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E2A EVIDENCE TO ACTION for Strengthened Reproductive Health

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

REPORT | E2A PROJECT

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 2020. E2A is led by Pathfinder International in partnership with ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.

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The first-time parent activities and results presented in this report were achieved through the efforts of a large team, including: Pathfinder/E2A staff in Cross River State, Abuja, and Washington, DC; Greater Hands Foundation staff; and Community Volunteers, health providers and young first-time mother peer leaders from project communities. Several individuals played a leadership role in the design and implementation of the Saving Mothers, Giving Life initiative's first-time parents component: Dr. Farouk Jega, Pathfinder Nigeria Country Director, Dr. Yemisi Femi-Pius, Cross River State Program Manager; Ms. Nenka Alobi, Senior Project Officer; Mr. Benjamin Asemota, Monitoring & Evaluation Officer; and Mrs. Arit Williams, Executive Director of Greater Hands Foundation.

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Finally—and most importantly—we thank the hundreds of young first-time mothers and their partners in Cross River State.

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Contents

Acronyms and Abbreviations

ANC	Antenatal care
CBO	Community-based organization
CHEW	Community health extension worker
CRS	Cross River State
CV	Community volunteer
E2A	Evidence to Action Project
FP	Family planning
FTM	First-time mother
FTP	First-time parent
GHF	Greater Hands Foundation
HREC	Health Research Ethics Committee
HTSP	Healthy timing and spacing of pregnancy
IRB	Institutional Review Board
IUD	Intrauterine device
LARC	Long-acting reversible contraceptive
LGA	Local government area
MNCH	Maternal, newborn, and child health
MOH	Ministry of Health
NPC	National Population Commission
PL	Peer leader
RH	Reproductive health
SMGL	Saving Mothers, Giving Life

I. Introduction

In 2018, the Evidence to Action (E2A) Project and Pathfinder International, in partnership with the Cross River State Ministry of Health (MOH), launched a new effort to advance postpartum health and gender outcomes for young first-time parents (FTPs) in Cross River State (CRS), Nigeria. Implemented through the *Saving Mothers, Giving Life* (SMGL) initiative, the FTP component focused specifically on healthy timing and spacing of pregnancy (HTSP), family planning (FP), exclusive breastfeeding, positive parenting, and related gender issues for young FTPs. The project defines FTPs as women under 25 years who are pregnant with or have their first child and their partners. Informed by a qualitative formative assessment conducted in 2017, E2A designed multiple, coordinated interventions addressing priority postpartum outcomes for this vulnerable youth population. The interventions targeted young first-time mothers (FTMs), their key influencers—especially partners/husbands and older women—and their communities, including a network of community- and facility-based health care providers. The SMGL FTP experience generated valuable evidence and insights about this vulnerable youth population and how best to respond to their complex health needs. This report presents an overview of SMGL's multi-intervention FTP component, the health- and gender-related results achieved, and several implementation learnings. The report also provides a set of conclusions and recommendations to inform future FTP programming in Nigeria and across the globe.

II. Background

The SMGL FTP component, along with similar efforts in Tanzania and Burkina Faso, form part of an evolving body of E2A work that increases global awareness of and generates evidence on programming for FTPs. E2A's focus on FTPs was triggered by efforts to understand the diversity of youth reproductive health (RH) experiences and needs. A 2014 review of global data pointed to a large sub-set of young FTMs who are at increased risk of poor pregnancy, delivery, and child health outcomes—a situation compounded by multiple factors that limit their access to timely health information and services. Despite these vulnerabilities, young FTPs have historically been overlooked by adolescent and youth FP/RH programs. As young women and men who have started having children, their needs often extend beyond the scope of many adolescent and youth programs. Similarly, the issues faced by young parents are not typically included in broader programs aimed at women of reproductive age or even married youth. E2A has made it a priority to close this global gap by reaching FTPs in multiple contexts—including CRS, Nigeria—with health and gender interventions and by gathering new evidence on effective programming for this sub-set of youth.

Saving Mothers, Giving Life (SMGL) Initiative

The SMGL Initiative (2014–2019) aimed to increase the coverage and quality of maternal, neonatal, and family planning/reproductive health services, as well as improve delivery outcomes in 108 public and faith-based health facilities in all 18 Local Government Areas of CRS, Nigeria. SMGL focused attention on the most vulnerable period for mother and baby—labor, delivery, and the first 48 hours postpartum—and applied a systems approach to strengthen existing health networks to address the three delays of maternal mortality: delays in deciding to seek appropriate services, delays in reaching those services, and delays in receiving timely, quality care. An additional component of the SMGL Initiative provided comprehensive FP services, with a focus on provision of long-acting reversible contraceptives. Working in partnership with the government of Nigeria and local health facilities and communities, the project was able to surpass its goals. Baseline (2014) and endline (2019) data from participating facilities showed that the project reduced the maternal mortality ratio by 66% and the neonatal mortality rate by 47%, and also increased contraceptive couple years of protection by 869%.

The importance of working with young, vulnerable FTPs also emerged over the course of implementing the SMGL program. Pathfinder Nigeria had been working in partnership with the CRS MOH since 2014 to improve maternal and neonatal health outcomes across the state and to strengthen FP services, including the provision of long-acting reversible contraceptives (LARCs). In the early years of the project, the SMGL team noted that high rates of early childbearing and low use of modern contraceptive methods combined to increase the risk of poor health outcomes for young women, including FTMs.

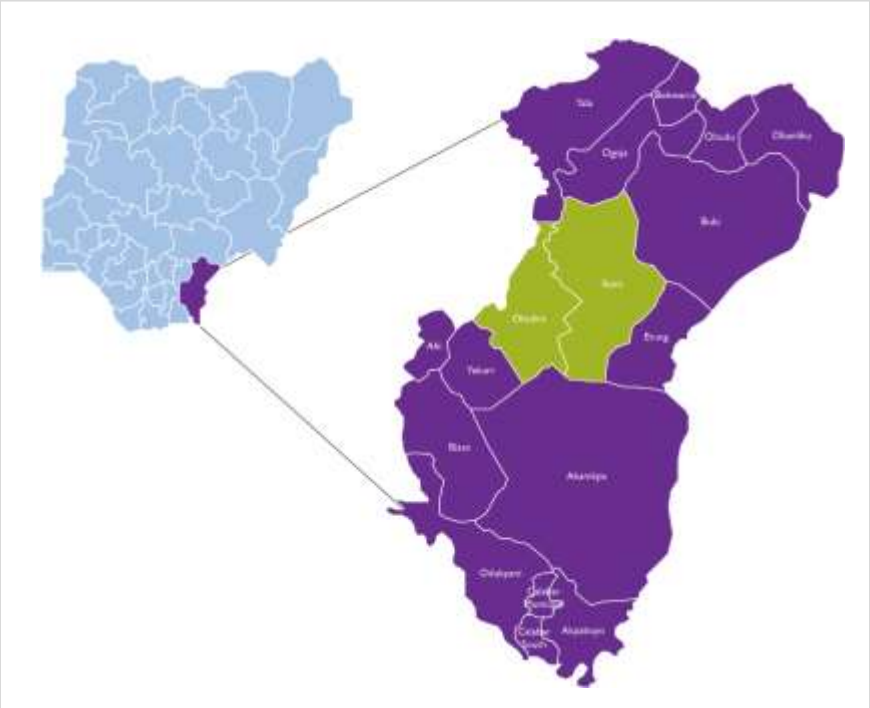
Data from Nigeria and CRS underscore the particular vulnerabilities of young women across multiple health issues. Sexual activity and motherhood begin early, with 18% of adolescent girls in CRS having begun childbearing.[1] Studies in Nigeria and globally show that adolescent pregnancy is associated with higher morbidity and mortality for both the mother and the child.[2] 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 RH issues during the FTP lifestage.[3]

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

[2] O.M. Loto, et al, "Poor obstetric performance of teenagers: Is it age- or quality of care-related?" *J Obstet Gynaecol*, (2004) 24(4):395-8.

[3] NPC Nigeria and ICF International, *Nigeria Demographic and Health Survey 2013*.

Figure 1: Map of Nigeria, showing Cross River State and project local government areas (LGAs)



Young FTMs in Nigeria typically lack sufficient accurate information about RH and MNCH, and are less likely to access maternal health care, specifically antenatal care (ANC) and skilled birth attendance.[4] A rapid review of records from select facilities in CRS showed that FTMs often sought ANC services late in pregnancy, which limited time to screen for risk factors and plan for safe delivery. In CRS, just 40% of deliveries happen at a facility with a skilled birth attendant, compared to a national average of 61%.[5] Postnatal health issues are also a concern. While breastfeeding is nearly universal (98%) in Nigeria, only 17% of mothers exclusively breastfeed their babies (0–6 months).[6] Evidence also shows that both mothers and babies are healthier if at least 24 months have elapsed between the last birth and the next pregnancy (or even 36 months from one birth to the next). However, rapid repeat pregnancies are common in Nigeria, with nearly one-quarter of all children born less than two years after their siblings.[7] This situation is compounded by low rates of modern contraceptive use, especially by young women. Just 27% of

[4] H. Suleiman Adamu, *Utilization of Maternal Health Care Services in Nigeria: An Analysis of Regional Differences in the Patterns and Determinants of Maternal Health Care Use* (Dissertation - University of Liverpool, UK April 2011).

[5] NPC Nigeria and ICF International, *Nigeria Demographic and Health Survey 2013.*

[6] Ibid.

[7] Ibid.

sexually active adolescent girls (15–19 years) in CRS currently use a modern contraceptive method (both married and unmarried).[8] In addition, 15% of married young women and 24% of sexually active unmarried young women in Nigeria have an unmet need for contraception.[9]

The limited use of FP/RH services is partly due to young FTMs' typical lack of control over decision making about their health. Key influencers, such as parents, in-laws, husbands/male partners, or perhaps older co-wives, often drive household decision making as well as health care spending. 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 many youth, adults, and service providers fear that use of any method of FP 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 LARCs, such as the intrauterine device (IUD) or implant.[10]

Young women who want to use contraceptive methods also face barriers on the supply side. These include: shortages of trained providers, contraceptive method stockouts, geographical distance to services, or health care provider biases related to the appropriateness of FP services for particular populations, such as young people. Provider biases can be particularly challenging to change and are based on the provider's own cultural and social norms and his/her observations and related assumptions about a client's personal characteristics, such as age, parity, or marital status.[11]

Finally, childbearing during adolescence frequently has adverse social consequences for young mothers, often foreshortening educational attainment and contributing to their social exclusion. FTMs—especially those who are unmarried—often face additional stigma and discrimination at the community and household levels, which further hinders their access to RH information and services. 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 childbearing, which, in turn, increase their risk of maternal and infant mortality and morbidity.[12] Furthermore, FTMs can quickly become isolated, with household responsibilities and limitations on their mobility keeping them at home and away from health information and services as well as supportive social networks. This isolation can affect their mental health and sense of wellbeing as new mothers.

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[8] Ibid.

[9] Ibid.

[10] O.M. Abiodun and O.R. Balogun, "Sexual activity and contraceptive use among young female students of tertiary educational institutions in Ilorin, Nigeria" *Contraception* 79 (2009): 146–149.

[11] Schwandt et al, "Contraceptive service provider imposed restrictions to contraceptive access in urban Nigeria" *BMC Health Services Research* (2017) 17:278 DOI 10.1186/s12913-017-2223-2.

[12] Extending Service Delivery Project, *Healthy Timing and Spacing 101 Brief* [see Handout 4-1], (Washington, DC).

III. FTP Formative Assessment

E2A conducted a qualitative formative assessment in 2017 to understand more about young FTPs in CRS, their specific FP/RH and MNCH needs, and the underlying gender and social norms that influence their ability to take timely health actions. In-depth interviews and focus group discussions with young FTMs, male partners, older women, and health providers yielded important insights into their experiences.

Key findings and program considerations that emerged from the formative assessment include:

- The FTP lifestage is a time of tremendous uncertainty and change for young women, their partners, and families, affecting all aspects of their lives, including union/relationship status, living arrangements, education, financial needs, and social stigma/isolation.
- FTMs do not make important decisions about their lives and health care independently. Partners and parents, especially the mothers of FTMs, play critical roles in determining if, when, and how positive health action is taken.
- Unmarried and married FTMs differ in their health care use, reflecting financial concerns and broader social stigma. In general, unmarried FTMs have fewer resources available to them and face greater real or perceived discrimination from providers, community members, and even their own family members, which delays or limits health action.
- While there is broad support for breastfeeding, exclusive breastfeeding is not practiced by young FTMs. Feedback from participants note traditional and cultural practices, often controlled by older women, that introduce other foods before the six-month period ends. Excessive infant crying is seen as a sign of hunger, which also leads to early weaning.
- Despite high acceptance for delaying the next birth, participants do not always see contraception as a safe means of spacing subsequent pregnancies. Fears about long-term safety and return to fertility are widely held, limiting actual and intended use of contraception.
- Parenting and childcare roles and responsibilities fall along clear gender lines, with young FTMs and their female relatives, especially the mothers of unmarried FTMs, providing the majority of daily care for babies. Male partners report interacting with their children, although several voice concerns about carrying very young infants.

Formative findings, along with poor health statistics, underscore the importance of working with young FTPs to address their health and wellbeing, and yield the following broad recommendations:

- Work with young FTMs to ensure positive health and gender outcomes throughout pregnancy, delivery, childbirth, and the early life of the child, including addressing HTSP/FP needs to support adequate spacing before the next pregnancy.

- Systematically engage the key influencers—focusing on male partners and mothers of FTMs—to build support for FTM/FTP health action and foster more gender-equitable roles and responsibilities.
- Address community attitudes and norms that can lead to isolation and stigmatization of young FTM/FTPs and hinder health action.
- Tailor FP/RH/MNCH information and service delivery to better reach and serve young FTM/FTPs and their influencers.
- Promote positive parenting and gender-equitable roles in caring for homes and children.
- Incorporate program elements (or link to other ongoing programs) that address educational and economic opportunities for FTMs and their families.

For SMGL, the vulnerable situation of FTPs in CRS highlighted an opportunity to push beyond pregnancy and delivery to address key postpartum priority areas, especially HTSP and FP.

Overview of E2A's Work with FTPs

First-time parents—defined by E2A as young women under age 25 who are pregnant with or have their first child, and their partners—have largely been overlooked in reproductive health programs for youth. Over the past five years, E2A has undertaken several conceptual and programming efforts that detail the FTP experience and explore how best to respond to their complex needs. Milestones of E2A's FTP work to-date include:

- A literature review, *Reaching Young First-time Parents for the Healthy Spacing of Second and Subsequent Pregnancies* (2014), which highlights the lack of programming dedicated to this vulnerable population;
- A technical consultation with 30 health and gender experts to outline the programmatic components, strategies and considerations for an integrated package of interventions for FTPs (2014);
- The development of a conceptual framework, which applies a lifestage and socioecological lens to explore the FTP experience (2017);
- Documentation of results and lessons learned from FTP programs aimed at reducing the social isolation of young FTMs and increasing their knowledge of and access to FP/RH services in Burkina Faso (Pathfinder International, 2013), Nigeria (E2A/Pathfinder, 2014) and Tanzania (E2A/Pathfinder, 2014);
- New programs in Burkina Faso, Nigeria, and Tanzania that expand FTP programming with FTMs, male partners, and other influencers and gather evidence on health and gender outcomes (2017-present).

IV. SMGL FTP Component

Launched in 2018, the new FTP component built on the strong facility and community platforms already established by SMGL in two of the 18 local government areas (LGAs) where the project operated, Ikom and Obubra. This included improved maternal, neonatal, and FP services at public and faith-based health facilities, and community-led activities to address the three delays associated with poor maternal health outcomes. A local community-based organization (CBO), Greater Hands Foundation (GHF), supported community-based MNCH/FP-related activities, 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 engage young FTPs and build their agency and a supportive environment for positive health action.

