FTM Mother IDI*

*Yes, there are benefits [to spacing births], it will help the mother to look good, reduce [the financial] burden for the father, and make the child grow well. FTM Mother IDI*

*She should wait four to five years [before having another baby], so she can go back to school and reduce the chances of unwanted pregnancy. FTM Mother IDI*

About half of the FTM mothers interviewed could name or describe at least one FP method. Mothers, overall, agreed that they would approve of their daughters using FP services as this would allow them to fully recover from their previous pregnancies, and would offer them opportunities to return to school

or continue a relationship with the baby's father. Only one FTM mother felt that FP was not appropriate for her daughter, as she felt it would be more appropriate for her as an unmarried mother to abstain from sex.

*If she gets pregnant now I won't be happy with her because we agreed she needs to go back to school. By September she will wean the child, so she can go back to school. FTM Mother IDI*

*I will approve [of her using FP], because she will not continue staying with me. When she goes back to her boyfriend, I don't know what they will do. FTM Mother IDI*

*Yes, I do advise her, she will do FP, we have it in our plans. She came to tell me about what they told them about family planning at the health centre. I advised that the FP is good so that she would not make any mistake and it is left to her to decide if she wants to do it or not. FTM Mother IDI*

### **Health providers and CHVs:**

All CHVs and health providers believed that the benefits of child spacing were numerous, particularly in terms of child health (a well-spaced child is healthy and strong) and maternal health (new mothers can fully recuperate from childbirth and be in good shape to have another pregnancy). They discussed how FP and spacing can also assist families who are concerned with finances to plan better for their children and their futures.

*[FP can] help the mother to be able to take care of herself and the baby. As time goes on, when you have more children, the older one can help you take care of the younger ones, so it is good. CHV FGD*

*It is because most mothers are young, and the men too are young and they don't have the means of training a child in a proper way. So with spacing, it will help them to train that child well because there is so much in a child that so many people don't know. CHV FGD*

*They are able now to control their births and have the number they can care for, not have the number the people can't even afford with the present economic state today. People are crying of hardship. It also helps the mother to have their rest and have their health in good condition. Health provider IDI*

*One of the benefits [of FP] is that it helps the woman to look young, live long, it helps the child to go to school, it improves the general health of the woman, it reduces the maternal mortality rate, and also reduces the infant mortality rate. Health provider IDI*

All health providers and CHVs from the three study sites believed that FP is safe for young FTMs, and they encouraged women to use modern contraception.

*Well, like the one I used to know, they used to educate us on these family planning tablets, but now there are certain things government has improved upon. So, we encourage them to use these modern ones like implants. CHV FGD*

## 4.2 Objective 2: Assess experience of facility- and community-based health providers and resource persons in providing services to FTMs and their partners.

### **Health providers:**

Across the three study sites (Ikom, Obubra and Emangabe), health providers were asked if there were differences in services provided to married and unmarried FTMs. Providers reported that all pregnant and postpartum mothers are treated the same, and they reported that counseling services and health education were conducted with all women together. However, they did report awareness of services being interpreted as preferential by the community. FP clients seen per month ranged from 20 on average in Obubra to as many as 200 in Ikom.

*No difference, since all of them stay together we educate them all together, we do not have to separate them so that the other one wouldn't feel bad. We always tell them to inform their husband and also have something to do and not to stay idle. Health Provider ID1*

The benefits of child spacing, as described by all health providers, were linked to better livelihoods, having a family with income, and good health for mothers and children.

*FP has really helped improve the way they are caring for their children and having the number of children they may want to and can afford to attend to them by caring for them. Before now, a woman can deliver up to ten children and would not be able to care for those children. Health Provider ID1*

Health providers noted the need to for special care of all FTMs, especially due to their inexperience and need for healthy timing and spacing between first and second pregnancies. The health providers highlighted their practices in this regard.

*For first time mothers, you have to be a little different, because you need to counsel the mother and then tell the mother that if you want to give birth, maybe in one year or two years' interval, you still have [the pregnancy], but we have to advise on the method that will return back your cycle early enough and then you make your babies. Health Provider ID1*

The health providers reported having adolescent clients, some with babies. They reported that many of them were still in secondary school or writing their final examinations, and in poor states of health. Health providers mentioned that some have accepted family planning, with many of them preferring implants or other long-acting methods.

*Yes, they have been coming. From 16, 17 years, even 15 years I have been having them here. Health Provider ID1*

*Two of them were carrying a baby on their back. Health Provider ID1*

*They are always taking the long-acting reversible method. Health Provider ID1*

*Most of them have not finished secondary school and their health status is not that good, because I have seen one of them in a poor state. Health Provider ID1*

While some health providers noted that they have some skills in immediate post-partum care, others stated they have not been trained on immediate post-partum family planning services, as they only counsel clients and advise clients to return after about 6 weeks post-partum.

*I have not been trained for the immediate post-partum and insertion. Health Provider ID1*

*We have never done that, we only counsel and advise them to come back when they [their babies] are 6 weeks old.*  
Health Provider IDI

The importance of engaging spouses in family planning services was highlighted by health providers, as they often request women to come with their husbands when they have unusual circumstances that require male partner involvement, including having many children, a pregnant woman testing HIV positive, for example.

*For married women with 3, 4, or 5 children, we advise them to come with their husbands, except for those ones that will say my husband said I should not use [FP]. But even at that, we still advise them to come with their husbands.*  
Health Provider IDI

*There was a woman that had six children and was delivering the seventh child. At delivery the man abandoned them because he had no money to even buy the things needed for delivery so we had to buy them. After she delivered, we called for the man and the man came and we educated him on family planning in our unit. In such a case, the man and the woman will come to the unit and we give them a date where the services may be rendered. The man was very happy, saying that he wasn't aware and he came with the wife and did the FP and I told him not to blame his wife, that men can still do FP to prevent pregnancy, so he was very happy.* Health Provider IDI

*Mostly when they [women] come for the first time and they are HIV positive, we must request for you to bring your husband.* Health Provider IDI

Health providers reported they do not impose family planning choices on clients, as this is usually based on individual needs. They educate them on what is available and guide them in making choices. They further noted that they have a range of family planning methods available in their centers including injectables, condoms, implants, and IUDs.

*I can't impose any method on a mother. Through counselling, we display the different methods and the woman will make a choice. Let's say you choose to take pills. We won't give Microgynon, we give Exluton [progesterone only pills], which is good for nursing mother, or the implant.* Health Provider IDI

*It depends on the individual; some will prefer injections and some will go for implants. Most people go for implant because it will cover them for more years.* Health Provider IDI

Most of the providers interviewed were community health extension workers (CHEWS), with basic training in general family planning services, although they only administer injections and pills on most occasions. Other services provided include ANC, immunization, post-natal care, health education, and home visits, which together all form part of the daily activities across centers. Service providers noted they particularly advocate for spacing between pregnancies during ANC visits.

