Increasing Access to Contraceptive Information and Services for First-Time Mothers in Akwa Ibom, Nigeria

Technical Brief
April 2017

About E2A

The Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls Project (E2A) is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project is designed to reduce unmet need by scaling up best practices to ensure that women and girls receive—and use—quality services through all stages of the reproductive lifecycle. Focusing on the promotion of global support for reduction of unmet need through the scale-up of proven best practices in family planning and reproductive health, E2A promotes gender equality, healthy reproductive health behaviors, and the development of compelling evidence for family planning use in accordance with national and international guidance and frameworks, including: the Global Strategy for Women's, Children's and Adolescents' Heath; Ending Preventable Child and Maternal Deaths; and FP2020. An eight-year Cooperative Agreement awarded in September 2011, E2A is led by Pathfinder International, in partnership with, ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.

E2A and first-time parents/mothers:

E2A has been building a body of work on first-time parents (FTP) and first-time mothers since 2013, beginning with a literature review, which highlighted the lack of programs dedicated to this vulnerable population. In 2014, E2A led a consultative process with a range of experts, defining the basic rationale and conceptual framework for targeting FTP. E2A's work over the past two years has focused on building experience and evidence on the practical 'how to' of implementing FTP programs. This has included documentation of a Pathfinder International project with young women and mothers in Burkina Faso, and integrating FTP interventions into ongoing E2A programs in Nigeria (as described in this brief) and Tanzania. These programs have shown that targeted FTP interventions can reduce young first-time mothers' social isolation and increase their knowledge of and access to sexual and reproductive health services.

Introduction

In developing countries, approximately 1 in 3 adolescent girls is likely to be married by age 18.[i] Globally, 1 in 5 adolescent girls has given birth by age 18 and in the poorest regions, the rate is 1 in 3.[ii] Several programs seek to delay marriage and first pregnancies among young women to improve their health and life outcomes. However, few programs target first-time mothers and their partners—referred to as first-time parents (FTP)*—to increase contraceptive use and promote healthy timing and spacing of pregnancies (HTSP).

HTSP encourages women to delay their first birth until at least age 18, and to space subsequent pregnancies by at least 24 months following a birth.[iii] Evidence shows that the 24-month interval results in healthier mothers and babies. However, many young women in sub-Saharan African countries experience early childbearing and rapid repeat pregnancies due to norms around fertility large families, and gender; inaccessibility of quality family planning (FP) services; and providers' assumptions and practices.

Increasing access to and use of contraception is critical to reducing maternal mortality and morbidity in sub-Saharan Africa, yet 67 percent of married adolescents in the region who would like to delay or space pregnancy for at least two years are not using any contraceptive method.[iv] There is an urgent need to help young women, especially first-time mothers, to access information and services that will allow them to make informed choices about their fertility, health, and well-being, as well as the health and well-being of their infants.

This technical brief describes the Evidence to Action (E2A) Project's FTP interventions in Akwa Ibom state, Nigeria, which were part of a task-sharing program that trained Community Health Extension Workers (CHEWs) to provide implants and injectables at health facilities. The interventions were implemented in collaboration with the Akwa Ibom State Ministry of Health (SMOH) from October 2015 to September 2016.

Box 1: First-time mothers and parents

First-time mothers are defined as adolescents and young women below the age of 25 years who are pregnant or have one child. ***First-time parents*** are first-time mothers and their partners/ husbands.