In designing the FTP component, E2A applied both lifestage and socioecological lenses to determine the appropriate content and structure.[13] Given that SMGL was already addressing antenatal and delivery outcomes, E2A and Pathfinder Nigeria decided to prioritize the postpartum phase of the FTP lifestage. Interventions focused on advancing FP, exclusive breastfeeding, positive parenting and related gender outcomes for young FTMs and their male partners. The FTP component also sought to strengthen the support of multiple influencers and systems for positive health action by young FTM/FTPs, including addressing the underlying gender and social norms that influence FTP relationships, choices, and actions.

The SMGL FTP component was guided by four broad objectives, aligned closely with E2A's global FTP approach:

1. Improve the capacity of Community Volunteers to provide health counseling and referrals for FTMs/FTPs at community level;
2. Strengthen the capacity of FTMs/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 FTMs/FTPs;
4. Contribute to the global evidence base on effective strategies to reach FTMs/FTPs with community-based FP information and services.

SMGL FTP Priority 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.

To meet these objectives, the team implemented a package of interventions across multiple levels of the FTP socioecological model to improve health-related knowledge, attitudes, communication, decision making, and service use by young FTM/FTPs. The component centered on small peer group activities with young FTMs to build their health agency and facilitate access to facility- and community-based services. It also included group activities with the male partners of FTM peer group members to foster healthy relationships and promote couples communication and joint decision making. Specific activities were included to generate evidence on both the implementation experience and on health and gender outcomes for FTMs and their male partners emerging from this programming effort. This report focuses on the first round of FTP activities implemented in 16 facilities and 37 communities through multiple

[13] For more information on E2A's FTP Framework, see https://www.e2aproject.org/publication/ftp-framework/

community-based resource persons, with supervision by Pathfinder Nigeria staff working on the SMGL project and technical support from E2A in Washington, DC.[14] The SMGL team coordinated all planning and implementation with the CRS MOH at central and LGA levels. SMGL and CBO staff provided close supervision of all FTP activities through routine meetings and reports, as well as field visits. Preparations for FTP activities began in early 2018, with the main period of implementation occurring from May through September 2018 and data generation continuing through the end of the year.

The following section presents the main interventions included in the SMGL FTP component, including capacity building and data generation (see Table 1).

[14] A second round of FTP activities was implemented in Ikom and Obubra in 2019, informed by the implementation learnings and program results presented in this document.

Table 1: SMGL FTP Interventions

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.

Community Volunteer Recruitment, Capacity Building, and Roles

SMGL CBO partner, GHF, had already established community-based networks and activities across Ikom and Obubra, and the new FTP component largely expanded this local capacity to implement activities with FTPs and their communities. Under SMGL, GHF had engaged CVs, drawn from their communities, who were trained to conduct MNCH and FP awareness raising activities, conduct home visits, and provide referrals to participating health facilities. However, given the high level of clinical knowledge and facilitation

skills needed to implement planned FTP activities, the SMGL and CBO team decided to recruit unemployed certified Community Health Extension Workers (CHEWs) to serve as FTP CVs. These CHEWs lived in the wards where the FTP component was implemented and were identified through the MOH, Primary Health Care Development Agency, training schools, and health facilities (especially those that had unemployed CHEW volunteers). After screening by the SMGL and CBO teams, 25 CVs, including a mix of women and men, were engaged by GHF to implement multiple FTP activities. SMGL and CBO staff conducted trainings on priority health issues, including: danger signs and three delays during pregnancy; HTSP and FP; exclusive breastfeeding; positive parenting; and gender norms and barriers to accessing services. Project roles and responsibilities (community awareness building, home visits, referral systems, linkages with facilities, monitoring reports, etc.) were also addressed.[15] As FTP interventions were rolled out, CVs received additional trainings on the peer group intervention (alongside peer leaders), the male partner group sessions, and sessions with older women. Each CV received a monthly stipend of 20,000 *naira* (approximately US $55) and a monthly transport allowance. CVs were directly supervised by GHF and worked closely with project staff to review progress and address challenges.

CVs were involved in every element of the FTP component and were the lynchpin connecting the different interventions. Each CV was responsible for:

- Coordinating with health facility staff on community activities and referrals;
- Liaising with community leaders and members regarding activities under the FTP component;
- Supporting two FTM peer groups in his/her community;
- Facilitating sessions with male partners;
- Conducting sessions with older women;
- Conducting home visits with FTM peer group members;
- Supporting project tasks, including monitoring reports and monthly review meetings;
- Coordinating data collection with project and research teams.

Community and Facility Orientations

As all facilities and communities were already involved with SMGL, FTP orientations focused on raising awareness about FTP needs and circumstances (drawing from available data and formative research) and FTP interventions. SMGL staff conducted orientations at participating facilities. Meetings with community leaders and members were conducted by GHF staff and CVs prior to the start of activities. These orientations also provided an opportunity to introduce new FTP CVs and begin the process of identifying potential young FTM peer leaders (PLs).

[15] As CVs were not yet within the formal MOH CHEW cadre, they could not provide contraceptive methods, but could counsel and refer for all MNCH/FP issues.

FTM Peer Leaders and Peer Groups

FTM peer groups formed the heart of the SMGL FTP component and have been part of E2A's FTP approach across multiple settings. The groups are grounded in the concept of creating safe spaces, peer networks, and role models for young women to learn and share. Fifty peer groups were established—24 in Ikom and 26 in Obubra. Groups were led by young women who met the criteria set by CBO and project staff, including: 1) FTMs (under 25 years with one child, and not pregnant with second child); 2) living in the localities identified for peer groups (and intending to stay at that location for at least six months); 3) literate in English; 4) demonstrated leadership skills, including strong communication skills; 5) able to prepare for, conduct, and report on peer group meetings; and 6) available to participate in monthly review meetings. Criteria were shared through community networks (e.g., community and women's leaders, participating facilities) to help identify potential PLs.

Fifty young FTMs were recruited to serve as volunteer PLs, with each one responsible for one peer group in her community. Project and CBO staff trained PLs on multiple topics including: basic MNCH/FP information, facilitation skills, a set of 14 activity cards that functioned as the peer group curriculum, and broader project tasks (e.g., maintaining group attendance records). Importantly, CVs also participated in this training, allowing PLs to begin building a connection with their primary resource person and also ensuring that CVs were fully aware of the technical content and gender/social issues being addressed in peer groups.

Topics Addressed in FTM Peer Groups

- Healthy timing and spacing of pregnancy
- Problem solving in intimate relationships
- Life aspirations
- Contraceptive methods: implants, injectables, oral contraceptive pills, condoms, emergency contraception
- Gender norms
- Communication and decision making among couples
- Desired family size
- Gender-based and intimate partner violence
- Exclusive breastfeeding
- Positive parenting

Once training was completed, PLs and CVs returned to their communities and began recruiting peer group members through their community contacts and peer networks. Criteria for eligibility included: age (under 25 years), parity (pregnant with or having one child) and living within the peer group location. The 50 peer groups met weekly from May to August 2018, conducting a total of 16 sessions. Groups convened within their communities, using churches or other structures as meeting spaces. On average, each group had approximately 12–15 members, with almost 600 young FTMs attending sessions over the four-month period. The CBO provided a small transport allowance to facilitate travel to and from the 16 planned peer group meetings. While the first and the last meetings were primarily for conducting baseline and endline surveys, the middle 14 "content" sessions addressed priority health and gender issues, such as HTSP, different modern

contraceptive methods, and problem solving within relationships. For the most part, activity cards were adapted from the GREAT toolkit, but E2A also designed two new cards, one on exclusive breastfeeding and the other on positive parenting.[16] As per intervention design, PLs facilitated one card per session, with each meeting lasting approximately 1.5 hours. CVs generally attended all sessions to answer questions and schedule home visits, often sitting in the background as groups conducted activities and stepping in only when needed.

CVs were responsible for daily supervision of PL activity. CBO and project staff also conducted visits to review activities and help troubleshoot any issues. Monthly meetings in each LGA also provided an opportunity for PLs, CVs, and staff to gather information and data on peer groups, address capacity building or informational needs, and plan activities for the next month.

Small Group Sessions with Male Partners

The SMGL FTP component provided an opportunity to develop a more structured intervention with the male partners of FTM peer group members. Given the high percentage of 'never married' FTMs and the range of FTP partnerships, the team opted not to conduct joint sessions with the FTMs and male partners, but instead developed a separate intervention that explored the same priority health and gender topics. Unlike the FTMs, no selection criteria (e.g., age, marital status) was set for the men, aside from being identified as a male partner by a peer group member. Noting the potential sensitivities of bringing together different categories of men (e.g., married vs. unmarried, older vs. younger) to explore sensitive topics, the project team decided that CVs should facilitate the male intervention, as their status as community resource persons could help overcome any inhibitions felt by male participants.

By design, the male partner intervention began after the FTM peer groups, allowing time for FTMs to identify any husbands or partners they wanted to invite to the program. 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 240 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.[17] The session plans, developed by E2A, were highly participatory and included a variety of activities and discussions. The first and last sessions included time for baseline/endline data collection, but also addressed content issues. Male partner sessions typically lasted 1.5 to 2 hours—longer than the FTM

[16] 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.

[17] Given uncertainties about the number of FTMs who have a male partner and men's interest in participating in the groups, the project team set the number of male partner groups at 20.

peer group meetings—given the volume of information/activities to cover. The six sessions were conducted from July to late August 2018.

Outreach Sessions with Older Women

Given the importance of working with key influencers, the SMGL FTP component included structured activities with older women related or linked to FTM peer group members. As with male partners, the older women intervention was phased in later, after both the FTM peer groups and male partner activities were well underway. The FTMs identified potential participants—primarily their own mothers, but also their mothers-in-law, aunties, sisters, and other close females. Unlike the FTM and male partner interventions, sessions with older women were not intended to be fixed groups. Instead, the sessions were kept flexible to allow women to attend as their interests and availability allowed, although they were encouraged to attend as many as possible. Three sessions were developed by E2A and conducted by CVs in August. They focused on postpartum health issues that are heavily influenced by these women, particularly HTSP/FP and exclusive breastfeeding (as highlighted in the formative findings). These sessions were primarily for sharing health information and addressing questions, but also included a few activities that encouraged older women to reflect on their own experience as young FTMs and build support for health agency and action by their daughters/daughters-in-law. A total of 1,613 women participated in the sessions, with many attending all three.

Household Visits by CVs

As noted above, home visits were a cornerstone activity of the FTP component. SMGL had established a tool for home visits during pregnancy, immediately after delivery, and six weeks postpartum to support maternal and infant health outcomes. The FTP component extended home visits further into the postpartum period for FTM peer group members and focused primarily on HTSP/FP information, counseling, and referral services, but also addressed other pre- or post-natal issues as relevant. CVs conducted 4–6 home visits with each peer group member from May to September 2018, often at the request of the FTM (or male partner) or as a follow-up to an earlier conversation or referral. As much as possible, CVs tried to engage male partners, older women, and other household members, and often helped to address different or conflicting perspectives on possible health actions. Home visits accounted for the large majority of FP referrals given and completed.

Facility-based FP Services

Through SMGL, the 16 health facilities participating in the FTP component already had the capacity to address the range of health services needed by FTM/FTPs—from ANC, through delivery, to FP and immunization. Providers had also been trained on youth-friendly service provision, including an orientation

on FTPs. As CVs were not able to provide contraceptives, referrals and linkages to facility providers were a critical element in ensuring that all program participants had access to the full range of relevant MNCH and FP/RH services, including all modern contraceptive methods. In addition, facility staff conducted mobile outreach, bringing FP and other services into the communities and increasing access for all clients, including FTPs.

FTP Component Data Collection

Multiple forms of data collection and analysis took place over the course of the FTP intervention to track the implementation process and also determine if health and gender outcomes were achieved. The main data sources included: 1) quantitative survey data collection at baseline and endline with FTMs and male partner program participants; 2) CV reports and referral data; 3) health facility data and referral tracking; 4) monthly team meeting and field visit reports; and 5) implementation team review meeting. Details about relevant data generation is presented in two different sections of this report, as follows:

- *Health and Gender Results (Section V):* this section primarily includes quantitative data collected through baseline and endline surveys with FTM and male partner program participants;
- *FTP Implementation Learnings (Section VI):* this section draws key learnings extracted from monitoring data and the direct experience of the implementation team, including PLs, CVs, and project and CBO staff.

V. SMGL FTP Results

The SMGL FTP component included data generation to capture progress in achieving priority postpartum health and gender outcomes of interest. Baseline and endline surveys were conducted with FTM peer group and male partner group participants, covering multiple topics including: 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 methodology and main results are presented below, with additional details and data tables included in the annexes.

Summary of SMGL FTP Results

1. The program attracted and retained FTPs from a diverse range of key sociodemographic characteristics, such as age and marital status.
2. Birth spacing timeframes increased from baseline to endline, indicating that FTPs now intended to wait three or more years before having another child.*
3. 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.*
4. 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.*
5. Couples communication on FP (past three months) increased significantly from baseline to endline. Reported discussions 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%.*
6. Joint decision making about FP use was reported by both FTMs and male partners at baseline and further reinforced at endline. At baseline, 82% of FTMs and 87% of male partners reported that they decided together to use FP; by endline, this had significantly increased to 96% of FTMs and 99% of male partners.*
7. Gender-equitable attitudes towards household roles and decision making changed positively for both FTMs and male partners, even with a relatively short intervention period. For example, the percent of male partners who 'strongly agreed' that they have the final say in all decisions in the home decreased significantly from 46% to 24%; FTMs who 'strongly agreed' that partner/husband had the final say also decreased significantly from 56% to 32%.*
8. Current voluntary use of modern contraceptive methods increased significantly over the course of the intervention, going from 26% to 79% among non-pregnant FTMs, and from 43% to 78% among male partners.**
9. Voluntary use of injectables and implants increased over the course of the intervention among FTMs, with implant use increasing from 17% to 65% and injectable use increasing from 2% to 8%.*
10. 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 to 95% at endline.*
11. Both FTMs and male partners demonstrated improved knowledge and attitudes about infant care/parenting attitudes and behaviors. For 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 to 49% at endline.*
12. Both FTM and male partner 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.

*p<.000, Pearson chi-square test of significance

**significant bivariate results confirmed through logistic regression analysis

Methodology

This pre-test/post-test study examined the effectiveness of a community-based FTP intervention for young FTMs and their male partners in Ikom and Obubra local government areas of Cross River State, Nigeria, in improving postpartum FP uptake, related FP attitudes, exclusive breastfeeding, couples communication, and gender equitable relationships. 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 at baseline before content sessions took place and at endline after the program concluded 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 asked to sign a consent form (with provisions for thumbprint signatures). Signed consent was obtained and a copy given to participants. Interviews were conducted in either English or Pidgin language, and refreshments and transport reimbursement were provided to the study participants. A full description of the methods and limitations may be found in Annex A. The final achieved sample size is shown in Table 2 (below).

Table 2: Criteria for selection of respondents and achieved sample size

Selected Participants	Baseline		Endline	
	Ikom	Obubra	Ikom	Obubra
First-time Mothers: At least 10 FTM members of selected project peer groups were sampled at baseline and endline in both LGAs	15 out of 24 peer groups randomly selected at baseline; total of 150 FTMs randomly selected from each of the 15 groups	17 out of 26 peer groups randomly selected at baseline; total of 188 FTMs randomly selected from each of the 17 groups	The same 15 peer groups selected at baseline were interviewed at endline; total of 149 FTMs randomly selected from each of the 15 groups	The same 17 peer groups selected at baseline were interviewed at endline; total of 190 FTMs randomly selected from each of the 17 groups
Male Partners of FTMs: All male partners participating in CV-led discussion groups in both LGAs were selected for the study and interviewed	All (census) 10 male partner groups selected at baseline; all members of each group interviewed at baseline for a total of 123 male partners interviewed	All (census) 10 male partner groups selected at baseline; all members of each group interviewed at baseline for a total of 122 male partners interviewed	All (census) 10 male partner groups selected at baseline; all members of each group interviewed at endline for a total of 114 male partners interviewed	All (census) 10 male partner groups selected at baseline; all members of each group interviewed at endline for a total of 111 male partners interviewed

RESULT 1: The program attracted and retained FTPs from a diverse range of key sociodemographic characteristics, such as age and marital status.