*CHEWs only give injections and pills.* Health Provider IDI

*I've been trained on everything, before now I was only doing the short-acting methods, [such as the] injectable, and distribution of condoms and pills. I was lucky; Society for Health (SFH) picked me up and trained me. When Marie Stopes came, they only trained the midwives. I have been trained by SFH and also FHI360 just last month.* Health Provider IDI

*We provide immunization, FP, antenatal care, post-natal care, health education, and home visits.* Health Provider IDI

*On daily basis, we take care of ANC registration and revisits, we conduct deliveries each time they come in, treatment of minor ailments, we carry out referrals where necessary, we carry out immunization services. The ones that are complicated, we refer them to a higher level or secondary level of care.* Health Provider IDI

*Yes, yes, yes...that is why we teach them during ANC visits to prevent the next pregnancy.* Health Provider IDI

Among health providers interviewed, most affirmed that they collaborate with Pathfinder staff in providing services to the community. Outreach FP services are provided across the three communities, but the health providers have only been involved in some of these. This has been linked to lack of resources, as they noted that they mainly partner with non-governmental organizations (e.g., Pathfinder, CBOs) during outreaches, as they are better equipped and have needed financial resources. They mainly said that Pathfinder and CBOs educate on available services, distribute condoms, and sometimes offer to provide FP services when there are no health providers in the area.

*Yes, because there are some communities out there under this ward that do not have these services like the insertion of implant. So, we do organize and pick the commodities here and go to those communities. Though they have some facilities, the health post, but don't offer the long-lasting services like insertion, so they go there to carryout insertion, so it is recorded under outreach services. Health Provider ID1*

*Like last month I went to a facility in BONEME, a difficult terrain to reach. They said the mothers are interested in doing the Long-acting reversible method which the provider could not perform. So, I asked them to pick a date so I can come and do it. Health Provider ID1*

The providers also reported handling referrals to their health centers, which has fostered collaboration between neighboring health centers.

*They are the people that refer pregnant women to this facility, these are their event forms, look at them we work together. Service Provider ID1*

*The women like our FP services, the data has increased because as they are leave with their babies, they also leave with their mama kid and pampers. Service Provider ID1*

Most challenges for health providers included stock-outs of drugs and consumables, as well as health worker staffing shortages. Providers believed if government can address these basic issues, service delivery will improve.

*Yes, recently we don't have drugs to take care of clients, and with the high cost of drugs now, a lot of people walk to the facility and still complain of not having money due to their economic situation. That is the big challenge. Service Provider ID1*

*I think [challenges will be resolved] if the government can employ more hands, provide mobility, water and consumables. Health Provider ID1*

Respondents mentioned, however, that Pathfinder/Nigeria supports them at least once per quarter with basic consumables and supplies.

*...it is Pathfinder that provided some of the safe delivery bags and after the mother delivered, we gave it to them. Like in this month of September, we have 20 deliveries for now, so we gave 20 bags. We give it to the person in charge who will give it to Pathfinder when requested. Health Provider ID1*

*This one [a supply of consumables] they brought last week, the one they brought before was around May or June. So, it's about once every three months. Health Provider ID1*

Despite the support from Pathfinder/Nigeria, some service providers believe they are not well-equipped to meet the FP concerns of FTMs and their families, suggesting they need to be updated on current practices and trends in FP service delivery.

*Because you know researchers and scientists everyday get updated, so we also need to be updated. Health Provider ID1*

*Even though I have not been trained on the long-lasting method, which is insertion [of implants], at least with the little knowledge I get from other people and I read novels, if I come across anybody I can pass on knowledge to that person.* Health Provider IDI

*We don't have most, we don't have tables, we don't have chairs, we don't even have office space for it. You will not find any FP written [materials, posters] on the wall, we don't really have space. So FP is combined with other spaces so we don't even have privacy.* Health Provider IDI

*For now, Pathfinder just provided us with consumables last week, so we don't really have challenges, unlike before now.* Health Provider IDI

Health providers reported benefiting from regular supervision, which is usually provided by the government and related partners. However, they think supervision can be improved by providing immediate heads at each unit to assist with complications.

*The person in charge of the facility carries out supervision in all the services. The Government and partners come, Pathfinder [also] comes.* Health Provider IDI

*He [the supportive supervisor] will come and stand and if you want to do something that is not right, he will tell you to stop, do it this way not like that way.* Health Provider IDI

*Maybe [supervision can be improved] by providing a head who oversees the affairs of that unit. In case the situation is beyond her, she will take it to the one in charge. And if it is over the person in charge, she will take it to the primary health care coordinator.* Health Provider IDI

Health providers also benefited from training. These trainings were mostly organized by partners, lasting for about three to ten days. Providers mentioned that they have greatly helped in improving service delivery, and discussed how they return to their local centers to train others who could not attend the training. However, providers believe they still need more training in in provision of LARCs, particularly immediate postpartum implants and IUDs.

*I went for BEmONC training and early newborn care training by Pathfinder. The training we had was on HIV services, ... on mectizan distribution, training on malaria... [and] distribution of nets [to prevent malaria], but not for FP.* Health Provider IDI

*Honestly the training for FP services has really helped me to improve.* Health Provider IDI

*Yes, we need training on LARCs (long-acting reversible methods) and also this immediate post-partum implant or IUD. Let's just say refresher course.* Health Provider IDI

*I need training on ... ANC and delivery and training on FP. Especially because I have not been called for a long time. I also need training on others. In all the care of PHC component, I think training is necessary for me to attend.* Health Provider IDI

*For example, as I went for workshops, when I came back I did the step down. Step down is what I was taught at the workshop. I came back to teach those that were not able to attend, so that they will have the knowledge.* Health Provider IDI

Feedback from clients, according to the health providers, has been satisfactory. They reported that the information provided is of good quality and highly beneficial. Service providers also noted that they render services without advance payment when there is a need for it. Work has been mostly stressful, and there is need to train more health providers to ensure optimal services are rendered to clients.

However, the motivation to continue working is relatively strong, especially with the continuous help of partners like Pathfinder who have, in most cases, provided basic equipment, including the solar panels and inverters.

*Because they seek the information and is often given to their satisfaction. They seek FP services and it is always given to them satisfactorily. Health Provider IDI*

*Because some of them may not register on time, some of them may be sick and they may say no money, they don't know that here we can render services even when they don't have money and their health declines. Health Provider IDI*

*Work is stressful, and we don't always feel happy when we do not have good report that a live is saved after cases. Service Provider IDI*

*I want my providers to be trained. Out of the 54 facilities only 3 have been trained on the long acting method so I want my providers to be trained. Service Provider IDI*

*Like these things that Pathfinder has brought really motivate me. In the past, during delivery, you will see me using a torch light [flashlight], but now Pathfinder has helped us with solar lights. Service Provider IDI*

### **SMGL community program staff and CHVs:**

CBO staff were interviewed and asked to give an overview of the SMGL services CHVs offered to pregnant women in communities in Ikom and Obubra. Generally, CHV give health talks to pregnant women, encouraging ANC visits, dietary advice, and referral services. CHVs also assist pregnant women in the community with an emergency transport system so they do not deliver at home.