Box 2: Nigeria, national indicators

Population: 182 million

Population ages: 50% under 30

Total fertility rate: 5.7

Modern contraceptive prevalence, married women & girls:

15-19 years: 1.2%

20-24 years: 6.2%

Modern contraceptive prevalence, unmarried women & girls:

15-19 years: 49.7%

20-24 years: 63.5%

Context

Nigeria is the most populous country in sub-Saharan Africa with a population of 182 million in 2015, and more than half of the population is below the age of 30.[v] It also has the tenth highest fertility rate in the world, with 5.7 births per woman[vi] and the fourth highest maternal mortality rate in the world, with 576 maternal deaths per100,000 live births. Contraceptive use among young Nigerian women is low.[vii] Only 1.2 percent of married adolescent girls (15-19)[1] and 6.2 percent of married young women (20-24)[2] use modern methods of contraception. Modern contraceptive prevalence rates for unmarried sexually active adolescents (15-19) and young women (20-24) are higher at 49.7 and 63.5 percent respectively. Overall, 19.8 percent of married young women and 33.2 percent of sexually active unmarried young women in Nigeria have an unmet need for contraception.[viii] In Akwa Ibom state, 17.9 percent of adolescent girls have started childbearing[ix] with age 15 being the average age of sexual debut for adolescents.[x] In addition, 24 percent of births that occur in Akwa Ibom are closely spaced with intervals less than 24 months.[xi]

In an effort to increase use of contraception and decrease unmet need for FP, the Nigeria Federal Ministry of Health approved a policy in 2014, which allows CHEWs to offer an expanded range of contraceptive methods, including injectables and implants. E2A designed and implemented the "CHEWs Injectables and Implants" project in Akwa Ibom state to support the operationalization of this policy as a means of demonstrating its potential contribution to increasing uptake and utilization of modern FP methods. The project also presented an opportunity for E2A to advance evidence-based approaches of reaching married and unmarried FTP with contraceptive information and services for HTSP.

Technical Strategy: Design and Implementation

E2A tested a three-pronged approach that worked at individual, community, and structural levels to strengthen family planning and sexual and reproductive health (FP/SRH) programming for FTP in Akwa Ibom. The interventions sought to:

1. Provide counseling and integrated FP/SRH/MNCH (maternal, newborn, and child health) services to FTP.
2. Increase the number of FTP in Akwa Ibom who have access to FP/SRH information and integrated FP/SRH/MNCH services, including at the community level.
3. Create an enabling environment for the provision of an expanded mix of FP methods, including for FTP.
4. Contribute to the global evidence base on effective strategies to reach FTP with community-based FP/SRH/MNCH information and services.

To meet these objectives, E2A and the Akwa Ibom SMOH supported 15 CHEWs working in 10 public health facilities in two Local Government Areas (LGAs) in Akwa Ibom state: Eket and Ikot Abasi. The FTP interventions in Akwa Ibom drew on lessons learned from Pathfinder International's previous FTP programming[3] and were designed to intervene at all levels of the socio-ecological model: individual, community, and structural (Figure 1).

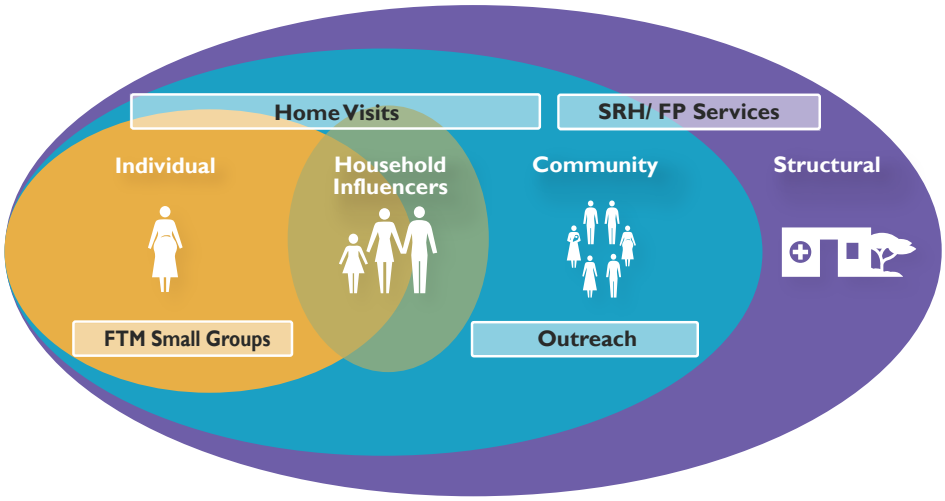
Individual Level

Small peer groups

Many first-time mothers in Akwa Ibom lack opportunities to build supportive social networks, as they enter into motherhood and take on household and childrearing responsibilities. The small peer groups, held monthly, were facilitated by leaders who were first-time mothers themselves. Small peer groups provided first-time mothers opportunities to exchange experiences related to SRH and FP with their peers in an effort to increase their social capital and contribute to the creation of supportive social networks.