Survey data provided rich information about the characteristics of young FTPs who joined and stayed engaged in FTP interventions, including their sociodemographic background and their access to financial support for health care. While there was some criteria set for FTM peer group members (under 25 years, pregnant with or having 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.

Sociodemographic Characteristics

Table 3 below presents select background characteristics of FTMs and male partners engaged in the SMGL FTP component (additional information is presented in Annex B). Almost all FTMs were within the required age limit at baseline, with roughly 63% aged 20–24 years and 29% aged 15–19 years, with a mean age of 20.6 years. Male partners were more likely to be older (mean age of 27 years), with 29% aged 30 years and older at baseline. Most FTMs reported that they were not married/living with their partner

(63%, n=228) at baseline, while 69% of male partners reported that they were either married or living with their partner at baseline. The majority of FTM participants (86%) had one child with a mean age of 6.9 months at baseline, with another 14% pregnant with their first child. Interestingly, the data also show that most (90%) male partners enrolled in the program were first-time fathers.[18] A majority of both FTMs and male partners who participated in the FTM program reported completing secondary or a higher level of education. While most (83%) male partners reported being currently employed at baseline, only about one-third of FTMs (36.1%) reported working at baseline, likely due to their recent pregnancy and delivery.

There were a few significant differences among FTMs between baseline and endline in some of these variables. Among FTMs, mean age and marital status were significantly different at baseline and endline. FTMs at endline were slightly older (21.1 years) than at baseline (20.6 years), perhaps largely due to the 4-month interval between data collection efforts. Interestingly, by endline, FTMs were more likely to be in union or married (45%) and were more likely to be working to earn money (57%). No significant differences were noted among male partners from baseline to endline with respect to these key demographic variables.

[18] While having one child was set criteria for enrollment of FTMs, it was not a criterion for enrollment of male partners.

Table 3: Percentage distribution of age, marital status, LGA, and education level by baseline/endline and participant group

Variable (number of cases)	FTMs		Male Partners	
	Baseline (n=338)	Endline (n=339)	Baseline (n=245)	Endline (n=225)
Age	(n=313)	(n=336)	(n=245)	(n=225)
15–19 years	28.7%	28.3%	2.0%	.9%
20–24 years	62.7%	67.8%	28.6%	30.2%
25–29 years	1.2%	2.7%	40.4%	39.1%
30 years plus	0.0%	0.3%	29.0%	29.8%
Don't know/missing	7.4%	0.9%***	0.0%	0.0%
Mean age (years)	20.60	21.05*	27.30	27.40
Marital status	(n=338)	(n=339)	(n=245)	(n=225)
Never married	62.7%	53.1%*	31.4%	31.6%
Living with partner/married	37.3%	45.4%*	68.6%	68.5%
Divorced/Sep/Widowed	0.0%	1.5%*	0.0%	0.0%
Number of living children	(n=338)	(n=339)	(n=245)	(n=225)
0	14.5%	7.7%	9.8%	4.4%
1	85.5%	92.0%	85.3%	90.2%
2	0.0%	0.3%*	4.9%	5.3%
Residential arrangement	(n=338)	(n=339)	(n=245)	(n=225)
Currently lives with partner	45.0%	43.4%	74.3%	72.9%
Education level	(n=338)	(n=339)	(n=245)	(n=225)
Primary	13.9%	10.9%	7.8%	9.3%
Junior Secondary (completed)	35.2%	36.6%	20.4%	16.9%
Secondary (completed)	47.6%	45.4%	51.8%	55.1%
Polytechnic	1.8%	2.9%	4.1%	3.1%
University	1.5%	4.1%	15.9%	15.6%

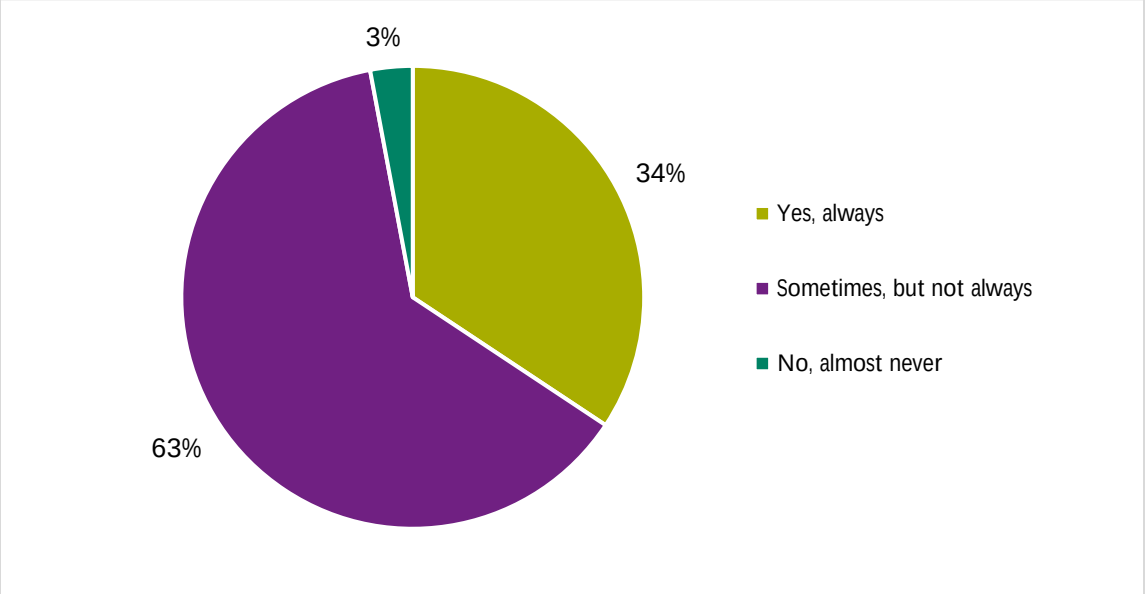
****p value<.000; ** p value<.01; * p value<.05*

Access to Financial Support

The study included questions regarding sources of financial support and accessibility of this support for FTM health care needs, providing possible insights into the relative independence and agency that FTMs have to seek services, including FP. About 70% of FTMs mentioned that their partner provided money for their health care needs (regardless of marital status, data not shown). This suggests that while FTMs may not be married or living with their partner, male partners are an important source of financial support for FTM health care needs. While partners may be an important source of support, Figure 1 shows that it is not always easy for FTMs to access this support. At baseline, 63% of FTMs reported that they can get support "sometimes, but not always" for their own health care needs. However, those relying on a partner or parent-in-law are nearly twice as likely (39%) to say that they "always" are able to get their health care

needs met, compared to FTMs relying on themselves, their own parent, or other person/source (20%, data not shown).

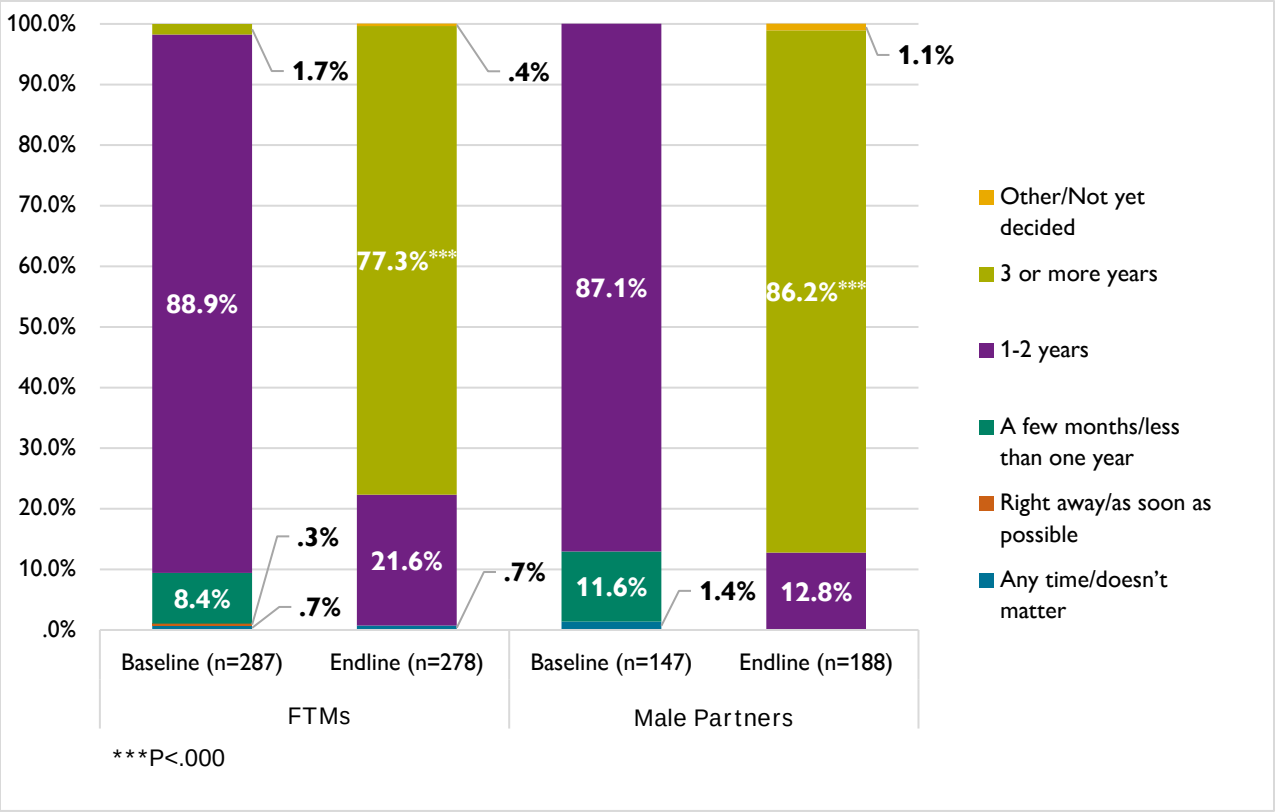
Figure 1: Percent of FTMs who can access financial support for health care when needed (Baseline: n=338)



RESULT 2: Birth spacing timeframes increased from baseline to endline, indicating that FTPs now intended to wait three or more years before having another child.

One of the key messages of the SMGL FTP program was to encourage a spacing gap of three years or more between births. Figure 2 shows that among FTMs and male partners who wished to have another child, 89% of FTMs and 87% male partners at baseline wished to have another child in 1–2 years. At endline, 77% of FTMs and 86% of male partners preferred to wait 3 years or longer ($p<.000$ for both comparisons, Pearson chi square test). Importantly, there was generally an alignment in birth spacing intentions for both FTMs and their male partners.

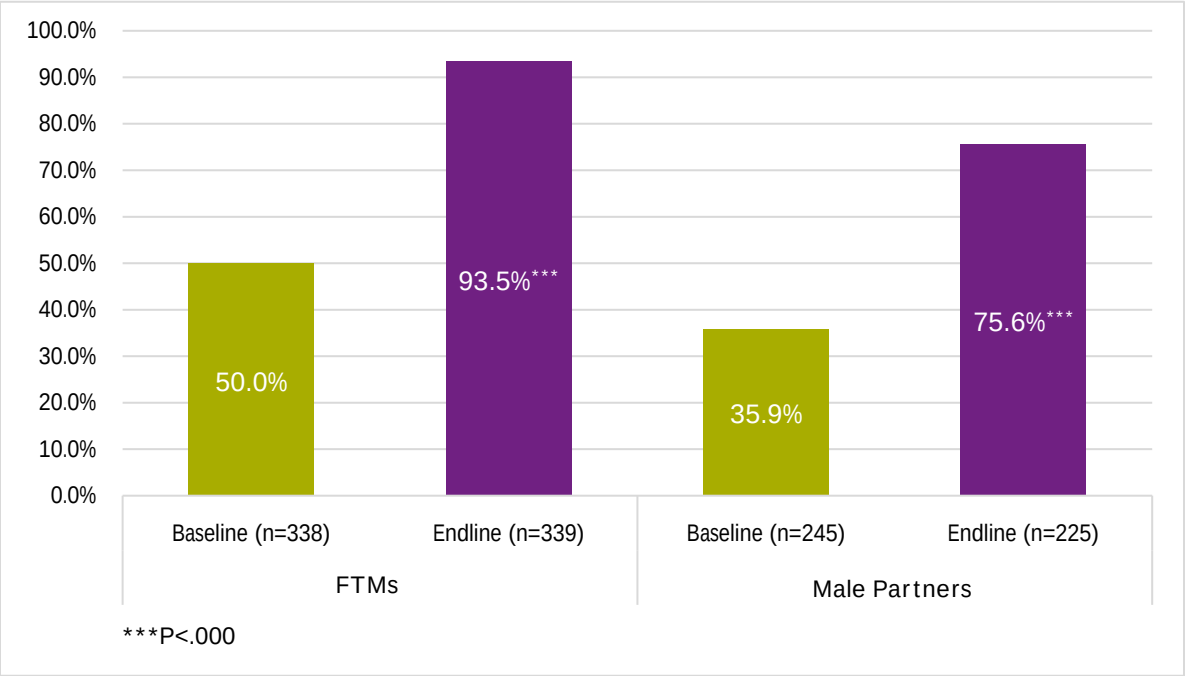
Figure 2: Among those who wish to have another child, preferred timing of next child, by participant group and baseline/endline



RESULT 3: 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.

Knowledge and use of postpartum FP were critical topics of emphasis for the SMGL FTP component. The percent of FTMs and male partners who could spontaneously recall at least three modern methods nearly doubled over the life of the program, increasing significantly among FTMs from 50% at baseline to 94% at endline (p<.000), and among male partners from 36% at baseline to 76% at endline (p<.000). Awareness of specific methods increased significantly before and after the program among both FTMs and male partners for nearly all methods. Additional data on awareness of specific methods by baseline/endline and participant group is presented in Table B-2 in Annex B.

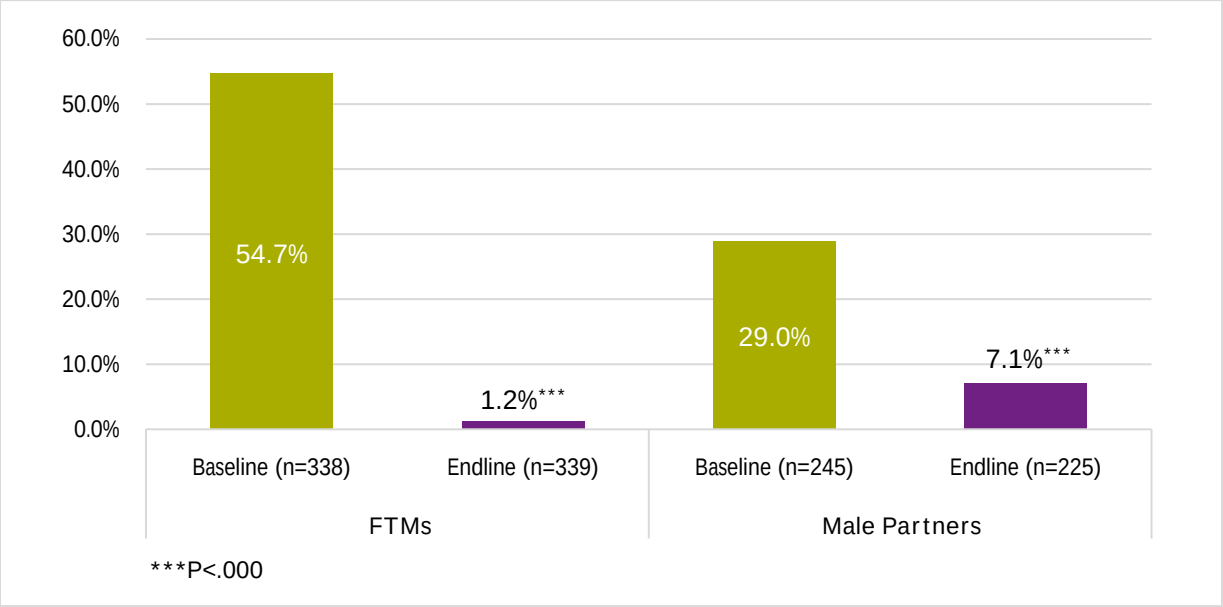
Figure 3: Percent who can name at least three modern contraceptive methods



RESULT 4: 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.*

Baseline and endline data explored several key attitudes about FP that could hinder FTP willingness and ability to use a modern contraceptive method. A key finding from the formative research conducted prior to the SMGL FTP effort was that many FTMs and their male partners believed that using contraception can damage a woman's reproductive organs and create difficulties in conceiving or can even cause permanent sterility after discontinuation. Thus, most believed that it is best for a woman to use FP for limiting only after achieving one's desired family size. Correcting this misconception was one area of focus throughout all FTP activities under SMGL. Figure 4 below presents the percent of interviewed participants who held this belief at baseline and endline. 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 (p<.000, Pearson chi-square test of significance).

