Improving Health and Gender Outcomes for First-Time Parents in Cross River State, Nigeria

In 2018, the Evidence to Action (E2A) Project and Pathfinder International, in partnership with the Cross River State (CRS) Ministry of Health, launched a new effort to improve postpartum health and gender outcomes for young first-time parents (FTPs).

Implemented through the Saving Mothers, Giving Life (SMGL) initiative, the FTP component focused on healthy timing and spacing of pregnancy (HTSP), family planning (FP), exclusive breastfeeding, positive parenting, and related gender outcomes for young FTPs—defined as women under 25 years who are pregnant with or have one child and their partners. E2A designed multiple, coordinated interventions targeting young first-time mothers (FTMs), their key influencers—especially husbands/partners and older women—and their communities, including a network of community- and facility-based health care providers, to achieve these outcomes:

- **Increased voluntary contraceptive use;**
- **Improved HTSP/FP knowledge, attitudes, and intentions;**
- **Improved knowledge, attitudes, and intentions for exclusive breastfeeding;**
- **Improved knowledge and attitudes for positive parenting;**
- **Improved gender-equitable attitudes related to household roles and decision making;**
- **Improved support from partners, families/households, and communities for FP use, exclusive breastfeeding, and positive parenting by young FTM/FTPs.**

PHOTOS Courtesy of Pathfinder Nigeria

MEETING AN URGENT NEED FOR HTSP/FP IN CROSS RIVER STATE

High rates of early childbearing and low use of modern contraceptive methods combine to increase the risk of poor reproductive health outcomes for young FTMs in CRS. Sexual activity and motherhood begin early in CRS; 18% of adolescent girls have begun childbearing.[1] Studies in Nigeria and around the globe show that adolescent pregnancy is associated with higher morbidity and mortality for both the mother and the child.[2] Young mothers are also at risk of rapid, repeat pregnancies, with 27% of sexually active 15–19-year-old adolescent girls (both married and unmarried) in CRS currently using a modern contraceptive method.[3] In addition, 15% of married young women and 24% of sexually active unmarried young women in Nigeria have an unmet need for contraception.[4] With nearly half (48%) of all pregnant women aged 15–24 in the South-South geopolitical zone (where CRS is located) expecting their first child, these statistics underscore the critical importance of addressing maternal, newborn, and child health (MNCH) and reproductive health (RH) issues during the FTP lifestage.[5]

1 NPC Nigeria and ICF International, Nigeria Demographic and Health Survey 2013.

2, 3, 4 Loto O.M, et al. 2004. Poor Obstetric Performance of Teenagers: Is It Age- or Quality of Care-Related? J Obstet Gynaecol, 24(4):395-8

5 Findings from a Formative Assessment of First-Time Parents in Cross River State, Nigeria, Evidence to Action Project, October 2018.

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The limited use of FP/RH services reflects the context-specific gender and social situation of young FTMs and FTPs which have strong implications for their health. Formative research in CRS shows that FTMs do not make important decisions about their lives and healthcare independently. Partners and parents, especially the mothers of FTMs, play critical roles in determining if, when, and how positive health action is taken. Other factors, such as financial concerns, real or perceived negative attitudes from health care providers, and broader social stigma also delay or limit health seeking. Despite high acceptance for delaying the next birth, FTPs do not always see contraception as a safe tool to space subsequent pregnancies. Fears about long-term safety and return to fertility limit actual and intended use of contraception, increasing risks of unintended pregnancies and poor health outcomes. For SMGL, the vulnerable situation of FTPs in CRS highlighted the opportunity to address key postpartum priority areas—especially HTSP and FP.

FOUR BROAD OBJECTIVES THAT GUIDED THE SMGL FTP COMPONENT

1. Improve the capacity of community volunteers (CVs) to provide health counseling, services and referrals for FTM/FTPs at community-levels;
2. Strengthen the capacity of FTM/FTPs to access health information and services at facility and community levels;
3. Create an enabling environment for the provision and use of health services by FTM/FTPs;
4. Contribute to the global evidence-base on effective strategies to reach FTM/FTPs with community-based FP information and services.