*We [our volunteers] give health talks with the women in the community to let them know the importance of early registration, danger signs, and what they are supposed to eat during pregnancy. We also offer every woman who delivers in the hospital mama's kits and we assist the women with an emergency transport system because the women complained that the reason why they deliver at home is because they don't find vehicles to take them to the hospital when their labor begins. So we have driver call lines given to them to call anytime they are in labor. CBO staff IDI*

During the SMGL project, the main task of most CHVs has been to visit communities and households, informing women about the benefits of ANC and hospital deliveries, and the risk of giving birth at home. CHVs reported that they identify unregistered pregnant women and encourage them to: enroll in ANC, be seen at least four times during pregnancy, and have deliveries in hospitals where they can be guided through the postpartum period. They also ensure the pregnant women are informed about family planning and child spacing. They generate demand for service uptake, particularly in a community where services are available, but patronage is poor.

*To identify pregnant women that are not registered in hospitals in order to attend antenatal and deliver at the hospitals. Also, to tell them about family planning and child spacing. Pathfinder staff IDI*

*We collaborate in the aspect of generating demand at the community level for service uptake through community mobilization, sensitization, conducting outreaches and home visits of pregnant women, to ensure that the pregnant women access antenatal care services and ensure the women attend antenatal care for not less than four times before their delivery. Because we discovered that most pregnant women do not bother about their health when it comes to antenatal care, because experience proves that some of them do not register even in their first trimester and they wait till about 8-9 months, while some do not register at all, that's the reason why some will eventually patronize the TBAs, while others who manage to register during their 8 months of pregnancy will eventually resort to faith-based attendance*

or TBA. This has to do with mindset and poor behavioral change. Having known this, we deploy our community volunteers who have direct interface with the community members and are respected in their communities, and who are fluent in their local languages to be trained to enable them pass direct information to facilitate and help in pulling out these clients to the health facilities for service uptake. CBO staff IDI

This SMGL project is all about informing women about the risks of giving birth at home. We normally go there, educate them on why they should visit the clinic, or possibly hospital, for their safe delivery. CHV FGD

CHVs dedicate about two to three days per week for these activities, although many are willing to spend more time working on this project if greater financial remuneration were possible.

Between two to three days because of farm work. CHV FGD

Yes, I will love to work more days, though some of the challenges lies on the financial aspect. CHV FGD

CHVs arrange community meetings where they communicate FP messages. However, CBO staff agree that there are differences in how services and messages are offered and communicated to FTM's vs. mothers with many children when conducting home visits. Both CBO and Pathfinder staff pointed out that the needs of adolescent mothers are unique and there should be specific considerations made by CHVs for working with this group.

They also noted differences in the approach used by CHVs during home visits with both married and unmarried clients to separately address the specific needs of both groups.

*Some [clients] will tell you they have children already, all of them are alive and none of them were delivered in the hospital. They will say that nothing will be wrong. For the first timers, they are easy to be talked to because they don't have experience yet. I usually use myself as example to talk to them being that I have gotten four children and have stopped having babies, yet I am strong and looking young. I tell them that if they adopt the messages and apply them then they will eventually be like me. CBO staff IDI*

*The unmarried ones have the right to decide for themselves because they are not living under anyone, but the married ones will want to hear from their husbands first before they make their decision. Pathfinder staff IDI*

Identifying pregnant women in the first trimester is difficult, so the CHVs encourage people to seek ANC and to plan for a facility-based delivery during sensitization visits, highlighting the benefits of the program.

*...unless the pregnancy pops up, one will not be able to identify it and it is absurd to pull someone to the hospital for a pregnancy test. Some of the women know that they are pregnant but they hide it from others, and we don't have pregnancy test kits to test the women during our outreaches in order to help us identify them. The CHVs [often] cover a large ward which encompasses many villages/communities. This gives the CHVs difficulties in identifying the community members and [getting] transportation in reaching them. CBO staff IDI*

One useful approach in communicating FP messages is to invite male partners to participate, as they are important decision-makers. However, despite using familiar, community-based communication channels (like the community announcers) to pass on the meeting invitation and information to the community, Pathfinder and CBO staff still often encounter low turnout (often due to farm work), and influential community members dissuading people.

*Yes, the challenge is that men are the deciding persons in their homes and even when the woman is ready to go to the hospital, she will be dependent on her husband to get transportation to the hospital and sometimes it takes a long time before the husband releases money for her for transportation. Some of the community members believe that there is no*

*need going to the hospital because their parents delivered hem in the farms and at homes and nothing [bad] happened to them. CBO staff IDI*

*We also discovered that after a pregnant woman has cooked, she selects the best parts of the meat and fish for her husband, and she ends up eating the chaff and lesser parts, irrespective that she is the one in need of more nutrients as a pregnant woman. So when we meet the men we tell them that family planning is not for the wife alone, but for both of them, and encourage them to help improve their wives' nutrition. CBO staff IDI*

*Actually, the community members are mostly farmers. Sometimes before we get to their community they have gone to their farms, so we hardly meet them at home. Our new strategy was to visit them on their market days and in the evenings or Sundays when they are at home. When we are giving them the health talks, they usually expect money and gifts from us. When we request for their names to keep record of attendance, they become afraid to give out their names, thinking their names could be used for rituals. Some are afraid of releasing their phone numbers. Pathfinder staff IDI*

CHVs contribute additionally to their communities by linking women to resources and groups within the community, which include women's groups, religious groups, trade unions and cooperative groups. These activities, in turn, facilitate their health outreach work, and assist them in conveying their FP/RH messages to these community groups, as the groups serve as a good platform for program activities.

*We helped them form cooperatives and some have benefitted from it, and even nowadays, government gave some poor people stipends monthly, and with that we are trying to help them to use it to their own benefit through contributions. CHV FGD*

Respondents noted that communities and religious organizations, particularly churches, have at times constrained FP/RH service provision efforts. Religious leaders may directly encourage women to avoid the healthcare sector and deliver births at home in order to promote their own faith-based health services and providers ("faith-based traditional birth attendants").

*One of [the challenges of doing outreach work] is from...religious leaders in the sense that some of the women are very gullible and easily deceived through fake prophecies from the religious leaders. They prophesy to the women that whether they will deliver their baby at home without anything taking them to the hospital, and the members will respond with an Amen. The interesting thing is that some medical personnel are also involved in the patronage of the faith-based TBAs. For the community leaders, most of them look for the monetary and material benefits but the enlightened ones do help us a lot in facilitating our job process. CBO staff IDI*

Relevant trainings are provided for CHVs, usually once in three months. These trainings focus on how to conduct outreach activities within the community, cover FP and MNCH services, and ensure roles of community volunteers within the project are well specified.