Figure 4: Percent **who agree that using contraceptives may negatively affect one's ability** to have children in the future



Husbands' or partners' approval for using a method of contraception (or perceived approval by FTMs) may also be a critical factor in facilitating acceptance and uptake of FP among married/in union FTMs. FTMs were asked if they thought that their husband/partner would approve if they wanted to use a method of contraception to space their next child, and male partners were asked if they themselves would approve of their wife/partner using a method of FP, as well as whether or not they would give her money to seek FP services. At baseline, only about two-thirds (67%) of the FTM participants thought that their partner would approve of their use of FP to space their next child, which increased significantly to 80% (p-value<.000, Pearson chi-square test) at endline. Male partners, however, were much more likely to approve at baseline (90%), and this did not change significantly at endline (94%). All (100%) male partners agreed that they were willing to support their female partner/wife with money to seek services at endline, which significantly increased from baseline (87%, p-value<.000, Pearson chi-square test).

Table 4: Percent distribution of FP attitudes by baseline/endline and participant group

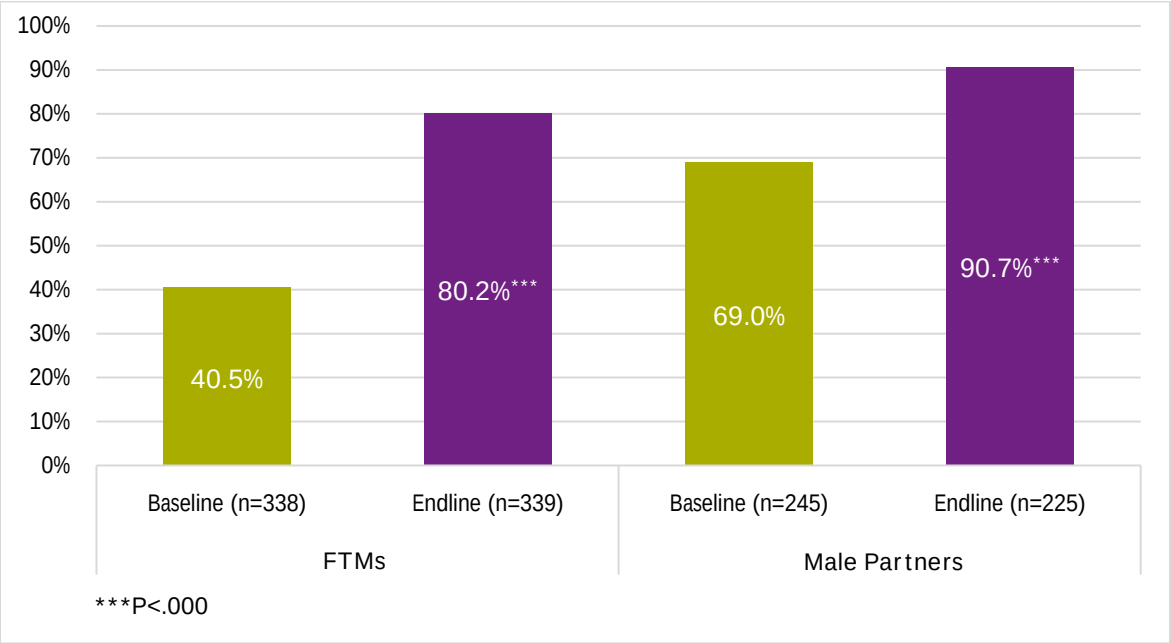
Variable	FTMs		Male Partners	
	Baseline (n=338)	Endline (n=339)	Baseline (n=245)	Endline (n=225)
Percent who (agree that husband/partner) would approve of using FP to space next child	66.9%	79.6%***	89.8%	93.8%
Percent who would give wife/partner money to seek services if she wanted to use FP to space her next birth			87.3%	100.0%***

***p value<.000

RESULT 5: Couples communication on FP (past three months) increased significantly from baseline to endline: reported discussions 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%.

Having discussions with one's partner or other influential person is often associated with interest in and use of FP. The SMGL FTP program included activities and discussion around partner communication on FP and birth spacing. Figure 5 (below) presents baseline and endline data on discussions about FP with partners and other influencers among both FTMs and male partners. Reported discussions about FP among FTMs (regardless of marital/union status) doubled from baseline (41%) to endline (80%, p-value<.000) and increased significantly among male partners from 69% to 91% (p-value<.000, Pearson chi square). Discussions among FTMs and male partners with other influential persons also increased from baseline to endline (data not shown); from 28% to 55% for FTMs (p-value<.000) and from 17% to 42% for male partners (p-value<.000). When asked with whom they discussed FP in the past three months, FTMs were most likely to report discussing FP with a mother (43%), sister (34%), or friend (51%) at endline (n=187, data not shown); male partners were most likely to discuss FP with a friend (74%) or a brother (21%) at endline (n=95, data not shown).

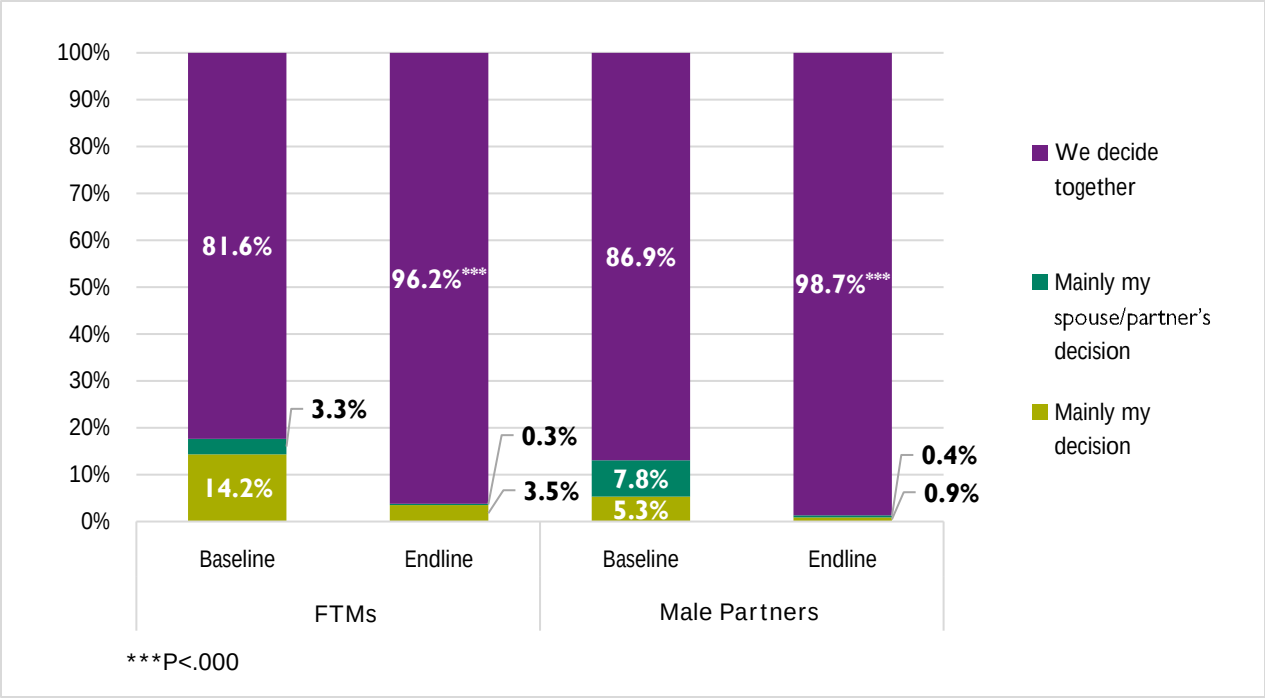
Figure 5: Percent who have discussed FP with their partner as a way to space children in past three months by baseline/endline and participant group



RESULT 6: Joint decision making about FP use was reported by both FTMs and male partners at baseline and further reinforced at endline.

Both FTMs and male partners were asked at baseline and endline about decision making responsibility related to FP (see Figure 6 below). The percentage of FTMs and male partners who reported that they decided together to use FP was high even at baseline: 82% (n=338) of FTMs and 87% (n=245) of male partners agreed that using FP was a joint decision before the intervention. However, this percentage significantly increased for both participant groups by endline; 96% (n=339) of FTMs and 99% (n=225) of male partners agreed that using FP was a joint decision by the end of the intervention (p-value<.000 for both groups, Pearson chi-square test). Perhaps even more importantly, relatively few FTMs reported that husbands/partners were the primary decision maker about FP, suggesting that contraceptive use was largely voluntary for these young women.

Figure 6: Decision making responsibility regarding using FP, by baseline/endline and participant group



RESULT 7: Gender-equitable attitudes towards household roles and decision making changed positively for both FTMs and male partners, even with a relatively short intervention period.

One of the objectives of the FTP program was to increase gender-equitable attitudes toward household roles, baby care, and couples decision making more generally. In order to measure gender-equitable attitudes toward household roles and decision making, items from the domain "Domestic chores and daily life" in the *Gender Equitable Men* ("GEM") scale, developed by Pulerwitz and Barker (2008)[19] were adapted for this evaluation and expanded based on findings from the formative assessment.[20] Eleven statements (both negatively and positively worded) measuring household roles and six items on general decision making were included, and a four-point response scale (strongly agree, agree, disagree, and strongly disagree) was employed. During data analysis, negatively worded items were reverse coded for scale consistency and responses were coded so that strong agreement with gender equitable statements had a higher score, and strong disagreement was assigned a lower score. The final women's scale included 12 items and had an acceptable Cronbach's alpha score of .606; the male partner scale included 16 items and

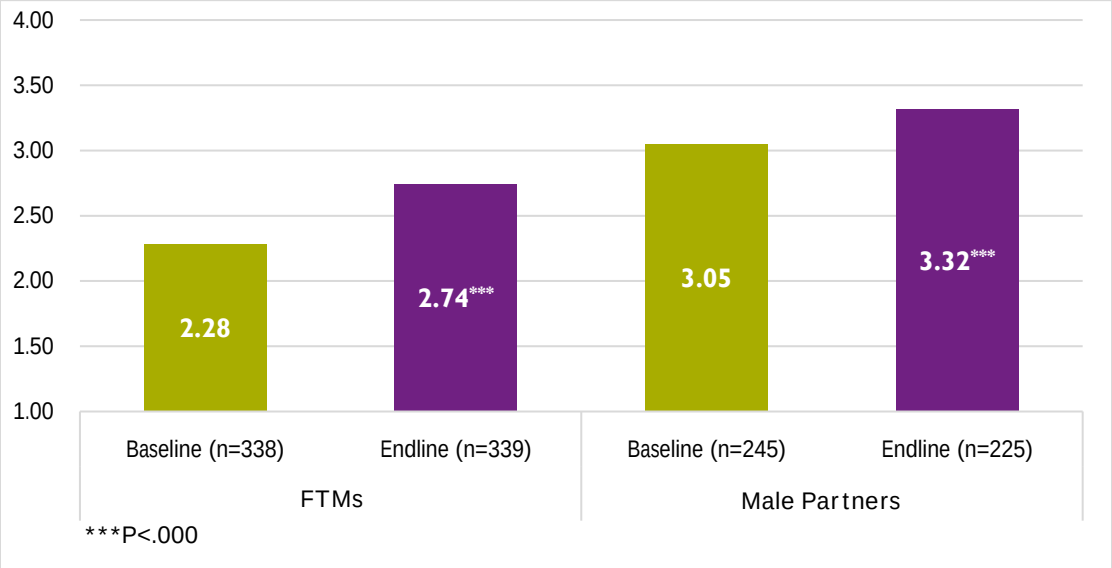
[19] Pulerwitz, Julie, and Gary Barker. "Measuring attitudes toward gender norms among young men in Brazil: development and psychometric evaluation of the GEM scale." Men and Masculinities 10.3 (2008): 322-338.

[20] GEM scale items pertaining to violence, sexual relationships, homophobia, or reproductive health and disease prevention were not included in this study, since these were not addressed in-depth across FTM and male partner activities.

also had a similar Cronbach alpha score of .642. These items and frequency distributions are presented in Tables B-4–B-5, Annex B.

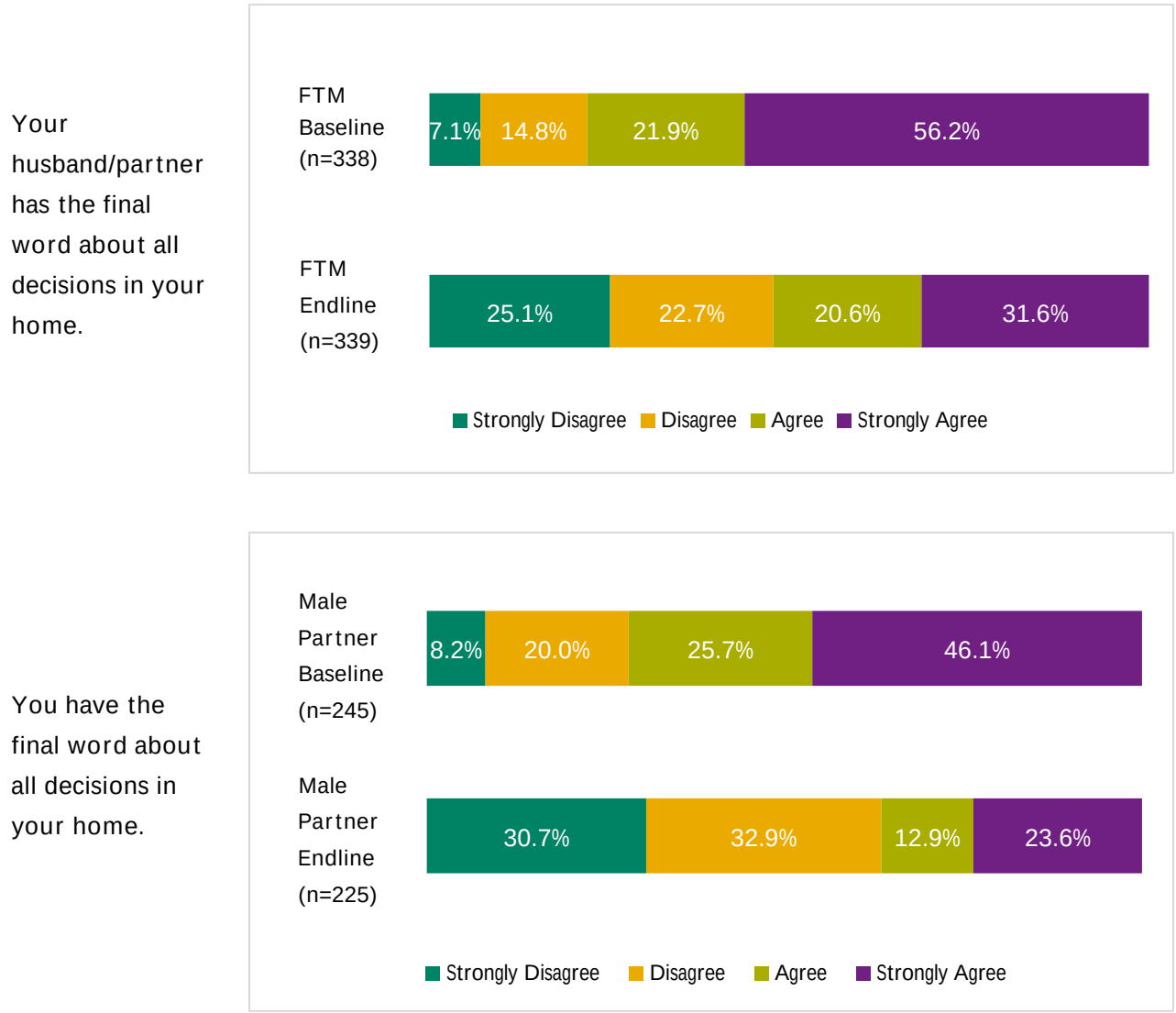
While reported joint decision making regarding FP use was already quite high at baseline, attitudes towards more general household decision making were less egalitarian at baseline. Figure 7 below shows that over the course of the program, the modified GEM scale score significantly increased in a more gender-equitable direction, from 2.28 (n=338) at baseline to 2.74 (n=339) at endline among FTMs, and from 3.05 (n=245) at baseline to 3.32 (n=225) among male partners. This means that gender equitable attitudes significantly improved among both FTMs and their male partners over the course of the relatively short intervention.