LEVERAGING SMGL FACILITY AND COMMUNITY PLATFORMS

Launched in 2018, the new FTP component built on the strong facility and community platforms already established by SMGL in two (Ikom and Obubra) of the 18 local government areas where the project operated. This included improved maternal, neonatal, and FP services at 16 public and faith-based health facilities, and community-led activities within facility catchment areas to address the three delays associated with poor maternal outcomes. A local community-based organization, Greater Hands Foundation (GHF), supported community-based activities related to maternal, newborn, and child health (MNCH) and FP, including broader awareness raising and home visits for tailored information and referrals, provided by local resource persons—known as community volunteers (CVs). While all SMGL activities reached FTPs, the new component made a deliberate effort to build FTP agency and foster a supportive environment for positive health action.

In designing the FTP component, E2A applied both a life-course and socio-ecological lens to determine the appropriate content and structure. Given that SMGL was already addressing antenatal and delivery outcomes, E2A and Pathfinder/Nigeria prioritized the postpartum phase of the FTP lifestage. Interventions focused on advancing FP, exclusive breastfeeding, positive parenting, and related gender outcomes (such as improved couples communication and joint decision making) for young FTMs and their male partners. It also strengthened household and community support for FTPs, including addressing the underlying gender and social norms that influence their relationships, choices, and actions.

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PROGRAMMING WITH A LIFE-COURSE AND SOCIO-ECOLOGICAL LENS

The SMGL FTP component included a package of interventions aimed at improving health-related knowledge, attitudes, communication, decision-making and service utilization by young FTM/FTPs.

INTERVENTION	DESCRIPTION
FTM PEER GROUPS 	Led by young FTMs, peer groups built FTM knowledge and skills related to HTSP/FP, contraceptive choice, exclusive breastfeeding, and positive parenting; addressed gender dynamics; and fostered healthier relationships. A total of 50 peer groups, comprising of 10–15 FTMs each, met for 14 sessions held weekly. Groups were supervised by CVs, who are certified community health extension workers attached to a local community-based organization and linked to nearby health facilities.
MALE PARTNER GROUPS 	CVs facilitated small group activities with male partners of FTM peer group members to explore couples communication and decision making related to HTSP, contraceptive choice, exclusive breastfeeding, and positive parenting, as well as foster more gender-equitable attitudes and relationships. Twenty male partner groups, comprised of 10–15 members, met for six sessions held weekly.
OUTREACH WITH OLDER WOMEN 	CVs conducted a series of three informational outreaches with older women influencers of FTM peer group members—typically their mothers and mothers-in-law—to provide information on HTSP and modern contraceptive methods and explore the gender and social barriers that limit health choice and action by FTPs.
HOUSEHOLD VISITS 	CVs conducted 4–6 home visits with each FTM peer group member to provide tailored counseling and referral services for antenatal care, safe delivery, FP, breastfeeding, and child health issues. When possible, CVs also engaged with male partners and household members to build support for FTP health action.
COMMUNITY- AND FACILITY-BASED INFORMATION AND SERVICE DELIVERY 	CVs and facility-based health providers conducted informational and service delivery outreaches to increase FTP access to FP/RH/MNCH services and build community support.
DATA GENERATION 	The project team generated data on both implementation and FP-related results, including: a quantitative baseline/endline with FTMs and male partners, referral data collected by CVs and confirmed at health facility, peer leader report, health facility data, and monitoring reports.

The FTP component centered small peer group activities with young FTMs and similar small group activities with their husbands/partners:

FTM Peer Groups

Grounded in the concept of creating safe spaces, peer networks, and role models for young women, 50 peer-led small groups were established in Ikom and Obubra. Criteria for eligibility included age (under 25 years), parity (pregnant with or having one child), and residence within the peer group location. Groups met weekly in their communities from May to August 2018 to conduct 14 sessions. Each week, a priority health and/or gender issue was addressed using activity cards designed by E2A or adapted from the GREAT Project.[6] On average, each group had approximately 12–15 members, with almost 600 young FTMs participating over the course of the intervention.