*They were trained on how to carry our activities and deliver our messages to the society, we also let them know that they are not doctors or nurses but educators to the communities. Pathfinder staff IDI*

Aside from SMGL, CHVs also reported they have been given related trainings from a wide variety of other non-governmental and local organizations implementing activities in the community. Trainings received include topics such as HIV, circumcision, and child welfare. Health providers also informally provide one-to-one training, mentoring activities, and supervision.

*Like the training from the Positive Development Foundation, that has to do with vulnerable children. We are trained on how to visit homes, advise the caregivers...on how to take good care of their children, how they can space their children, so they can be able to take good care of them, so they can give them a good education. Then the HIVAIDS training from the EHF last year, which I am doing the job now, going places for outreach. CHV FGD*

*They [health providers] help in training us...since we are a volunteer in that hospital, when we get there [to a health facility], they ask us to assist them and they assist us as well, and we love helping out and we learn as well.*  
CHV FGD

CBO and Pathfinder staff report that they collaborate closely with facility-based providers. According to CBO staff, facility-based providers helped oversee activities of the CHVs, and provided supervision and feedback to CBO management. Facility-based providers also accept referrals from CHVs. Pathfinder staff visit facilities, providing project-level support and collecting data in registers.

*We work hand in hand with [health providers], [and we] also help in disseminating information...from the facility to the community.* CHV FGD

*Yes, they accept our referrals, it makes them work happily with us, and they also involve us in any activity that relates with the community. We are like ambassadors; they give listening ears whenever we refer.* CHV FGD

*We work hand-in-hand, we visit the facilities and track data in their registers.* Pathfinder staff IDI

*They help us in overseeing the CHVs and they report to us the CHVs who are not doing well.* CBO staff IDI

According to CBO staff, implementation of project activities at the community level by CHVs involves coordination, as well as monitoring and evaluation of activities. One of the biggest challenges encountered is related to tracking referred women for follow-up.

*Some of the young women do not have phone numbers for easy tracking, some of the communities do not have access to mobile network service. Consequently, we end up visiting the women when they are busy and unavailable at home. Also, if we can conduct community-based test and other services it would be more workable for us because the women mostly complain that they don't like going to the hospital because they don't like the way they are always treated at the hospital. If we can do the preliminary services and refer them to go to the hospital to complete the rest of the services it will better pull out the women, it will make a great difference if we can take some of the services to the community.*  
CBO staff IDI

Supervisors oversee activities of CHVs, as they report attending all meetings and outreaches conducted. CBO respondents noted that they have M&E officers who visit the CHVs and the communities to which they are assigned. According to Pathfinder, supervision visits are conducted weekly or monthly where they interact with community members, CHVs, and facility staff. They noted that providing relevant feedback helps at improving services rendered.

*Interact with the community members, the facilities also play an oversight functions, they tell us whether the CHVs have been visiting or not, we also meet the CHVs in their communities and monitoring their register to know what they are doing. This way, we let them understand that it's not just their thing, we also convene meetings with the CHVs where we discuss challenges, best practices and ways forward.* CBO staff IDI

*There is no specific person in charge of giving them feedback. Whoever went for supervision can give them feedback on whatever he or she observed. We also address our observations during our monthly meetings.* CBO staff IDI

According to the CHVs, the community appreciates their work, judging from the number of community members attending their outreaches. CHVs also report that interaction with other CHVs and WDC members can assist them to coordinate activities and exchange ideas about how to persuade the community to accept their health messages. CBO staff and CHVs requested increasing their visibility further by receiving and displaying project branded materials (e.g., branded shirts), when conducting their activities, as this further facilitates acceptability in the community.

Yes, they value our contribution, if someone doesn't value our contribution they won't give you attention. Each time we go there, they take care of us very well, showing that they value our contribution. CHV FGD

As a WDC [ward development committee member] or as a volunteer, when you are visiting any community, you first meet with the WDC member there. He is the one that will take the message to the town announcer that these people are coming for so and so. CHV FGD

They need branded T-shirts which they can dress in while on duty so as to give them a better identity before the community members. They need a uniquely designed t-shirt so that people will know that they are on assignment. Pathfinder staff IDI

Please take the piece of advice back to the NGO [Pathfinder/Nigeria]. They should do something so that people can respect us as volunteers by providing umbrellas or T-shirts [branded materials] and they should please increase the stipends. CHV FGD

### **4.3 Objective 3: Assess acceptability and interest in participating in a program targeting first-time mothers and their partners on the above outcomes of interest.**

A final objective of this study was to gauge interest in and barriers to participating in a proposed program for FTMs, their male partners, and mothers to FTMs. Respondents were first asked about their usual sources of health information to better understand the channels and sources of information which may reach FTMs and their families.

#### **FTMs:**

FTMs reported that they mostly obtain information on FP/RH from health workers in health facilities, although they also reported getting some information on radio and television.

*I get information from nurses at the health centre. Married FTM IDI*

*I get the information on radio and television. Married FTM IDI*

Some FTMs reported they have been educated by community or church volunteers, but mainly on exclusive breastfeeding or general healthcare. They noted that they would like to know more about various FP methods. Unmarried FTMs reported some financial constraints to participating. Some married FTMs expressed willingness to participate in outreach programs, but with the permission of their husbands.

*Yes, I was informed about exclusive breast feeding by community workers. Married FTM IDI*

*We also have youths that talk to us about healthcare even in the church also. Unmarried FTM IDI*

*I wish to know the different methods of family planning. Married FTM IDI*

*I have never come across such outreach groups here. Married FTM IDI.*

*I would like to join the outreach, but my husband would not allow me because of my baby. Married FTM IDI*

### **Male partners:**

Men reported receiving health information from a wide variety of sources, including a doctor, nurse, or clinic; traditional media like radio and television; social media like Facebook; church or school; or through a “town crier,” or a local mobilizer who shares information through community outreach.

Husbands also reported receiving health information from CHVs and feeling comfortable talking to them. They noted CHVs meet with the community during gatherings, including market days, festive periods, religious gatherings, and others. They also noted that village heads, women leaders, religious leaders, and youth leaders are important opinion leaders that can be helpful during outreaches. They, however, reported that men rarely discuss FP/RH issues during such meetings.

Men were asked about their own interest in participating in the program, as well as approval for their wives to participate. Nearly all men mentioned that they would be eager to participate, and several mentioned the desire to participate in home visits specifically. All but two men reported that they would be glad to allow their wives to become involved in such outreaches during their wives’ free time. However, several men mentioned that they would not be available to babysit during their wives’ meetings, and one man mentioned that this would make it difficult for both to attend meetings at the same time.

*For now, the baby is small I won't allow her but when the baby is bigger I will allow her. If she can work with the baby, then no problem. Male Partner IDI*

*I will support her if she has chance but I will ask her first she will carry the baby with her because she can't leave the baby with me. Male Partner IDI*

*If the baby does not disturb, she will come but if the baby disturbs, she will not. Male Partner IDI*

*She will be able if only she will come with baby. Male Partner IDI*

*It depends on the time because we both can't go for meetings. Male Partner IDI*

### **Mothers of unmarried FTMs:**

For FTM mothers, religious groups, TV, radio, and town announcers have been important sources of health information in the community. According to some mothers, there are existing groups in the community that have been involved in health outreaches, who have also contributed to sharing relevant health information.