Figure 7: Mean GEM scale scores, by participant group and baseline/endline



An example of change over time on an individual GEM attitude/item from these scales is shown below in Figure 8. This item is part of both the FTM and male partner final GEM scales and was concerned with whether the male partner/husband had "the final word" about household decision making. As shown in Figure 8 below, the percentage who agreed or strongly agreed with the statement "your husband/partner has the final word about all decisions in your home" decreased significantly from baseline to endline for both FTMs and male partners.

Figure 8: Percent distribution of GEM scale item ("final word"), by participant group and baseline/endline

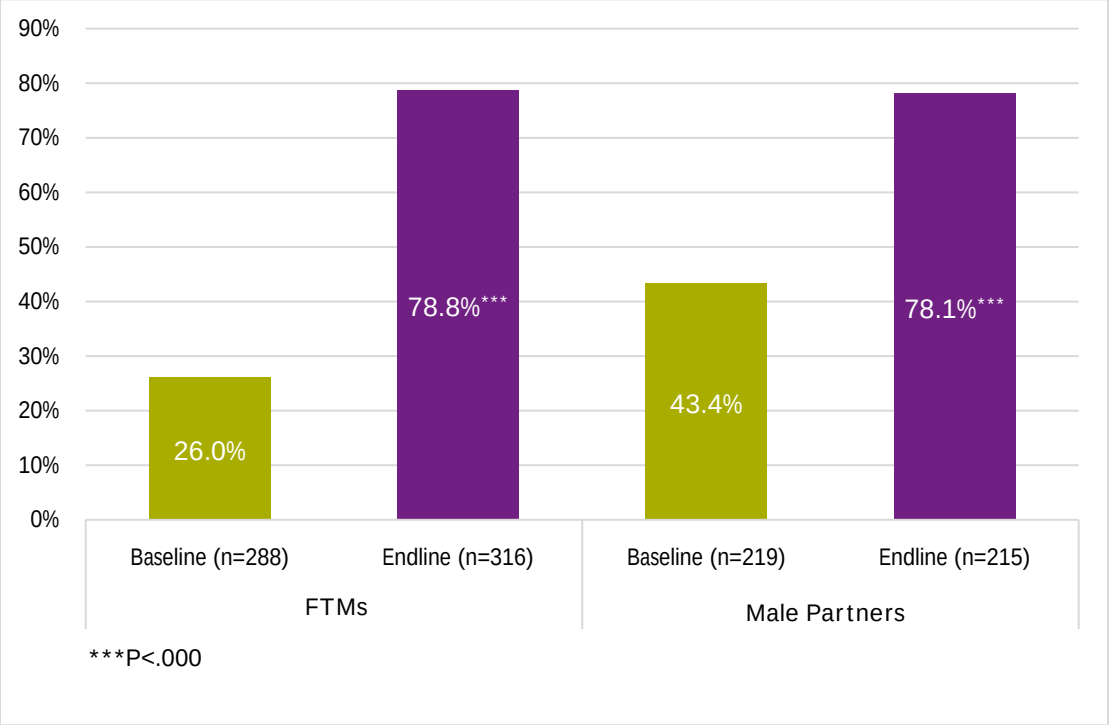


RESULT 8: Current voluntary use of modern contraceptive methods increased significantly over the course of the intervention, going from 26% to 79% among non-pregnant FTMs, and from 43% to 78% among male partners.

The key objective of the FTP program was to increase voluntary use of a modern contraceptive method. All interviewed participants were asked if they had used any modern contraceptive method before they became pregnant with their first child. At baseline, 41% of FTMs and 76% of male partners had ever used a method of FP before their partner became pregnant, mostly male condoms (data not shown). Figure 9

(below) shows that current use of FP among both FTMs and male partners significantly increased from baseline to endline. Current use increased from 26% to 79% among non-pregnant FTMs, and from 43% to 78% (n=215) among male partners (p-value<.000 for both groups, Pearson chi-square test). Importantly, other positive changes in FP knowledge, attitudes, communication, and decision making all support the overall increase in informed, voluntary contraceptive use by FTP participants.

Figure 9: Current use of modern contraceptive method (among those not currently pregnant)



A logistic regression analysis was also performed to confirm the bivariate findings above, predicting current use of modern methods of FP (implants, IUDs, injectables, oral contraceptive pills, male or female condoms, emergency contraception, or standard days method) among both FTMs and male partners (separately). Regression results (including pairwise correlation coefficients) are shown in Table B-3, Annex B. All demographic variables were included in the model, as well as attitudes toward FP, discussion about FP, perceived partner approval for FP, perceived gender roles related to household work and baby care, and household and family decision making, as well 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, even after controlling for other factors

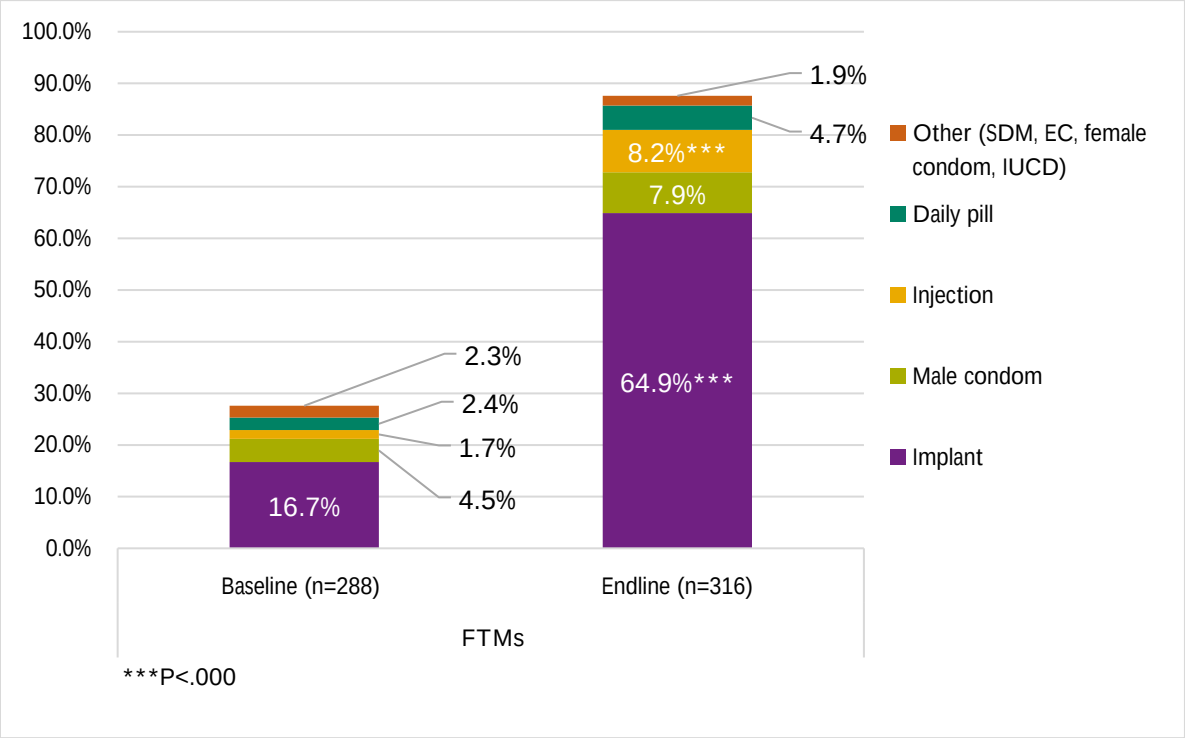
related to FP use, including demographic factors. FTMs were approximately five times more likely and male partners approximately four times more likely to be using a modern method of FP at endline, as compared to baseline, even after taking into account age, marital status, education level, age of youngest child, and attitudes and perceived social support related to FP use.

RESULT 9: Voluntary use of injectables and implants increased over the course of the intervention among FTMs, with implant use increasing from 17% to 65% and injectable use increasing from 2% to 8%.

Figure 10 (below) shows current use of FP, disaggregated by type of method currently used among FTM respondents not pregnant at the time of data collection. The graph below reveals that use of implants and injectables increased significantly from baseline to endline for non-pregnant FTMs, with implants the most commonly used method among all respondents.[21] Of interest is the increase in use of LARCs, specifically the implant. At baseline, only 17% of FTMs (n=287) reported using an implant at baseline, whereas 65% of FTMs (n=316) were using implants at endline ($p<.000$, Pearson chi-square test). Importantly, use of implants aligns with the overall spacing intentions indicated by both FTMs and male partners.

[21] Men's use of implants also increased significantly from baseline to endline, but since nearly all male partners had an FTM partner in the program, this information is presented for FTMs only.

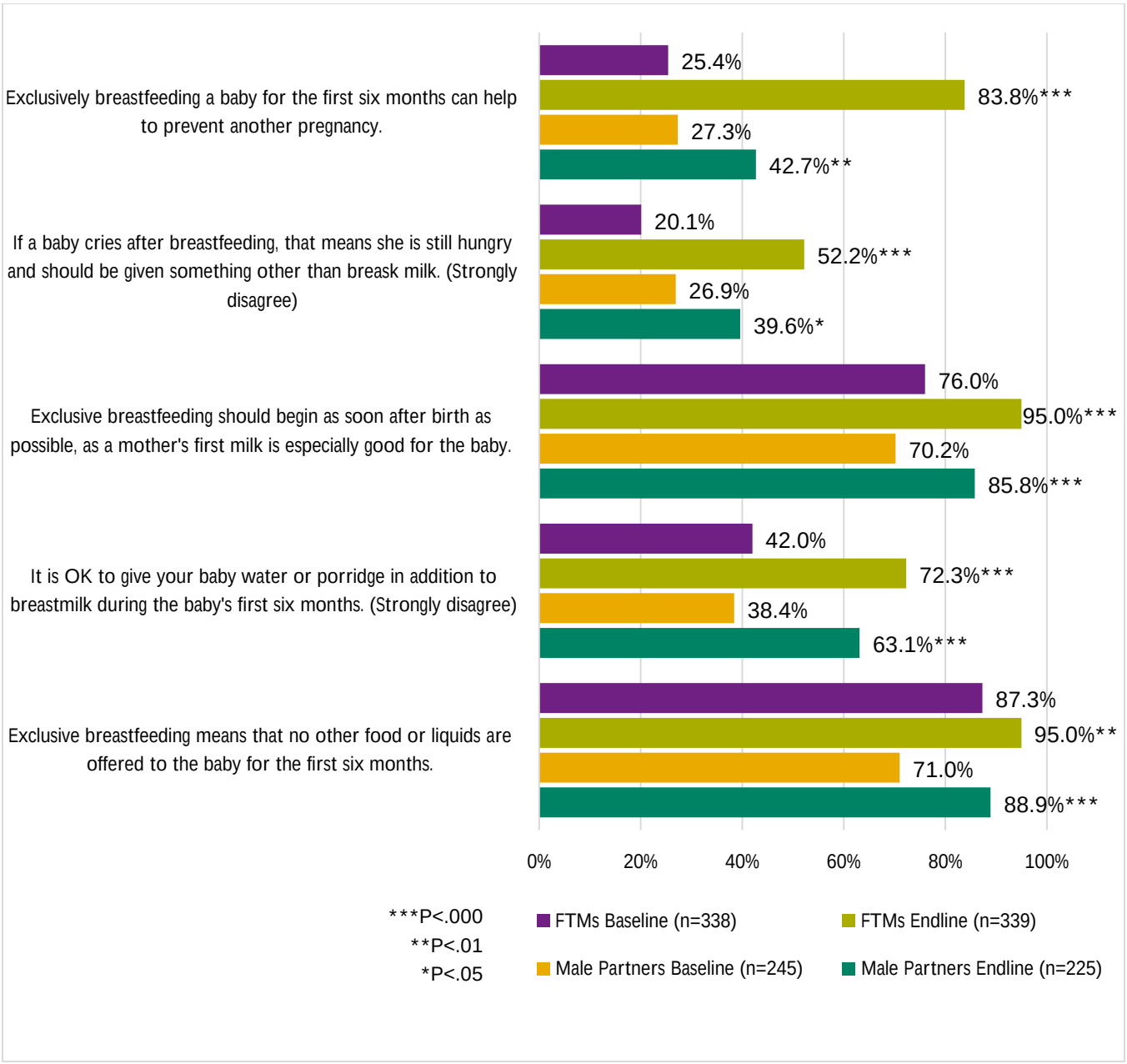
Figure 10: Current use of modern contraception by method (among FTMs not currently pregnant)



RESULT 10: Knowledge about exclusive infant breastfeeding improved.

The formative assessment revealed that while respondents were familiar with the term "exclusive breastfeeding," definitions of what this entailed varied widely. For example, several respondents believed that exclusive breastfeeding did not prohibit early infant feeding of water or porridge. Therefore, in addition to topics on contraception, couples communication and decision making, the FTP program included information on exclusive breastfeeding for infants. Breastfeeding knowledge and behaviors were included in baseline and endline surveys as statements with four-point Likert scale responses and were developed based on formative research findings. Figure 12 below shows the proportion of FTMs and male partners who strongly agreed with key program messages before and after participating in the program. The percentage of both FTM and male partners who strongly agreed with positively worded statements or strongly disagreed with negatively worded statements increased or decreased significantly (at the p<.05 level or less) for all items from baseline to endline. For example, at baseline, only three-quarters (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;" whereas 95% of FTMs at endline agreed strongly with this statement.