Small Group Sessions with Male Partners

CVs led small group activities with the husbands/partners of FTM peer group members. By design, the partner intervention began after the FTM peer groups, allowing time for FTMs to identify husbands or partners that they wanted to invite to the program. No other criteria were set for male partners. CVs and male motivators (the partners of FTM peer group leaders) reached out to these men to inform them about the small group meetings and secure their participation. In total, 20 male partner groups were formed in July, engaging over 230 men in six weekly sessions on priority health and gender topics: HTSP/FP methods, exclusive breastfeeding, child development and parenting, gender norms/ roles, fatherhood, and healthy relationships.

TOPICS ADDRESSED IN FTM PEER GROUPS

- Healthy timing and spacing of pregnancy
- Problem solving in intimate relationships
- Life aspirations
- Overview of modern contraceptive methods
- Gender norms
- Communication and decision-making among couples
- Desired family size
- Gender-based and intimate partner violence
- Exclusive breastfeeding
- Positive parenting

6 The Gender Roles, Equality and Transformations (GREAT) project was led by the Institute for Reproductive Health of Georgetown University and implemented by Pathfinder International and Save the Children in Northern Uganda.

DELIVERING RESULTS

E2A and Pathfinder Nigeria made a deliberate effort to generate data that could capture progress in achieving priority health and gender outcomes of interest under the FTP component of SMGL.

METHODOLOGY

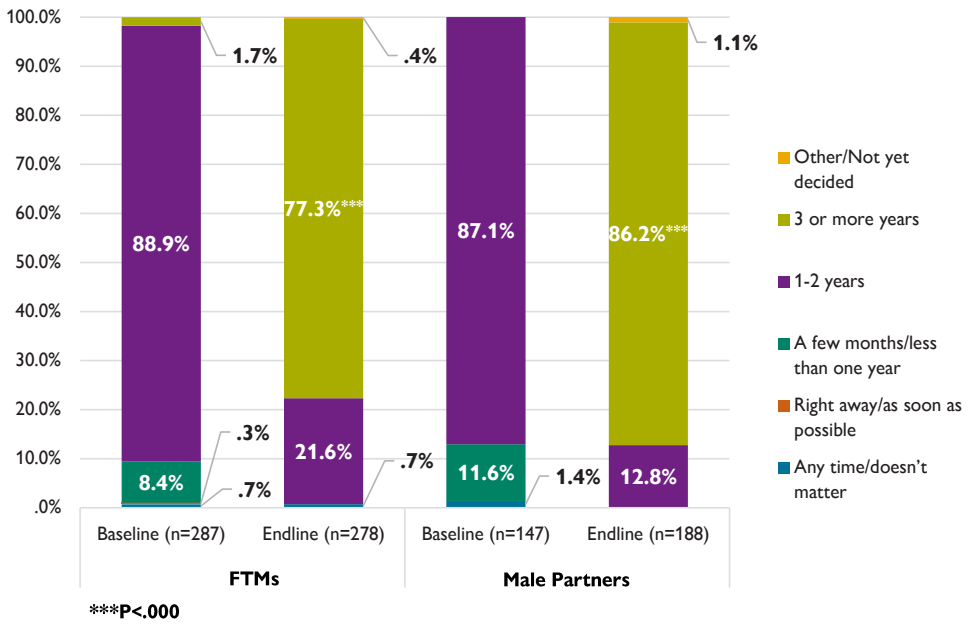
A pre-test/post-test study examined the effectiveness of FTP interventions for participating young FTMs and their husbands/partners in improving: HTSP/FP knowledge, attitudes, intentions, communication, decision making, and use; knowledge and attitudes about exclusive breastfeeding and positive parenting; and broader gender equitable attitudes related to household roles and decision making. The study protocol and other required documents were submitted to and approved by the Government of Cross River State of Nigeria Health Research Ethics Committee (CRS-HREC) in Calabar, Nigeria.

Using Android-based mobile phones with the Open Data Kit (ODK) application, a trained research team of field-based staff conducted face-to-face, structured interviews—using standardized, pre-coded questionnaires—before content sessions took place at baseline and after the program concluded at endline with a sample of FTMs and a census of male partner participants. Baseline data collection took place in May 2018 for FTMs and July 2018 for male partners, and endline data collection for both FTMs and male partners took place in August/September 2018. For all interviews, participants were provided with a summary of the study and requested to sign a consent form (with provisions for thumbprint signatures). The research team obtained consent and provided a copy to participants. Interviews were conducted in either English or Pidgin language, and refreshments and transport reimbursement were provided to the study participants. In total, 338 FTMs from 32 peer groups participated in the baseline, and 339 at endline. All male partners participated in the baseline (n=245) and endline (n=225).