*I've met people that talk to women in the community here about how to take care of the children and not allow your children to play anyhow to avoid injuries. FTM mother IDI*

Mothers believe that participation in outreaches may be hypothetically beneficial for their daughters and that they could convince them to participate in the program, especially since they have been the main person supporting their daughters during pregnancy through child birth and child care.

*Yes, I will be supportive. As she goes and gets the information, she will come and tell us. FTM mother IDI*

Yes, as long as the group activities have benefits, she will have the time to participate. FTM mother IDI

### **CBO/Pathfinder staff:**

The proposed program concepts were also shared with key implementing staff for their reactions and ideas. CBO/Pathfinder staff were particularly supportive of planned outreaches targeting FTMs, as both CBO and Pathfinder staff have conducted training for CHVs on how best to educate the community with regards to uptake of maternal health and FP services. They also noted that partnering with health providers in the delivery of their services might be a useful approach in reaching the community.

In addition, these staff envisioned few potential challenges in the training of CHVs to counsel FTMs to improve breastfeeding and weaning, improve maternal wellbeing, teaching families to play and interact with their children, or for couples to talk more and make decisions together. They emphasized that it would be essential for the training to be practical and address basic contextual issues.

*I don't think there will be many challenges, just that our people believe in practical things...they will tell you that they are tired of hearing all the time, and that they need to see something visible [concrete action]. Pathfinder staff IDI*

*I don't think there will be a challenge if the objective of the training is correctly passed across. CBO staff IDI*

*There won't be much resistance if the message is well passed to the people through a good approach and the right perspective. CBO staff IDI*

## **V. Discussion**

This study attempted to explore important family planning and reproductive health issues related to FTMs in Cross Rivers State, Nigeria. Experts have recommended further understanding the perceptions of women on their reproductive health beliefs before implementing RH interventions.<sup>14,15</sup> Therefore, the findings of this study are expected to guide the design and implementation of relevant programs and interventions in CRS that can address crucial health outcomes among FTMs, including breastfeeding and nutrition, FP, parenting, couple communication, and decision-making, as well as overall support towards improved health.

This study is not without limitations. The qualitative research methods used have several well-known limitations discussed in the methods section, such as the lack of generalizability of qualitative findings to all sub-populations of interest, biases inadvertently or deliberately introduced by flawed respondent recruitment strategies (or lack of adherence to the intended recruitment strategy), moderator biases which can interfere with respondent explanations, non-response of respondents due to socio-cultural and power differences, or fear of negative consequences if the discussions are inadvertently or intentionally disclosed. This assessment worked to reduce these limitations through means such as selection of participants at household level, appropriate moderation of FGDs and IDIs, and ensuring the full confidentiality of respondents and their responses at all steps of the study.

Despite these potential limitations, one important finding in this study is that about half of the young mothers described their status as a new FTM as a challenging time of anxiety and uncertainty in many aspects of their lives, over which they had very little control. FTMs reporting uncertainties and a period of difficult adjustment surrounding their own partnerships and pregnancies were relatively young, having a low economic status, and had experienced an apparent break in their education. Many unmarried and married FTMs were adolescents who were reportedly still in school at the time they became pregnant and were forced to drop out in order to have their baby. According to health providers, their adolescent pregnant clients were often seen in poor states of health, especially in terms of nutritional status.

In addition, many FTMs reported that their pregnancy preceded their union/marital status, and their own marital status was often confirmed and even determined by the father's acceptance of the pregnancy. Indeed, some husbands even expressed uncertainties about their marriages, as the pregnancy was unplanned and unexpected. FTMs sometimes reported a rejection of the pregnancy by their partners. This rejection led to either a pregnancy which was "hidden" (kept secret) until the second trimester, or a pregnancy which was acknowledged, but resulted in an unplanned residential change, a return to the natal family home, and/or reliance on parents or other family members for support. Moreover, a few adolescent FTMs even ended up in tenuous polygamous relationships or informal marriages as either second or third wives. The experience for FTMs is even more difficult when the husbands/partners are young, poorly educated and without jobs,<sup>16</sup> as many cases observed in this study.

Few FTMs, either married or unmarried, reported making decisions about healthcare services for themselves or for their infants. Challa et al.<sup>17</sup> note a complex interplay of interacting and conflicting social factors affecting the abilities of young women to make informed decisions about their RH. Agus and Horiuchi<sup>15</sup> report that in many African settings, women have been traditionally excluded in health decision-making and have limited access to adequate health, food, and education. In this assessment, husbands/male partners of FTMs in union and mothers of unmarried FTMs were particularly involved in the decisions on nutrition and health of their partners/daughters and babies. Unmarried FTMs who had recently delivered were young, without jobs, and lacking support from the fathers of their children. Unplanned pregnancies, which may lead to union dissolution or even abandonment of FTMs and their babies, often resulted in FTMs relying on their mothers or other family for support and "surrendering" required healthcare decision-making to their parents, or even heeding child care advice which was, at best, unhelpful, and at worst, may actually have been harmful to an infant's or mother's health. This was also observed by Agus and Horiuchi<sup>15</sup> who reported that pregnant women tended to unquestioningly heed family advice as a "last-chance" strategy to avoid losing this critical source of support.

These difficulties faced by young pregnant women or mothers in CRS at the family level are exacerbated by negative community attitudes towards adolescent mothers and women who are in relationships characterized by domestic violence. CBO staff, volunteers, community leaders, and service providers all mentioned their belief that the phenomenon of unmarried adolescent mothers is a result of poor youth behavioral choices and a lapse in moral judgement, responsibility, and guidance among both youth and parents involved. They also consistently reported that women are primarily responsible for any domestic violence they experience due to their sexual "misbehavior", their appearance (i.e., provocative dressing), or the way they speak to and interact with their male partners or other family members. This

persistent and judgmental perception of youth as irresponsible, immature or disobedient on the part of adult community members and gate-keepers very likely affects their ability to get needed information/services, either before becoming pregnant or as first-time mothers. Onasoga et al.<sup>18</sup> also noted that adolescents are continually at increased risk of unplanned pregnancies and unsafe abortions in many African settings owing to societal stigma and negative reactions from parents and communities on the use of contraceptives in this age group, as confirmed by mothers of FTMs, health workers, and CHVs.

A positive finding in this assessment regarding ANC and delivery services was that most FTMs and male partners reported that they preferred facility-based deliveries. Respondents reported that they considered facility-based maternity care “safer” than home-based care or deliveries assisted by traditional birth attendants, perhaps due to the recent and ongoing sensitization efforts of the SMGL Project to promote ANC and facility-based deliveries in these same communities. Those married and unmarried FTMs who reported giving birth in a clinic or hospital generally reported that, overall, they received good care at the health facilities.