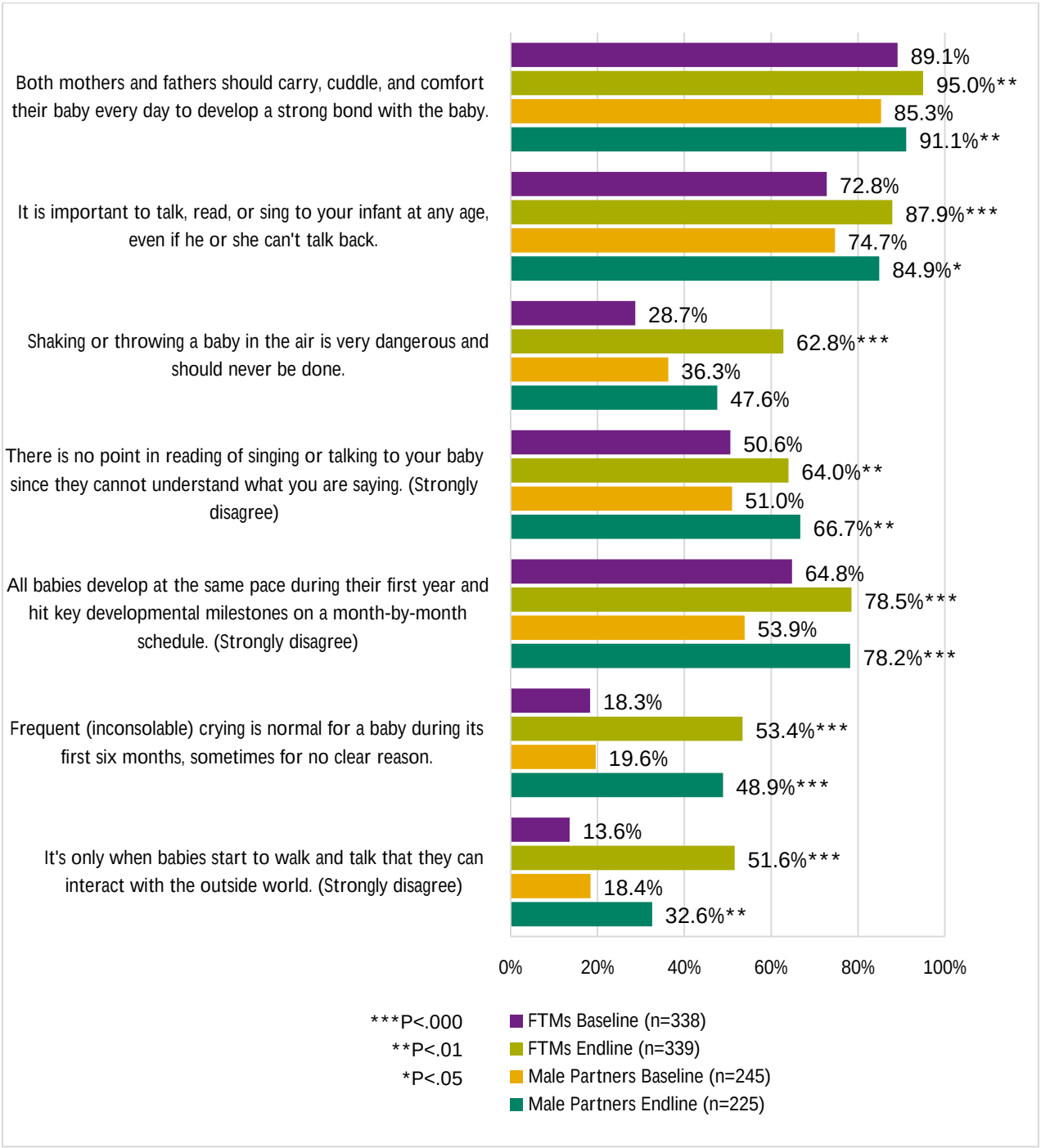
Figure 11: Percent of FTMs who strongly agree (or disagree) with key breastfeeding attitudes and behaviors



RESULT 11: Both FTMs and male partners demonstrated improved knowledge and attitudes about infant care/parenting attitudes and behaviors.

The FTP program also included information about infant care and parenting attitudes and behaviors, and select behaviors were included in baseline and endline surveys as statements with four-point Likert scale responses. Figure 13 below shows the proportion of FTMs and male partners who strongly agreed with key program messages on infant care and parenting before and after participating in the program. The percentage of both FTMs and male partners who strongly agreed with positively worded statements or strongly disagreed with negatively worded statements increased or decreased significantly (at the $p<.05$ level or less) for all items from baseline to endline, except for one item on throwing a baby in the air (among male partners). For 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;" whereas 49% of male partners at endline agreed strongly with this statement.

Figure 12: Percent of FTMs and male partners who strongly agree (or disagree) with key parenting attitudes and behaviors



RESULT 12: 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.

Finally, the SMGL FTP wanted to understand the response of participants to the overall program, and questions about participant experiences and satisfaction were included at endline. About 85% of male partners and FTMs reported receiving "a lot of new information or help" from the program. All (100%) reported that they would recommend the program to any friend/family member who might be expecting their first baby. Participants were also asked to rank benefits received in order of their importance. Around half of FTMs (51.3%) and male partners (47.6%) mentioned that information about health was the biggest benefit of the program. Approximately 37% of both FTMs and male partners reported that "suggestions for improving my relationships" were also an important benefit of the program.

VI. SMGL FTP Implementation Learning

For E2A and Pathfinder/Nigeria, SMGL provided a critical opportunity to expand programming for young

Summary of Implementation Learnings from the SMGL FTP Component

1. FTM peer groups provide a safe space to address priority health issues and the gender-related factors that influence communication, decision making, and relationships.
2. FTM peer leaders are a strong resource and role model for other young women, but need ongoing capacity building and support.
3. Male partners are important participants in FTP programs—not just as influencers, but as co-parents in their own right—although special efforts may be needed to identify and engage them.
4. Older women are very involved in providing support for their households, including young, new parents, and should be included in programs aimed at FTM/FTPs, even if in a limited way.
5. Home visits are a key approach to provide tailored counseling and referrals for FTMs (especially for those who would not otherwise seek services) and to engage key household influencers.
6. Broader community engagement should be conducted throughout the program to ensure that support for key health messages and FTPs is continuously being built.
7. Working with unemployed CHEWs as CVs was an effective approach to deliver counseling and referral services and implement complex interventions, but this has implications for cost and sustainability.
8. The pacing and sequencing of interventions should be carefully planned to optimize implementation efficiencies and manage workloads.

FTPs and enrich the evidence on the potential impact of this programming on their health and wellbeing. Previous FTP efforts by E2A had largely focused on HTSP/FP-related activities mainly with FTMs; in contrast, the SMGL FTP initiative incorporated additional health and gender issues relevant for the FTP lifestage (e.g., exclusive breastfeeding and positive parenting, health communication and decision making), and also engaged key influencers more systematically. Importantly, robust data generation, including baseline and endline surveys with FTMs and male partners yielded important results and findings on the effectiveness of FTP-focused programs.

Throughout the planning and implementation stages, several important learnings emerged on how to structure and carry out programming for young FTPs. These learnings were informed by project team experiences and monitoring data, as well as a workshop for implementers held in October 2018 to extract the key implementation successes, challenges and adjustments made over the course of this first round of FTP activity.[22]

LEARNING 1: FTM peer groups provide a safe space to address priority health issues and the gender-related factors that influence communication, decision making, and relationships.

Project data and feedback from FTMs underscore the interest and active participation of group members throughout the intervention, with 599 young women attending at least 12 of the 14 content sessions. FTMs generally did not report challenges with being able to join or continue weekly participation in the peer groups, perhaps reflecting a relatively high level of agency or independence for these particular young women. The provision of transport reimbursement was a critical element for some, especially those living in more rural locations.

Feedback from PLs and observations by CBO and project staff noted high levels of engagement and enjoyment throughout the peer group sessions. As one PL noted, it was exciting for FTMs to realize that *"life didn't end with having a baby"* and that there was more to do and learn. Importantly, all 50 groups were composed of diverse FTMs in terms of age and marital status, indicating that mixed groups worked well in this context. The presence of CVs at most sessions did not seem to constrain participation, and FTMs generally appreciated having regular access to a knowledgeable provider. PLs ranked the most popular sessions for their groups and three topics consistently emerged on top: HTSP, solving problems, and gender roles. This feedback indicates that these issues resonated well with peer group members and that they felt comfortable discussing difficult topics (e.g., addressing conflict in relationships) with their

[22] The workshop was conducted in Ikom October 2–4, 2018 and included peer leaders, CVs, facility providers, and CBO and project staff.

peers. Overall, the peer group approached worked well within the CRS context, providing important support for using peer group interventions to reach and engage diverse young FTMs.

LEARNING 2: FTM peer leaders are strong resources and role models for other young women, but they need ongoing capacity building and support.

Overall, the 50 PLs engaged in the SMGL FTP component were able to execute their assigned tasks well—from convening groups, to facilitating activity cards at each session, to serving as a critical point of contact for FTM peer group members and their influencers. Many reported having initial reservations and fears that they would not be able to fulfill all the responsibilities asked of them, but that their confidence grew through the initial training and as activities rolled out. Some PLs noted that their male partners were initially suspicious about the program, but that their fears were allayed once they learned more about the peer groups and the actual content included. As PLs gained experience over the course of the intervention, their capacity to serve as a resource person—not just for peer group members, but for other young women in the community—also increased. In many instances, the FTP PLs were recognized for their leadership by the general community. PLs themselves reported high levels of satisfaction in taking on this role and *"being an agent for change"* in their communities.

Throughout the intervention, PLs worked closely with the CVs and many relied on their support to prepare for and conduct activities. Even with stronger PLs, CVs were more involved than initially planned, often working with PLs ahead of each session to help them run through the activities and then attending group meetings to answer technical questions and support facilitation. Interestingly, both PLs and CVs felt that the initial training provided by the project was adequate as a first step. However, continuous and onsite support from CVs was critical for the success of the peer groups and should be included as part of the design of the FTP program.

LEARNING 3: Male partners are important participants in FTP programs—not just as influencers, but as co-parents in their own right—although special efforts may be needed to identify and engage them.

Working with key influencers was a priority for the SMGL FTP component to ensure that young FTMs—who are typically most directly affected by all of the health issues occurring over the FTP lifestage—are supported in taking positive health action. The formative findings highlighted the importance of men as influencers, as well as their own uncertainties and needs as they enter into new roles as partners and fathers. The small group activity was therefore designed to provide information on key topics (HTSP/FP, exclusive breastfeeding, positive parenting) and also explore the underlying gender roles and norms that influence their engagement as partners and fathers. Overall, the response from the male partner

participants throughout the intervention was very positive, and 96% of all group members attended every session. CVs reported that men were highly engaged throughout the six sessions, which were often even more participatory in nature than the FTP peer group activities. Interestingly, they noted that the topics that most resonated with the male partners included those that explored household roles and relationships with their partner, as well as HTSP—very similar to the most popular sessions identified by FTM peer group members.

While male partners responded well to the intervention once they joined, there were some initial challenges with identification and recruitment. The project team relied on FTM peer group members to contact their male partners (if they wished) and notify the CV if he wanted to be involved. However, several FTMs were reluctant to reach out to the men directly, and CVs reported that some men did not want to discuss the proposed activity with them (especially if they were female CVs). Given the initial poor response from the men, the SMGL team adjusted the recruitment approach and used "male motivators"—most of whom were the husbands or partners of FTM PLs—to reach out to other men. This peer-to-peer approach worked well, as male partners were more comfortable discussing the proposed activity and also appreciated knowing someone who would be in the group. While CVs led the sessions with the men, male motivators continued to play an important role by encouraging attendance and maintaining order during meetings. In a few instances, they also helped to counter negative attitudes from other men in the community about the male partner groups. Using men to reach male partners was a critical learning of the project, along with engaging male partners earlier in the project (e.g., via home visits or through community leaders) to inform them about the intervention and encourage participation.

LEARNING 4: Older women are very involved in providing support for their households, including young, new parents, and should be included in programs aimed at FTMs/FTPs, even if in a limited way.

The formative assessment pointed to another critical influencer of FTM/FTP health choice and action throughout the FTP lifestage—older women, especially the mothers of the FTMs. This finding was reinforced over the course of the FTP program. These women are very invested in their children and grandchildren and provide a wide range of support. In the CRS context, older women were often the primary income earners for their family, including for any FTMs (especially those who were unmarried) or FTPs within their household. As such, they sometimes had competing priorities (e.g., being away from home to conduct business) that made it difficult for them to join in home visits or the sessions with older women. PLs and CVs noted that it was sometimes challenging to notify them about activities or find convenient meeting times (the timeslot right after religious services often worked well). Despite this, participation levels were strong and over 1,600 women attended at least one session, with many joining all three. Importantly, the implementation team felt that the targeted older women's overall response to key

messages/ideas (e.g., on HTSP/FP and breastfeeding) was very positive, as was their support for FTM/FTP health action. The CRS experience highlighted the importance of reaching older women and cultivating their role as allies for FTMs/FTPs. Including them in focused, brief activities—even if relatively limited in terms of time and content—worked well, and earlier engagement could also help more older women plan for and attend activities.

LEARNING 5: Home visits are a key approach to provide tailored counseling and referrals for FTMs (especially those who would not otherwise seek services) and to engage key household influencers.

While FTMs and key influencers had many interactions with CVs over the course of the FTP program, home visits provided an important opportunity for personalized services and support that was appreciated by all program participants. Home visits largely occurred in response to FTM requests and/or specific counseling or follow-up needs, and most referrals occurred during these home interactions. PLs noted that CVs often went beyond covering health-related topics to help FTMs with personal problems or talk with partners or household members about difficult issues. Having multiple points of contact over the four-month intervention period proved instrumental in building trust and confidence in the CV and, importantly, in creating linkages with the broader health system.

At the same time, CVs noted that home visits were very time-consuming, especially given travel distances and scheduling/communication challenges. There were also other intervention-related needs that required additional visits, such as meetings with male partners and older women to recruit them for upcoming activities. The project team saw the need to better align different health- and project-related needs and optimize the timing and content of each home visit. Having more structured home visits while still retaining the flexibility to respond to FTP needs was a key learning from CRS.

LEARNING 6: Broader community engagement should be conducted throughout the program to ensure that support for key health messages and FTPs is continuously being built.

For the SMGL team, another key learning from the CRS experience was the importance of having a continuous process of community engagement that builds support for FTPs throughout the intervention. Since all the health facilities and communities were already familiar with the larger SMGL initiative, the project and CBO teams planned on community orientations at the beginning of the FTP component only. These early meetings on the FTP program were generally well received, and community leaders were very helpful with start-up activities, including identifying possible PLs. However, CVs and CBO staff noted that some communities began voicing concerns as they learned more about the specific issues discussed with FTMs and male partners (e.g., with FP use by young people). While this only occurred in a few areas, it

took time and effort from the implementing team to address these concerns and continue to build support for FTP interventions. In addition, more frequent contact with the broader community would have helped to reinforce some of the key FTP- and health-related messages raised in FTM peer groups and sessions with male partners and older women. Overall, the SMGL team noted the value of having a continuous and planned approach to community engagement, with structured activities and touchpoints that build community understanding of, involvement with, and support for young FTPs.

LEARNING 7: Working with unemployed CHEWs as CVs was an effective approach to deliver counseling and referral services and implement complex interventions, but this has implications for cost and sustainability.

As noted in all the above learnings, CVs played a critical role in implementing and supporting all FTP activities and in providing tailored counseling and services for FTPs. Given the high levels of skill and time involved, the project's approach of using unemployed CHEWs, engaged through a local CBO, worked very well—creating a pool of higher caliber community-based resource people who could dedicate 100% of their time to FTP activities. It also proved to be a positive situation for the CVs, giving them new skills and valuable experience and exposure in communities and with the CRS MOH. The project also provided some income, which, even if relatively modest compared to a CHEW salary, was appreciated by the CVs as they awaited an official posting. As an additional benefit, CVs expressed interest in continuing to reach FTPs in their current communities and wherever their official postings may eventually take them.

For E2A, the CRS experience was an interesting contrast to other FTP programming experience, which largely worked with community health workers within the MOH system. While this approach does have implications for the costs and longer-term sustainability of FTP interventions, the overall success of all CV interventions conducted over a relatively short time highlights the potential benefits of working through community-based resource persons with the motivation, skills, and time needed to fulfill their pivotal role.

LEARNING 8: The pacing and sequencing of interventions should be carefully planned to optimize implementation efficiencies and manage workloads.

Given the multiple interventions included in the SMGL FTP component, the project team carefully planned the rollout of activities to allow adequate time to prepare for each activity and to ensure that implementers (especially CVs) were not overburdened. As all activities revolved around FTMs, the peer groups began first, with other interventions added in once FTMs were more comfortable with the program and could request home visits and name male partners and older women to include in activities. In general, all activities moved smoothly and the implementing teams were able to manage their workloads.

The October implementers workshop provided an important opportunity to review the overall phasing and pacing of activities, and in general, no major changes were suggested. CVs did note, however, the importance of engaging key influencers as early as possible, both to ensure full support for FTM engagement in the program, as well as to generate interest in their own participation through planned activities and home visits. Given the demands of establishing peer groups and providing health services for FTMs, the team flagged home visits as the most feasible approach for reaching influencers early in the project (as noted above). CVs also suggested having peer groups meet every two weeks rather than weekly, which would allow more time to conduct home visits. The overall FTP implementation experience underscored the value of mapping out all interventions in detail to ensure that activities build upon one another as needed, while also keeping within the time and resources available for execution.

VII. Emerging Recommendations

The SMGL FTP component generated a wealth of experience and evidence, from the formative assessment, through the intervention implementation period, to the baseline/endline assessment. The implementation learnings and project results presented in this report provide important insights on the "how to" of programing for young FTPs and on the potential impact achieved as a result of such efforts. Looking across the totality of the SMGL FTP experience, several broader conclusions and recommendations emerge to inform and advance future programs for this important youth population in Nigeria and across the globe.