Survey data provided rich information on HTSP, FP, and related gender outcomes from the young FTPs who participated in FTP interventions. While there were some criteria set for FTM peer group members (under 25 years, pregnant or with first child) and male partners (identified as a male partner by a peer group member), activities were otherwise open to FTPs who wanted to participate, and the program attracted diverse FTPs when considering their age, marital status, and other background characteristics. Importantly, the vast majority of FTM and partner participants stayed engaged throughout the group activities. The following results highlight some of the changes that emerged over the course of the intervention.

1 Birth spacing timeframes increased from baseline to endline, indicating that FTPs now intended to wait three or more years before having another child.

FIGURE 1: Among those who wish to have another child, preferred timing of next child, by participant group and baseline/endline



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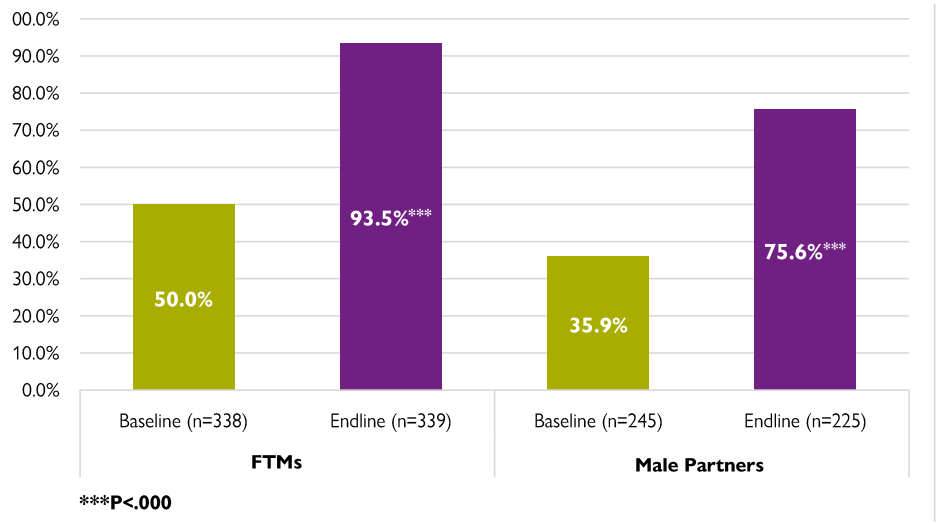
"I learned so many things about family planning. Before, I thought there were only two methods of family planning...During the sessions, I understood we now have about nine methods that one can use to prevent herself from [getting pregnant] until [she is] ready."

—Queen Esther, FTM

2 **FTP knowledge of FP methods increased over the course of the intervention,** with the percent of FTMs and male partners who could spontaneously recall at least three modern methods increasing significantly from 50% to 94% for FTMs, and 36% to 76% for male partners.

FIGURE 2: Percent who can name at least three modern FP methods



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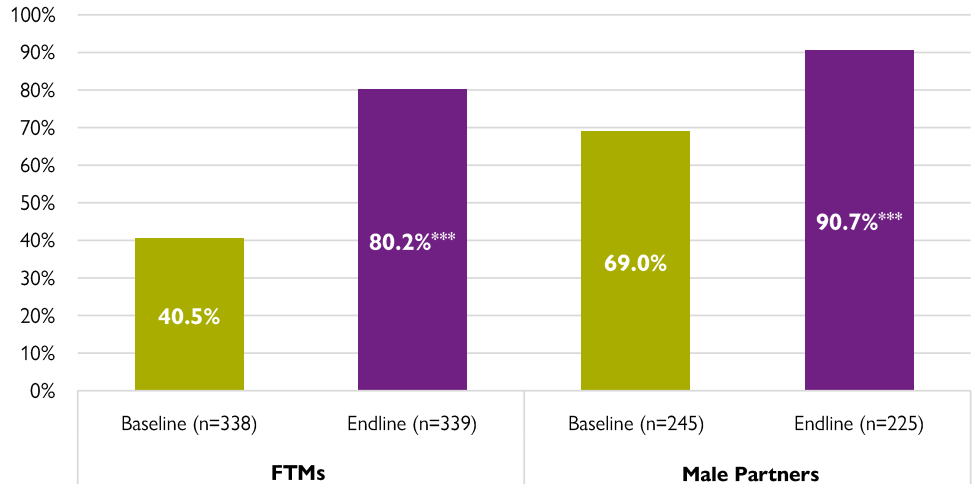
3 **Attitudes about contraceptive use, safety, and partner support changed significantly in the desired direction.** For example, at baseline, 55% of FTMs and nearly 30% of male partners agreed that using FP could negatively impact a woman's ability to have children in the future; at endline, only 1% of FTMs and less than 10% of male partners held this belief.