However, despite preferring facility-based deliveries, this study revealed that *married* FTMs (who were also slightly older and more financially stable than unmarried adolescents) were more likely to access ANC earlier and to access safe delivery services in a health facility than unmarried FTMs. Unmarried FTMs often attended ANC in the sixth month of pregnancy or later, due to delayed acknowledgement of the pregnancy, lack of money to access services, and lack of support or even discouragement from their mothers. Unmarried FTMs also reported not visiting the hospital after a home delivery, while most married FTMs reported they visited the hospital soon (within a few days) after a home delivery for further medical checks.

The lack of finances, limited access to hospitals, and the closure of a facility or unavailability of a trained provider were widely reported as critical barriers to hospital delivery by unmarried FTMs, mothers of unmarried FTMs, and some husbands/partners in this study. Nearly all FTMs who delivered at home or outside of a facility mentioned that they had planned to deliver in a facility, but at the time of labor, they did not have the resources, transport, or time to reach a functioning, open facility. Some authors affirmed this, citing low income, maternal education, and physical proximity to health services as factors determining utilization of ANC services.<sup>14</sup> In a multi-site study across Burkina Faso, Ethiopia and Nigeria, Hounton et al.<sup>19</sup> highlighted that marriage and immunization were important determinants of use of FP among sexually active or child-bearing adolescents. For many unmarried FTMs residing with their mothers, the use of health services heavily depended on their mothers’ recommendations, as FTMs generally believe they are older and more experienced. This was also observed in some studies, where parity and age influenced the use of ANC services, as many older women with higher parities tend to believe in their personal experiences and pass this across to younger FTMs.<sup>14,15</sup>

This assessment also gathered information on breastfeeding attitudes and practices. Breastfeeding a baby is considered a powerful social norm in CRS (and in fact, was reported to be a taboo not to breastfeed an infant), and all respondents believed that breastmilk is critical for a baby to develop and grow. The practice of exclusive breastfeeding, including giving newborns colostrum, also appears to be well understood by many FTMs, and awareness of the concept of exclusive breastfeeding was strongly linked with the use of health facilities and advice given by health workers during ANC health talks and

after delivery. Hounton and colleagues<sup>19</sup> noted that mothers who frequent maternal and child health services have more favorable reproductive health outcomes due to their increased exposure and better knowledge of healthy practices and behaviors.

However, beliefs about a baby's crying stemming from unsatisfied hunger, a general intolerance of a crying baby (especially by male partners), and advice from mothers of FTMs, male partners, and some health staff negatively influenced exclusive breastfeeding practices. In fact, this study found that many FTMs began weaning their infants as early as one month of age, and often by three months. FTMs were not able to exclusively breastfeed their babies as they had been influenced by their partners and/or family members that breastmilk was not sufficient to satisfy a baby's hunger, and as such, needed to be complemented with water, infant formulas, and solid weaning foods. Studies (e.g., Kronborg et al.<sup>16</sup>) have shown that FTMs are extremely vulnerable post-delivery to influence (reflecting the uncertainties earlier mentioned), and that initiating and sustaining breastfeeding among FTMs can be challenging, with many recommending increased public awareness, family assistance, and supportive work policies to improve breastfeeding practices.<sup>20,21</sup> Some authors further suggest that breastfeeding support should be comprehensive and possibly focus on facilitating a transition to motherhood, familiarizing and reading baby's cues, and building up FTMs' confidence in their ability to produce sufficient breastmilk and care for their babies.<sup>16</sup>

This study sought to understand a variety of infant parenting practices among FTMs, mothers to unmarried FTMs, and male partners. All respondents reported some socio-cultural care-giving practices in their family, which included massaging the baby's body and a practice of throwing an infant up in the air to make him/her strong, brave, and to improve reflex responses. In addition, all respondents understood that babies communicate with their parents from a very early age, even through crying, which indicates that parents and other caregivers generally understood the concept of bonding with an infant through responding to an infant's attempt to communicate its needs. Respondents spent time playing, singing, and talking to their infants, even before they could talk or sing in return, another form of parent-baby bonding (and beneficial for an infant's language development). Occasionally, FTMs became angry with their babies, and a few FTMs said they shouted at or physically punished their infant in response. Neither male partners nor mothers of unmarried FTMs reported *physically* punishing a child in response to their anger or child's behavior, although several male partners mentioned that they shouted at or scolded their infants in response to crying or accidentally breaking or spoiling something of value.

Male partners said they spent varying amounts of time carrying and looking after the baby while their wives/partners did other household chores. From interviews conducted with male partners and other types of respondents, it was evident that men do care for and provide support to their wives in a variety of child care tasks and household chores, despite the more negative perceptions and norms that a man must have been "charmed" or "bewitched" to do so. However, there were a wide variety of responses and approaches to sharing household chores. Some men, for example, did not wish to be bothered to hold their children or help with chores, while others mentioned that they were proud to look after their infants; for most men, this would take place *after* the infant is a few months old. Most fathers expressed that they were unwilling to carry their newborns, but a few were willing do so with extra care.

Nearly all FTMs and male partners agreed that birth spacing is beneficial for the mother, infant, and family, and could name at least one benefit of child spacing. Married FTMs tended to name birth-spacing benefits related to improved health of a mother and child, whereas unmarried FTMs named benefits linked to the prevention of unwanted pregnancies and induced abortion. This has been observed by some authors, noting that the perception of the benefits of FP differs between married and unmarried women, and sometimes may be associated with the inherent sociocultural practices within such communities, including extended postpartum abstinence discussed previously.<sup>17,22</sup> Although many FTMs would want to wait considerably before having a second child (three to five years), either to stabilize an otherwise precarious household financial situation, or to enable them to continue their education. Hence, in the absence of opportunities to continue their education, there is increased likelihood that many FTMs may become pregnant again within short intervals. In a Nigerian study, Schwandt and colleagues<sup>23</sup> did note many urban Nigerians were aware of the risk of short birth intervals, but observed that about 25% of births in Nigeria had birth intervals of less than 24 months. This invariably implies that awareness of risk does not necessarily result in longer birth intervals.

However, while FTMs, male partners, and mothers to unmarried FTMs could easily name benefits of birth spacing, awareness and knowledge of specific contraceptive methods was lower, especially among those who have never used a method of FP. Most FTMs and male partners could name or describe at least one modern FP method, but did not know how any of the methods are used. Some were not sure whether FP was safe, and were concerned that use of FP might “spoil the womb,” thereby negatively affecting a woman’s future fertility. Married FTMs generally thought FP is safe and beneficial, but unmarried FTMs (especially never users) were less likely to believe that FP is safe for young mothers to space their children. Several men mentioned that they prefer “the local method” of spacing (extended postpartum abstinence). A few men mentioned that FP is only appropriate for women who have finished childbearing or for women in school so that they can “concentrate on their studies.” Most male partners were either not sure or did not believe that FP is safe, but despite this apprehension about the safety of FP, most would approve of their wives/partners using FP if they wanted to do so to space their births. FTM mothers overall agreed that they would approve of their daughters to be given FP services as this would allow them to fully recover from their previous pregnancies, and would offer opportunities to return to school or to continue a relationship with the baby’s father.