Recommendation 1: Invest in multi-faceted programs for FTPs that advance FP/RH/MNCH and related gender outcomes for these young mothers and their male partners.

The results generated by the SMGL FTP component provide compelling new evidence on the potential benefits of working with young FTMs and male partners. The SMGL package of interventions addressed multiple issues relevant to the FTP lifestage and across the FTP socioecological model, including the gender and social norms that influence health choice and action. Even with a relatively short, but intense, multi-intervention effort, significant improvements were achieved across all health and gender outcomes of interest—from increased FP use, to improved attitudes about gender roles and household decision making. Importantly, positive changes were seen with diverse FTMs and male partners, indicating that these interventions resonate with FTPs of different characteristics and in different situations. The strong results, along with high levels of engagement by program participants, demonstrate the importance of investing in this type of program, ideally addressing all FP/RH/MNCH priorities across the FTP lifestage.

Recommendation 2: Use community-based interventions to increase FP uptake among FTPs, reaching young women and their partners soon after they have had their first child.

Interactions with FTMs and male partners in CRS suggest that young FTPs may be particularly open to HTSP and FP use, as they face the practical and financial realities of raising a child. Community-based interventions such as the small group activities and especially home visits have tremendous potential to tap into this interest and provide timely FP counseling and services. Such approaches may work better than clinic-based services (e.g., postpartum FP or postabortion care services, or even FP integration into ANC), especially where there are inequities in access and use of health care by young FTMs/FTPs, as many young FTMs do not routinely access health facilities or may not be ready to consider FP options when they do. The strong uptake of contraceptive methods, including LARCs, by diverse FTPs in CRS highlights the value of including community-based approaches to reach this particular segment of youth.

Recommendation 3: Support facility- and community-based networks of health providers and resource persons to establish a strong platform of integrated information and service provision across the FTP lifestage.

Related to the above recommendation, the SMGL experience demonstrated that strong, linked community- and facility-based programs can address a range of postpartum FTP needs and could potentially meet the full spectrum of health issues that occur during the FTP lifestage. For many health systems, the task of providing a continuum of integrated care is a daunting one. But the SMGL FTP experience shows that with careful coordination, more holistic and responsive care is possible. Community-based resources like CBOs, CVs (or similar community health workers), PLs, and others provided FTPs with tailored and timely access to information and services, including information about health behaviors that do not require a facility visit (e.g., exclusive breastfeeding). At the same time, linkages with health facilities were critical to ensuring that FTPs could access the full range of services they needed, especially as CVs mainly provided counseling and referral services only. While the SMGL FTP component was relatively small in terms of geographic scale and the health issues addressed, it proved to be a successful platform for delivering integrated services for FTPs with the potential for adding other services, such as ANC and planning for safe delivery.

Recommendation 4: Include couples-oriented activities and interventions within FTP programs.

The SMGL experience demonstrated that young FTMs and their male partners were interested in exploring health and gender issues. Although this program worked with young women and men separately, the findings and results show that they were often in alignment in terms of the issues that resonated the most (e.g., HTSP, problem solving in relationships) and the positive changes achieved (e.g., shifts in attitudes about household gender dynamics and birth spacing). This suggests that couples-oriented

interventions or joint activities could work well—even in a context where many FTPs are not in formal unions or necessarily living in the same household. Even periodic touchpoints that allow FTMs and male partners to share important issues being raised in their separate groups could be an effective approach to helping FTPs learn, share, and advance together.

Recommendation 5: Continue to build the context-specific knowledge base on FTPs and FTP programming to inform and advance this new and promising field.

For E2A and Pathfinder Nigeria, it was a specific priority to generate data on the challenging situation and needs of FTPs in CRS and on the meaningful advancements that can be achieved through careful programming. Formative research from CRS underscored just how much context mattered in shaping FTP health-seeking options and actions, highlighting the situation, needs, and intentions of young FTPs—and the resources, individuals, and systems available to support them—that needed to be addressed through the SMGL FTP component. Importantly, as seen above, the CRS experience also demonstrated that the FTP interventions resulted in meaningful, positive improvements in key health and gender outcomes. Such evidence is vital to building global understanding and programming to support young people as they navigate this pivotal lifestage, and additional areas (such as intervention "dosage," cost-benefit analysis, and longer follow-up of FTPs) should also be addressed. Evidence generation takes time and resources—especially if considering interventions and results across the FTP lifestage and beyond—but such investment is critical to continue to advance the FTP programming from "promising" to "proven."

Annex A: Baseline/Endline Methods

This study examined the effectiveness of the community-based intervention for young FTMs and their male partners in two local government areas of Cross River State, Nigeria, in improving demand for HTSP and postpartum FP. This study had two objectives:

1. To demonstrate if the program resulted in any significant increases in key FP utilization and related attitudinal and behavioral outcomes/indicators, including HTSP, postpartum family planning, exclusive breastfeeding, couples communication, and positive parenting.

2. To obtain program feedback and experiences from participants and understand program implementation lessons learned from conducting both home visits and peer groups for FTMs and their partners, which may be applied when designing other FTP programs in Nigeria and elsewhere.

Study Design

The study employed a quantitative pre-test/post-test approach to evaluate outcomes related to knowledge, attitudes, and behaviors on FP and HTSP, exclusive breastfeeding, child development and parenting, and gender equitable relationships among FTMs and their male partners participating in the program from the two LGAs where the program was implemented (Ikom and Obubra). Baseline and endline structured interviews were carried out using pre-coded questionnaires administered to FTMs (under 25 years) and their male partners who were members/participants of intervention groups ("peer group sessions"), before and after participation in these groups.

Sample Size

Using a sample size calculation, it was determined that a sample of 300 FTM peer group members and 200 male partner group members would be sufficient to detect a 10 percentage point increase in current use of FP (a key program outcome indicator) from an assumed baseline value of or near zero. This would yield a sample that would detect a significant difference from baseline to endline at the $p<.05$ level of significance with a design effect of 2.0. The FTM sample was proportionately allocated to each of the two LGAs based on the total number of peer groups in each LGA. The study included the same peer groups before and after the intervention, although individual members may have shifted over time. Due to the smaller size of the male partner program, all male partners participating in the program were interviewed. The final achieved sample size is shown in Table A-1 (below).

Table A-1: Criteria for selection of respondents and achieved sample size

Selected Participants	Baseline		Endline	
	Ikom	Obubra	Ikom	Obubra
First-time Mothers: At least ten (10) FTM members of selected project peer groups were sampled at baseline and endline in both LGAs	15 out of 24 peer groups randomly selected at baseline; total of 150 FTMs randomly selected from each of the 15 groups	17 out of 26 peer groups randomly selected at baseline; total of 188 FTMs randomly selected from each of the 17 groups	The same 15 peer groups selected at baseline were interviewed at endline; total of 149 FTMs randomly selected from each of the 15 groups	The same 17 peer groups selected at baseline were interviewed at endline; total of 190 FTMs randomly selected from each of the 17 groups
Male Partners of FTMs: All male partners participating in CV-led discussion groups in both LGAs were selected for the study and interviewed	All (census) 10 male partner groups selected at baseline; all members of each group interviewed at baseline for a total of 123 male partners interviewed	All (census) 10 male partner groups selected at baseline; all members of each group interviewed at baseline for a total of 122 male partners interviewed	All (census) 10 male partner groups selected at baseline; all members of each group interviewed at endline for a total of 114 male partners interviewed	All (census) 10 male partner groups selected at baseline; all members of each group interviewed at endline for a total of 111 male partners interviewed

Data Collection

Baseline data collection took place May 9–18, 2018 for FTMs and July 9–15, 2018 for male partners. Interviews took place during the initial meeting of group activities and were conducted with recruited FTMs and male partners/fathers who agreed to enroll in their respective group-based activities and consented to participate in the study. A fieldwork schedule with the list of the community volunteer names, ward name, number per group, date, time, and venue for the meeting was made available to the research team to facilitate effective communication. The research team typically arrived 30 minutes prior to the start time of data collection for each group. At baseline, FTM and male partner group members were first addressed by Pathfinder representatives and then by the research field team lead. The aim was to give the participants a brief orientation on both the program and the study (as it was also the first session), to seek their consent, and to explain the procedure for the baseline data collection. Time was given to answer participants' questions. Research team members were then assigned to respondents for data collection.

A trained research team of field-based staff conducted face-to-face, structured interviews using standardized, pre-coded questionnaires at both baseline and endline. The questionnaires included

background and contact information, participation in any previous home visits, as well as responses to questions measuring key program indicators at baseline and endline. Endline questionnaires used with recruited FTMs and male partner participants included program indicators measured at baseline, as well as questions on program participation (exposure) and feedback. For all interviews, participants were provided with a summary of the study and were asked to sign a consent form (with provisions for thumbprint signatures). Signed consent was obtained and a copy given to participants. Interviews were conducted in either English or Pidgin language. Refreshments and transport reimbursement was provided to the study participants. Endline data collection for both FTMs and male partners took place from August 20 to September 2, 2018.

The following measures were taken for data quality control and assurance:

- Only qualified and experienced research assistants were recruited to perform fieldwork.
- Interviewers were trained at both baseline and endline during a residential, five-day training to understand objectives, process, and output requirements for consistency and completeness.
- All data collection tools were piloted in a non-program area during training with all team members for suitability, reliability, coherence, and clarity. Corrections were made as needed.
- Built-in consistency checks and skips were included in the mobile phone data entry application.

Data Management and Analysis

Data was collected using Android-based mobile phones with the Open Data Kit application. Using the Open Data Kit platform enabled data collection through mobile phones and data transmission from all study locations to be aggregated into a web-based cloud storage platform known as *ona.io*. Data was uploaded into this storage server and monitored centrally by the study Data Manager during the period of field data collection. Data was then downloaded into Excel, cleaned, labeled, and checked for inconsistencies, and converted into SPSS for analysis.

SPSS Version 22 was used to perform data analysis. Simple frequencies and bivariate analyses were conducted to describe the sample and perform the analysis. One-tailed Pearson chi-square tests for categorical data and ANOVA F-tests for continuous data were used to determine the statistical significance of differences between baseline and endline and other variables of interest. In addition, a logistic regression analysis of current use of a modern FP method by FTMs was also performed to determine if a significant change in uptake of FP (after controlling for key demographic variables, partner characteristics, couples communication, and attitudes) took place over the course of the intervention.

Ethical Review

The study protocol and other required documents were submitted to the government of Cross River State of Nigeria Health Research Ethics Committee (CRS-HREC) in Calabar, Nigeria, and to PATH's research determination committee in the United States in late 2017. E2A and Pathfinder Nigeria received approval to proceed with the research from the CRS-HREC on March 2, 2018. On February 26, 2018, the application was approved by PATH's research determination committee and determined to be "not research," therefore did not require any additional US-based Institutional Review Board (IRB) review, including PATH/US IRB.

Study Limitations

This study employed a one-group, pre-test/post-test design, a basic quasi-experimental design that measures the same outcomes among a group of participants before (pre-test) and after (post-test) a program or intervention is implemented. While it is one of the most commonly used methodologies in evaluating program research, it still has a number of important limitations. Because testing only included a single group (the "treatment" group—those who participated in the program), and because by design, there was no control or comparison group, there is no way of assessing whether pre-testing biased the post-test results (test-retest effect). In addition, because male partners were nominated by FTMs also included in the program, there could likely have been "contamination" or some effect of a couple talking with each other and with friends, family, church leaders, or other community leaders about similar subjects, thus resulting in more positive outcomes than if they had participated in the program alone. Related to the limitation of contamination, it is important to note that the men's intervention began several weeks after the FTM intervention and the start of home visits, so there may have been additional contamination based on the timing of the men's intervention vis-à-vis the women's intervention. As noted in many other sociological and public health research programs, it is impossible and unethical to isolate the participants completely to prevent this limitation.

This study relied on data obtained from self-reported information gathered during face-to-face interviews, subject to both courtesy and recall bias. It is possible that respondents may have felt some social pressure to respond in a more positive way (in terms of desired program outcomes), given that data was collected in face-to-face interviews, as well as by an independent research group coordinating with the implementation team. In addition, interviews were conducted in Pidgin language and the tool included a number of scale items (in the form of statements) that are highly sensitive in terms of language and may have been slightly altered during translation. Interviewers were trained during a five-day residential workshop and received training on interviewing skills. They also rehearsed these statements in Pidgin to minimize this potential limitation.

Another important limitation is related to "history" or the possibility that other FP activities took place in CRS, Nigeria, in the same or nearby geographic areas, which also may have resulted in increased health knowledge and healthier behaviors. For example, if another partner organization conducted mobile FP outreach at the same time as the program, then program participants may have been exposed to other health promotion activities and may have been influenced by these other activities outside of the program. Pathfinder CRS program staff were consulted and reassured the E2A research team that no other partner activities had taken place at the same time, and monitoring and referral data seem to triangulate a high level of FP uptake by program participants.

"Maturation" regarding participant attitudes and behaviors is also a potential concern. Participants might have changed between the pre-test and the post-test in ways that they were going to regardless of the program/intervention because they are growing and learning, especially as parents of young infants. This may be more likely for FTMs than for male partners, since their program was around 4 months long, and male partners met for less than two months. This limitation was minimized by ensuring that baseline and endline data collection coincided tightly with program implementation, so that long time gaps between implementation and data collection were minimized.

A final limitation is related to the self-selection of program participants and propensity of more empowered individuals to participate. In other words, those who are more likely to use FP, who are more interested in improving their health, and who have better access to health services generally, may be over-represented in the program. Thus, these results may not be representative of the general population if the program were more widely implemented. While it is highly likely that participants had some propensity toward the information and messages received during the program, baseline attitudes and knowledge were consistent with findings from a community qualitative study on the same topics and health behaviors conducted by E2A in the same LGAs during the previous year.[23]

[23] G. Morgan, A. Akiode, D. Adeloye, and A. Kanesathasan, *A Time of Uncertainty and Opportunity: Findings from a Formative Assessment of First-time Parents in Cross River State, Nigeria* (Washington, DC: Evidence to Action Project, July 2018).