4 **Couples' communication on FP (past three months) increased significantly from baseline to endline:** Reported discussions with their partner about FP among FTMs (regardless of marital/union status) doubled from baseline (41%) to endline (80%) and increased significantly among male partners—from 69% to 91%.

FIGURE 3: Percent who have discussed FP with their partner as a way to space children in past three months by baseline/endline and participant group



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5 **Joint decision making about FP use was reported by both FTMs and male partners at baseline and further reinforced at endline.** The percentage of FTMs and male partners who reported that they jointly decided to use FP was high even at baseline—82% of FTMs and 87% of male partners. This significantly increased by endline for both participant groups to 96% of FTMs and 99% of male partners.

6 **Gender-equitable attitudes towards household roles and decision making changed positively for both FTMs and male partners, even with a relatively short intervention period.** As an example, the percent of male partners who "strongly agreed" that they had the final word in all decisions in the home decreased significantly, from 46% to 24%; FTMs who "strongly agreed" that their partner/husband had the final say also decreased significantly, from 56% to 32%.

7 **Current voluntary use of modern contraceptive methods increased significantly over the course of the intervention**—from 26% to 79% among non-pregnant FTMs, and from 43% to 78% among male partners.

FP USE AND PROGRAM EXPOSURE

E2A conducted a logistic regression analysis to confirm the bivariate findings, predicting current use of modern methods of FP (implants, IUDs, injectables, oral pills, male or female condoms, EC, or standard days method) among both FTMs and male partners (separately). All demographic variables were included in the model, as well as attitudes towards FP, discussion about FP, perceived partner approval for FP, perceived gender roles related to household work and baby care, household and family decision-making, as a variable representing time (baseline/endline, with baseline as the reference category). This analysis revealed that for both FTMs and male partners, time was highly significant (p<.000) with odds ratios of 5.3 for FTMs and 4.2 for male partners, indicating that modern FP uptake significantly increased from baseline to endline. FTMs were approximately five times more likely and male partners approximately four times more likely to be using a modern contraceptive method at endline, as compared to baseline, even after controlling for other factors related to FP use, including demographic characteristics.

FIGURE 4: Current use of modern contraceptive method (among those not currently pregnant)

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9 **Knowledge about exclusive infant breastfeeding improved.** For example, at baseline, 76% of FTMs strongly agreed that "Exclusive breastfeeding should begin as soon after birth as possible, as a mother's first milk is especially good for the baby," which increased significantly to 95% at endline.

10 **Both FTMs and male partners demonstrated improved knowledge and attitudes about infant care/parenting attitudes and behaviors.** As an example, at baseline, only 20% of male partners strongly agreed that "Frequent (inconsolable) crying is normal for a baby during its first six months, sometimes for no clear reason," which increased significantly to 49% at endline.

11 **Both FTMs and male partners reported high levels of satisfaction with the program**—with all (100%) reporting that they would recommend the program to any friend/family member who might be expecting their first baby.

This work was made possible by USAID through E2A/Pathfinder in close collaboration with the Ministry of Health and the Greater Hands Foundation (GHF). The Evidence to Action (E2A) Project is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and facilitating the scale-up of best practices that improve family planning services. The project is led by Pathfinder International, in partnership with ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.

Read the full report at e2aproject.org

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