Many authors report that informational programs for youth on contraceptive methods, as well as increased availability of contraception for sexually active youth is often interpreted by communities as facilitating and encouraging adolescent premarital sex.<sup>17</sup> This results in adolescents who need contraception choosing not use it or using it secretly, as they fear being discriminated against and stigmatized, especially in communities with strong religious and traditional beliefs.<sup>17,22</sup> In such communities, it has been recommended to offer community health programming in basic healthcare and FP (such as an FTP program), so that essential healthcare services, including contraception, are available to both adolescents and adults at community level, and also so that community health workers are better trained to identify and refer severe or life-threatening cases to appropriate health facilities.<sup>23,24</sup> Indeed, the study points to limited awareness and use of FP services, and a need to increase awareness across study sites. However, effective counselling on FP services, encouraging spousal communication, and contextual considerations should be incorporated into outreach activities focused on delivery of accurate and comprehensive information on FP methods.<sup>25-27</sup>

A final observation in this study shows that the different groups of participants (FTMs, mothers, husband/partners, CHVs, CBO/Pathfinder staff, and health providers) all expressed a willingness to participate in RH community outreaches. CHVs gave suggestions for improving their outreach work, including branding and context consideration during such activities. This is a positive assessment outcome toward establishing interventions targeting FTMs in CRS. In an assessment by Zamawe et al,<sup>28</sup> the authors concluded that community media-driven outreaches increased the utilization of maternal health services in rural limited-resource settings. Idowu and colleagues<sup>26</sup> observed in a preliminary assessment in Nigeria that most women were willing to adopt postpartum FP services, hence a need for well-packaged awareness campaigns tailored to contextual needs to guarantee increased uptake of services.<sup>18,19</sup>

## VI. Program Considerations

This study provides important insights into marriage and pregnancy, ANC, delivery care-seeking, breastfeeding, parenting, birth spacing, and FP use among FTMs aged 18-24 years and fathers of an infant less than one year old. This section presents proposed considerations for potential incorporation into a program for FTMs aged 15-24 years, male partners, and mothers to FTMs.

- Work with young FTMs themselves to build understanding and skills to address the varied health and gender-related factors that are critical to ensure good outcomes throughout pregnancy, childbirth and the early life of their child. Regardless of their individual characteristics and situations, FTMs are generally uninformed and unprepared for the health journey of becoming a mother – especially as so many are coping with unplanned pregnancies and unexpected motherhood. Given the fluid natures of relationships, living situations and support, all FTMs would benefit from programs that build their RH/MCH/FP knowledge and related lifeskills and access to quality health care. An essential part of this must focus on gender norms and roles, including helping FTMs build the planning, decision-making, communication and negotiation skills they need to take more control of their personal situations and options. With the stigma and isolation that some FTMs experience, there is also great value in creating a safe space where young women can come together to learn and build new connections with others in their same situation.
- Many adolescent FTMs reported feeling condemned by their communities for being young, unmarried and pregnant. Given that marital status is so fluid, it is likely that many, if not most, FTMs face the emotional and mental toll of stigma, as well as the very real health consequences of not seeking timely health services for themselves and their child. Programs should address community norms and attitudes that can lead to isolation and stigmatization of young FTMs through incorporating a peer group approach for FTMs.
- Two of the greatest challenges FTMs face are interrupted education and income-generation activities, especially among unmarried FTMs. Across the board, FTMs, male partners and older women flagged how unexpected parenthood disrupted educational plans and raised financial

concerns. There is a need to advocate for and to link to other ongoing programs that address educational and economic/vocational opportunities for FTMs and their families.

- Although male partners and older women may be most influential with different FTMs – male partners within marriage, and mothers for unmarried FTMs – they consistently have a say in critical choices and decisions for all FTMs. Many male partners are themselves young First-Time Fathers also coping with unexpected fatherhood. Older women are taking on roles and tasks as mothers and grandmothers that push beyond traditional practices. As such, these key influencers also need basic RH/MCH/FP information and access to services to support decisions and actions throughout the FTP lifestage. Programs should systematically engage the key influencers – the male partners of FTMs and the mothers of FTMs – to build support for FTM action and foster more gender-equitable roles and responsibilities. In addition, programs should build an understanding of gender norms and power dynamics, and encourage influencers to change some of the relational barriers to better health and life options for themselves and their partners/daughters.
- FTM mothers supporting their unmarried daughters have an unusual burden to both care for and provide financial support for their postpartum daughters and grandchildren. These mothers may already have strong support networks within their families or in their communities, but interventions targeting them directly, or their daughters indirectly, may be helpful to alleviate some of the stress and burden in their lives.
- At the community level, programs should also build an understanding of the FTP lifestage and the complex situations of FTPs in CRS with community leaders and members – especially those gatekeepers responsible for the well-being of adolescents and youth – including support for FTP choice and timely access to AYRH services.
- Supportive traditional practices related to postpartum care of newly delivered mothers exist (e.g., *omugwo*), and may be very beneficial in assisting a new mother to rest and recover fully, receive social support during a potentially isolating time, and receive baby care and breastfeeding advice while still learning to care for an infant. The program design team might incorporate these practices into the concept and “branding” of the program, whereby the program is positioned as an extension of this traditional postpartum care.
- All respondents believe that breastmilk is vital for infant growth and development. Most respondents are aware of the concept and benefits of exclusive breastfeeding, but do not necessarily practice it. FTMs are strongly influenced to introduce infant weaning before six months by male partners and their own mothers to appease a crying child who is perceived to be hungry and not satisfied by breastmilk alone. Education for FTMs, partners, and mothers of FTMs on exclusive breastfeeding, the nutritional “completeness” of breastmilk for infants under six months of age, and timing of weaning needs to be emphasized, including parenting information on reasons for infant crying (not just related to hunger).
- Education on the purpose and importance of colostrum is also critical for antenatal clients and for postpartum nursing mothers and family members during counselling for both groups of clients. This information should be reinforced during supportive supervision at facility level as well.
- Appropriate and adequate maternal nutrition during breastfeeding should be discussed with all ANC and postpartum clients, including the need to prevent dehydration. Fruits should also be

encouraged; while they may contain sugars (believed to cause gastrointestinal problems for the infant), they also contain valuable vitamins and minerals for the post-partum breastfeeding mother.