Annex B: Data Tables

Table B-1: Percentage distribution of age, marital status, LGA, and education level by baseline/endline and participant group

Variable (number of cases)	FTMs		Male Partners	
	Baseline (n=338)	Endline (n=339)	Baseline (n=245)	Endline (n=225)
Age				
15–19 years	28.7%	28.3%	2.0%	.9%
20–24 years	62.7%	67.8%	28.6%	30.2%
25–29 years	1.2%	2.7%	40.4%	39.1%
30 years plus	0.0%	0.3%	29.0%	29.8%
Don't know/missing	7.4%	0.9%***	0.0%	0.0%
Mean age (years)	20.60	21.05*	27.30	27.40
Number of cases	313	336	245	225
LGA				
Ikom	44.4%	44.0%	50.2%	50.7%
Obubra	55.6%	56.0%	49.8%	49.3%
Number of cases	338	339	245	225
Marital status				
Never married	62.7%	53.1%*	31.4%	31.6%
Living with partner/married	37.3%	45.4%*	68.6%	68.5%
Divorced/Sep/Widowed	0.0%	1.5%*	0.0%	0.0%
Number of cases	338	339	245	225
Number of living children				
0	14.5%	7.7%	9.8%	4.4%
1	85.5%	92.0%	85.3%	90.2%
2	0.0%	0.3%*	4.9%	5.3%
Number of cases	338	339	245	225
Residential arrangement				
Currently lives with partner	45.0%	43.4%	74.3%	72.9%
Number of cases	338	339	245	225
Education level				
Primary	13.9%	10.9%	7.8%	9.3%
Junior Secondary (completed)	35.2%	36.6%	20.4%	16.9%
Secondary (completed)	47.6%	45.4%	51.8%	55.1%
Polytechnic	1.8%	2.9%	4.1%	3.1%
University	1.5%	4.1%	15.9%	15.6%
Number of cases	338	339	245	225
Works to earn money				
Yes	36.1%	56.9%***	82.9%	86.7%
Number of cases	338	339	245	225

****p value<.000; ** p value<.01; * p value<.05*

Table B-2: Percent distribution of FP method awareness by baseline/endline and participant group

Variable	FTMs		Male Partners	
	Baseline	Endline	Baseline	Endline
Awareness of FP methods				
Female or male sterilization	1.8%	5.3%**	0.0%	.9%
Implant	67.8%	92.0%***	52.7%	83.1%***
IUD	11.5%	13.6%	3.3%	20.0%***
Injectable	45.9%	79.6%***	29.8%	61.8%***
Daily oral contraceptive pill	42.3%	69.0%***	16.7%	48.4%***
Male condom	44.1%	83.2%***	74.3%	90.7%***
Female condom	11.8%	68.7%***	11.4%	48.4%***
Emergency contraception	10.9%	52.5%***	14.3%	32.4%***
Standard days method/CycleBeads ®	6.8%	7.4%	8.2%	5.8%
Number of cases	338	339	245	225

****p value<.000; ** p value<.01; * p value<.05*

Table B-3: Regression results – FTMs

Variable	B	OR	P-value Signif
Aged 20–24 years (reference is 15-19 years)	.088	1.092	.741
Aged 25 years or older (reference is 15–19 years)	.028	1.028	.959
Ever married (reference is never married)	.311	1.365	.195
Age of child (months)	.224	1.251	.000
Primary or junior secondary education (reference is university)	.343	1.409	.208
Completed secondary education (reference is university)	.027	1.027	.961
Currently employed (reference is not employed)	-.124	.884	.605
Resident of Ikom LGA (reference is Obubra LGA)	-.545	.580	.023
Discussed FP with partner/husband in the past three months (reference is did not discuss FP)	1.229	3.417	.000
Discussed FP with other family or friends in the past three months (reference is did not discuss FP)	.477	1.612	.042
Believes that male partner would approve of using FP (reference is not approve)	.540	1.715	.058
Believes that using FP would negatively affect future fertility and health (reference is that it will not affect it)	-.745	.475	.023
GEM scale (reference is negative gender attitudes/beliefs)	.283	1.327	.319
Time (reference is baseline)	1.666	5.289	.000
Constant	-3.797	.022	.000

Table B-4: Regression results – Male partners

Variable	B	OR	P-value Signif
Aged 15–24 years (reference is 25–29 years)	.783	2.188	.009
Aged 30 years or older (reference is 25–29 years)	.466	1.594	.107
Ever married (reference is never married)	.729	2.073	.005
Age of child (months)	.059	1.061	.000
Primary or junior secondary education (reference is university)	.387	1.473	.340
Completed secondary education (reference is university)	.713	2.040	.024
Currently employed (reference is not employed)	-.191	.826	.579
Resident of Ikom LGA (reference is Obubra LGA)	-.493	.611	.051
Discussed FP with partner/wife in the past three months (reference is did not discuss FP)	.786	2.194	.012
Discussed FP with other family or friends in the past three months (reference is did not discuss FP)	1.673	.002	5.329
Believes that using FP would negatively affect future fertility and health (reference is that it will not affect it)	-.441	.643	.182
GEM scale (reference is negative gender attitudes/beliefs)	.205	1.227	.560
Time (reference is baseline)	1.437	4.207	.000
Constant	-3.979	. 019	.004

Table B-5: GEM scale items and alpha scores by participant group

FTM GEM scale items (Alpha=.606)	Male Partner GEM scale items (Alpha=.642)
Men and women should share household chores.	Changing nappies (Pampers, Huggies, napkins, etc.), giving a bath, and feeding kids is the mother's responsibility (Strongly Disagree)
A woman's role is taking care of her home and family. (Strongly Disagree)	Men and women should share household chores.
It is good for a man to help his wife with baby care and household tasks so she can rest.	A woman's role is taking care of her home and family. (Strongly Disagree)
It is shameful for a man to be found by friends and neighbors washing his wife's clothes. (Strongly Disagree)	It is good for a man to help his wife with baby care and household tasks so she can rest.
It's the women's responsibility to take the lead in providing care for the children. (Strongly Disagree)	It is shameful to be found by friends and neighbors washing your wife's clothes. (Strongly Disagree)
Men can cook the evening meal for the family.	It's the woman's responsibility to take the lead in providing care for the children. (Strongly Disagree)
Men do not know how to take care of a baby without a woman. (Strongly Disagree)	Men can cook the evening meal for the family.
A father's role is just to provide the material needs a child requires; it is unimportant that he spend time with the family. (Strongly Disagree)	Men do not know how to take care of a baby without a woman. (Strongly Disagree)
Your husband/partner has the final word about all decisions in your home. (Strongly Disagree)	A father's role is just to provide the material needs a child requires; it is unimportant that he spend time with the family. (Strongly Disagree)
When it is a question of children's health, it is best to do whatever the father wants. (Strongly Disagree)	Men who are seen playing, dancing, or singing with their children are considered to be a "woman wrapper" or controlled by their wives. (Strongly Disagree)
When your spouse/partner and you disagree, your husband usually gets his way most of the time. (Strongly Disagree)	Men who are actively involved in their families and children's lives are admired by their male friends and neighbors.
	You have the final word about all decisions in your home. (Strongly Disagree)
	Your spouse/partner and you usually make important decisions in the household together as a couple.
	When it is a question of children's health, it is best to do whatever the mother wants.

Your spouse/partner comfortably question your opinions when she disagrees with you.
When you disagree with your spouse/partner, the best way to let her know you are upset is by sitting down and discussing the issue.

Scale Item	FTMs		Male Partners	
	Baseline	Endline	Baseline	Endline
Changing nappies, giving a bath, and feeding kids is the mother's responsibility.				
Strongly Disagree	24%	5%	33.5%	52.4%
Disagree	10%	6%	14.7%	19.6%
Agree	12%	9%	15.9%	5.8%
Strongly Agree	55%	80%	35.9%	22.2%
Signif	***	***	***	***
Men and women should share household chores.				
Strongly Disagree	25%	14%	4.5%	2.2%
Disagree	17%	8%	3.7%	.9%
Agree	25%	14%	29.0%	16.0%
Strongly Agree	34%	64%	62.9%	80.9%
Signif	***	***	***	***
A woman's role is taking care of her home and family.				
Strongly Disagree	8.9%	13.0%	15.1%	24.4%
Disagree	5.9%	9.1%	7.8%	17.3%
Agree	19.5%	20.1%	35.5%	23.1%
Strongly Agree	65.7%	57.8%	41.6%	35.1%
Signif	NS	NS	***	***
It is good for a man to help his wife with baby care and household tasks so she can rest.				
Strongly Disagree	1.8%	1.5%	.8%	.4%
Disagree	3.6%	.6%	.4%	0.00%
Agree	19.5%	11.5%	20.8%	8.4%
Strongly Agree	75.1%	86.4%	78.0%	91.1%
Signif	**	**	**	**
It is shameful to be found by friends and neighbors washing your wife's clothes.				
Strongly Disagree	36.1%	60.2%	51.8%	67.6%
Disagree	24.9%	16.8%	25.3%	18.2%
Agree	10.7%	7.7%	10.2%	6.2%
Strongly Agree	28.4%	15.3%	12.7%	8.0%
Signif	***	***	**	**
It's the women's responsibility to take the lead in providing care for the children.				
Strongly Disagree	21.3%	39.5%	46.5%	49.3%
Disagree	16.0%	17.1%	25.7%	22.7%
Agree	21.6%	16.2%	17.1%	13.3%
Strongly Agree	41.1%	27.1%	10.6%	14.7%
Signif	***	***	NS	NS

Men can cook the evening meal for the family.				
Strongly Disagree	21.3%	39.5%	14.3%	5.3%
Disagree	16.0%	17.1%	9.0%	1.3%
Agree	21.6%	16.2%	30.2%	19.1%
Strongly Agree	41.1%	27.1%	46.5%	74.2%
Signif	***	***	***	***
Men do not know how to take care of a baby without a woman.				
Strongly Disagree	13.6%	35.4%	36.3%	49.3%
Disagree	24.0%	23.3%	29.8%	29.8%
Agree	23.7%	17.1%	11.8%	10.2%
Strongly Agree	38.8%	24.2%	22.0%	10.7%
Signif	***	***	**	**
A father's role is just to provide the material needs a child requires; it is unimportant that he spend time with the family.				
Strongly Disagree	33.1%	67.8%	56.3%	73.3%
Disagree	22.5%	14.5%	29.0%	15.6%
Agree	22.8%	6.2%	6.1%	4.0%
Strongly Agree	21.6%	11.5%	8.6%	7.1%
Signif	***	***	**	**
Men who are seen playing, dancing, or singing with their children are considered to be a "woman wrapper" or controlled by their wives.				
Strongly Disagree	71.9%	72.0%	68.6%	75.1%
Disagree	16.9%	12.7%	21.2%	12.9%
Agree	3.8%	3.8%	4.5%	2.7%
Strongly Agree	7.4%	11.5%	5.7%	9.3%
Signif	NS	NS	*	*
Men who are actively involved in their families and children's lives are admired by their male friends and neighbors				
Strongly Disagree	.6%	1.5%	.4%	1.8%
Disagree	3.0%	2.1%	2.9%	1.3%
Agree	33.7%	11.8%	27.8%	10.2%
Strongly Agree	62.7%	84.7%	69.0%	86.7%
Signif	***	***	***	***
Your husband/partner (you) has the final word about all decisions in your home.				
Strongly Disagree	7.1%	25.1%	8.2%	30.7%
Disagree	14.8%	22.7%	20.0%	32.9%
Agree	21.9%	20.6%	25.7%	12.9%

Strongly Agree	56.2%	31.6%	46.1%	23.6%
Signif	***	***	***	***

Your spouse/partner and you usually make important decisions in the household together as a couple.				
Strongly Disagree	2.7%	1.5%	.4%	.9%
Disagree	1.5%	1.8%	2.4%	.9%
Agree	23.1%	18.3%	29.4%	16.0%
Strongly Agree	72.8%	78.5%	67.8%	82.2%
Signif	NS	NS	**	**
When it is a question of children's health, it is best to do whatever the father (mother) wants.				
Strongly Disagree	16.6%	20.6%	15.9%	15.1%
Disagree	14.8%	18.0%	21.2%	24.9%
Agree	34.0%	25.7%	33.1%	21.3%
Strongly Agree	34.6%	35.7%	29.8%	38.7%
Signif	NS	NS	*	*
When your spouse/partner and you disagree, your husband (you) usually get your way most of the time.				
Strongly Disagree	12.7%	18.0%	8.2%	16.0%
Disagree	25.4%	23.0%	28.6%	36.0%
Agree	34.3%	30.1%	33.9%	24.4%
Strongly Agree	27.5%	28.9%	29.4%	23.6%
Signif	NS	NS	**	**
Your spouse/partner comfortably questions your opinions when he/she disagrees with you.				
Strongly Disagree	7.1%	6.5%	7.3%	4.9%
Disagree	9.8%	7.1%	7.8%	6.2%
Agree	39.1%	26.0%	43.3%	29.8%
Strongly Agree	44.1%	60.5%	41.6%	59.1%
Signif	***	***	**	**
When you disagree with your spouse/partner, the best way to let her know you are upset is by sitting down and discussing the issue.				
Strongly Disagree	1.2%	2.7%	4.9%	0
Disagree	1.2%	1.2%	4.9%	.4%
Agree	18.3%	13.3%	22.9%	14.2%
Strongly Agree	79.3%	82.9%	67.3%	85.3%
Signif	NS	NS	***	***

****p value<.000; ** p value<.01; * p value<.05*

Scale Item	FTMs		Male Partners	
	Baseline	Endline	Baseline	Endline
Exclusive breastfeeding means that no other food or liquids are offered to the baby for the first six months.				
Strongly Disagree	2.1%	0.0%	6.9%	3.1%
Disagree	3.3%	.9%	6.5%	2.2%
Agree	7.4%	4.1%	15.5%	5.8%
Strongly Agree	87.3%	95.0%	71.0%	88.9%
Signif	**	**	***	***
It is okay to give your baby water or porridge in addition to breastmilk during the baby's first six months.				
Strongly Disagree	42.0%	72.3%	38.4%	63.1%
Disagree	23.7%	13.9%	26.5%	16.4%
Agree	19.8%	5.6%	16.3%	8.9%
Strongly Agree	14.5%	8.3%	18.8%	11.6%
Signif	***	***	***	***
Exclusive breastfeeding should begin as soon after birth as possible, as a mother's first milk is especially good for the baby				
Strongly Disagree	1.8%	0.0%	5.3%	.9%
Disagree	5.3%	.3%	3.3%	3.1%
Agree	16.9%	4.7%	21.2%	10.2%
Strongly Agree	76.0%	95.0%	70.2%	85.8%
Signif	***	***	***	***
If a baby cries after breastfeeding, that means she is still hungry and should be given something other than breast milk.				
Strongly Disagree	20.1%	52.2%	26.9%	39.6%
Disagree	22.2%	20.4%	26.1%	19.6%
Agree	30.2%	9.4%	18.4%	17.8%
Strongly Agree	27.5%	18.0%	28.6%	23.1%
Signif	***	***	*	*
Exclusive breastfeeding a baby for the first six months can help to prevent another pregnancy.				
Strongly Disagree	35.8%	6.5%	34.3%	25.8%
Disagree	23.1%	1.2%	23.7%	14.2%
Agree	15.7%	8.6%	14.7%	17.3%
Strongly Agree	25.4%	83.8%	27.3%	42.7%
Signif	***	***	**	**

****p value<.000; ** p value<.01; * p value<.05*

Scale Item	FTMs		Male Partners	
	Baseline	Endline	Baseline	Endline
It's only when babies start to walk and talk that they can interact with the outside world.				
Strongly Disagree	13.6%	51.6%	18.4%	31.6%
Disagree	15.4%	20.9%	23.3%	18.7%
Agree	37.6%	11.2%	25.3%	19.6%
Strongly Agree	33.4%	16.2%	33.1%	30.2%
Signif	***	***	**	**
Frequent (inconsolable) crying is normal for a baby during its first six months, sometimes for no clear reason.				
Strongly Disagree	30.5%	16.5%	28.2%	14.2%
Disagree	33.7%	11.8%	25.7%	10.2%
Agree	17.5%	18.3%	26.5%	26.7%
Strongly Agree	18.3%	53.4%	19.6%	48.9%
Signif	***	***	***	***
All babies develop at the same pace during their first year and hit key developmental milestones on a month-by-month schedule.				
Strongly Disagree	64.8%	78.5%	53.9%	78.2%
Disagree	13.6%	14.5%	19.6%	9.8%
Agree	13.3%	2.4%	12.7%	6.7%
Strongly Agree	8.3%	4.7%	13.9%	5.3%
Signif	***	***	***	***
There is no point in reading or singing or talking to your baby since they cannot understand what you are saying.				
Strongly Disagree	50.6%	64.0%	51.0%	66.7%
Disagree	34.0%	22.4%	28.6%	24.0%
Agree	6.8%	4.1%	7.3%	4.4%
Strongly Agree	8.6%	9.4%	13.1%	4.9%
Signif	**	**	**	**
Shaking or throwing a baby in the air is very dangerous and should never be done.				
Strongly Disagree	26.3%	16.8%	28.2%	22.7%
Disagree	24.9%	9.1%	18.8%	16.0%
Agree	20.1%	11.2%	16.7%	13.8%
Strongly Agree	28.7%	62.8%	36.3%	47.6%
Signif	***	***	NS	NS
It is important to talk, read, or sing to your infant at any age, even if he or she can't talk back.				
Strongly Disagree	3.6%	.3%	.4%	1.3%
Disagree	5.3%	1.2%	1.6%	1.3%
Agree	18.3%	10.6%	23.3%	12.4%
Strongly Agree	72.8%	87.9%	74.7%	84.9%
Signif	***	***	*	*

Both mothers and fathers should carry, cuddle, and comfort their baby every day to develop a strong bond with the baby.				
Strongly Disagree	0.0%	.9%	0.0%	1.8%
Disagree	.3%	0.0%	0.0%	0.0%
Agree	10.7%	4.1%	14.7%	7.1%
Strongly Agree	89.1%	95.0%	85.3%	91.1%
Signif	**	**	**	**

****p value<.000; ** p value<.01; * p value<.05*

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