- FTPs and their relatives are generally successful in bonding with their infants, are playful with them, and understand that even small babies can communicate with a parent or caretaker. They describe parenting practices which promote social bonding and language development, such as smiling with, talking to, or singing to an infant. Positive parenting and gender norms around childcare need to be further explored, discussed, and addressed through peer group interaction. Physical and verbal (shouting) punishment of infants should be discouraged.
- Fathers could be taught and encouraged to hold their newborns, even when they are less than a few months old to increase baby-father bonding.
- Traditional newborn care practices include throwing a baby up into the air to make the baby strong and brave, and to test its reflexes. This practice may cause unintentional injuries, is therefore unsafe for newborn infants, and should be explored in further detail.
- Child spacing is a well understood and highly valued concept in these communities, and postpartum abstinence is traditionally and non-traditionally practiced. A mother's rest and recovery, as well as improved family finances, are key persuasion points for continuing to promote HTSP for FTMs and male partners, respectively, and spark discussion on tools for birth spacing. These messages should also be shared during routine training and supportive supervision of health providers who offer FP, so that these messages are reinforced among providers as well.
- FTMs and male partners lack "deep" knowledge of FP and have a variety of concerns about the safety and long-term effects of FP. In addition, FP is often seen as something to be used to limit, rather than space, one's children. Communication programs need to focus on improving FP knowledge, and should address ideational factors such as rejection of myths and misconceptions and self-efficacy, among others. This is especially true for younger, unmarried FTMs who had lower levels of knowledge and previous experience using FP.
- Male-engagement activities seeking to increase knowledge and use of FP as a tool for spacing are critical, especially for married or "in-union" couples. Male partners generally make decisions related to healthcare seeking, and provide the needed resources to access healthcare and FP. They can greatly facilitate or hinder access to and use of FP for their FTM partners.
- Married FTMs mostly relied on condoms as a method of FP. It could be helpful to conduct one-to-one counseling sessions with these women to see if a longer-term method may be more appropriate for their RH needs and goals. Referrals could be provided for those interested in trying a different method.
- All FTMs reported being satisfied with wait time, provider treatment, counseling received, and price charged for the service (condoms and injectables were free, but several women reported paying 1000-1500 Naira for an implant). However, most respondents cited payment as one of the main barriers to safe delivery services. There is great need to ensure policies regarding services, fees, and payment for contraceptive methods are adhered to at facility level, consider innovative voucher or savings/loans schemes for vulnerable and impoverished women, and to

advocate at the state and national level for a greater level of subsidization of MNCH services or implementation of a low-cost national health insurance program.

- Participants seem willing and potentially interested in a program targeting FTPs. The issues discussed (child's health and nutrition, mother's health, and use of FP) seem relevant issues for participants, especially those with young infants, and nearly all male partners agreed that it would be a potentially useful and interesting program for both themselves and their wives/partners.
- CHVs also recognize the potential benefits of this program, as described, and expressed an eagerness to be involved. They would appreciate it if the activities have a distinct and recognizable "branding" and if they could receive t-shirts, bags, or other materials with this branding that would help raise their visibility and profile in their respective communities.
- Finally, given the important and influential role that parents have in teaching their daughters how to care for and parent an infant, and given the decision-making authority of husbands and fathers around these issues, it will be important to apply a socioecological approach in promoting discussion, information-sharing, and joint decision-making among FTMs and their influencers. These discussions and interactions should address issues including gender, poverty, and the maternal and reproductive health needs of young FTMs. This may increase a program's capacity to engage with a community and improve the success of a FTP program in CRS.

Combined with the fact that these vulnerable youths are also first-time parents, it is evident that young first-time mothers in CRS are in great need of "wrap-around", multisectoral services, information, and responses in order to ensure their future health, social, and financial well-being. In the context of the socio-ecological model, it is equally critical for FTP programs to extend services and information to household influencers, such as male partners and parents, as is relevant and appropriate. Programs should facilitate dialogue between adolescents, household, and community-level influencers, as well as build support at community-level for youths' access to services, school, vocational training, and even psychosocial support. Ideally, addressing inequities in income, education, employment and place of residence are needed to improve overall quality of life of young parents in the population.<sup>19,30</sup>

As noted previously, the major limitation of this study relates to the degree of representativeness of the sample population. Nevertheless, given the effort to interview a variety of FTMs and their influencers at various levels of the socio-ecological model, this study provides important findings on relevant RH interventions and further research needed. From these findings, it is apparent that the knowledge, attitudes, and practices of FTMs (married or unmarried), mothers, husbands/partners, health providers, CHVs regarding the health outcomes of interest among FTMs (including postpartum contraceptive use, child health and nutrition, positive parenting, and family roles and responsibilities, among others) appear to vary across the selected study sites and among different subgroups of FTMs. Further, nearly all respondents reported positive experiences with ongoing outreaches on FP/RH in their respective communities and expressed a willingness to participate. It is hoped that these findings will contribute to the development of a new and comprehensive activity focusing on reaching young FTMs and their male partners with relevant critical information and services.

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## Appendixes

### Appendix I. Participant category and the inclusion criteria

Facility-based family planning providers – who offer FP services at the three study facilities
Married FTMs, aged 18-24 years, who are not pregnant and are facility FP clients since the birth of their child
Married FTMs, aged 18-24 years, who are not pregnant and who have not used FP since the birth of their child
Unmarried FTMs, aged 18-24 years, who are not pregnant and are facility FP clients since the birth of their child
Unmarried FTMs, aged 18-24 years, who are not pregnant and who have not used FP since the birth of their child
Community leaders – who are members of the WDC and that are nominated by the leadership of the group for the respective facility
Key CBO staff/Pathfinder staff – The persons that will be interviewed under these organizations will be staff of the said organizations and will be person with some knowledge of the design and implementation of the SMGL project in CRS.
Married FTMs, aged 18-24 years
CBO CHWs – This will be community health volunteers that support the house to house demand generation component of the SMGL project. They will be SMGL under the leadership of the Greater Hands, the CBO leading the demand generation bit of the project in Ikom.
Husbands/partners of married FTMs aged 18-24 years
Mothers of FTMs aged 18-24 years who live with an unmarried FTM who is 18-24 years

## Appendix 2. Notation adapted from the Jefferson Transcription System

Symbol	Notation
(.)	A full stop inside brackets denotes a micro pause, a notable pause but of no significant length
(0.2)	A number inside brackets denotes a timed pause. This is a pause long enough to time and subsequently show in transcription.
[	Square brackets denote a point where overlapping speech occurs.
> <	Arrows surrounding talk like these show that the pace of the speech has quickened
< >	Arrows in this direction show that the pace of the speech has slowed down
( )	Where there is space between brackets denotes that the words spoken here were too unclear to transcribe
(( ))	Where double brackets appear with a description inserted denotes some contextual information where no symbol of representation was available
<u>      </u>	When a word or part of a word is underlined it denotes a raise in volume or emphasis
↑	When an upward arrow appears it means there is a rise in intonation
↓	When a downward arrow appears it means there is a drop in intonation
→	An arrow like this denotes a particular sentence of interest to the analyst
CAPITALS	where capital letters appear it denotes that something was said loudly or even shouted
Hum(h)our	When a bracketed 'h' appears it means that there was laughter within the talk
=	The equal sign represents latched speech, a continuation of talk
::	Colons appear to represent elongated speech, a stretched sound



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