E2A worked with CHEWs and other providers at the intervention health facilities to create the small peer groups. These groups met regularly at the health facility

Figure 1. FTP interventions: socio-ecological model



[1] 15-19-year-olds will be referred to as adolescent girls in this brief.

[2] 20-24-year-olds will be referred to as young women in this brief.

[3] This includes: the PRACHAR (Promoting Chan ge in Reproductive Behavior of Adolescents) Project in Bihar, India; the GREAT (Gender Roles, Equality & Transformations (GREAT) project) Project in Northern Uganda; and the Young Married Adolescents project in Burkina Faso.

Box 3: E2A's "CHEWs Injectables and Implants" project

E2A implemented the FTP interventions as part of ongoing task-sharing interventions in Akwa Ibom. The project trained 15 CHEWs from 10 health facilities in the Local Government Areas of Eket and Ikot Abasi to counsel on and provide injectable contraceptives and implants and to refer for IUCDs and permanent methods. CHEWs participated in periodic demand-generation and service delivery outreaches to provide integrated services including injectables—which included home visits. They deliberately targeted young couples, especially first-time parents, with focus on healthy timing and spacing of pregnancy messages.

to develop knowledge and skills related to FP, SRH, gender-equitable relationships, and human rights.

CHEWs and service providers selected the first-time mothers that became small group leaders based on predetermined criteria, including: being a first-time mother under the age of 25, living in the catchment area of a project health facility, being literate in English, possessing strong communication skills, and ability to commit time to prepare, conduct,. It was also required that they report on small peer group meetings at least once or twice a month and participate in up to three review meetings with CHEWs. The approach to identifying small group leaders was concentrated at health facilities, specifically through identifying young clients who came to the facility for antenatal care (ANC), prevention of mother-to- child transmission of HIV (PMTCT), and immunization services. This approach differed from Pathfinder's projects in other countries, which identified young women through household mapping at the community level. The reason for this difference is because, in Nigeria, CHEWs spend a large portion of their time working at health facilities, and the broader "CHEWS Injectables and Implants" project was primarily focused on supporting CHEWs to provide contraceptive services at health facilities.

Twenty-three first-time mothers were selected as group leaders. All group leaders were first-time mothers who had already given birth. Thirteen group leaders were adolescents 15-19 years, while 10 were young women 20-24 years. They completed a three-day skills-building training using a module produced by E2A, Pathfinder International, and the Akwa Ibom SMOH.[4] The training covered topics including: basic SRH and HSTP information, facilitation skills, and tips on how to organize small peer groups and use small group activity cards, which were adapted from the GREAT[5] project.

Box 4: Small peer group facilitators

23 first-time mothers were trained to lead small peer groups

- 13 trained leaders were ages 15-19
- 10 trained leaders were ages 20-24
- 315 first-time mothers participated in the peer groups.

Immediately after the training, an initial four small peer groups were created in the two LGAs (two in Eket and two in Ikot Abasi). First-time mothers who demonstrated the strongest skills during the group leader training were selected to lead these first four groups. The other trained leaders joined the groups as participants. CHEWs and service providers continued to identify first-time mothers through facility-based services, while group members were encouraged to tell other first-time mothers in their communities about the project activities. New groups were created in a cascade manner as additional first-time mothers expressed interest in joining the small peer groups. The leaders of these additional groups were selected from the 23 young women who completed the training.

Small peer group meetings took place at health facilities and participants were identified among first-time mothers living within the facility catchment area. Participants were offered a transport reimbursement to attend small peer group sessions, which facilitated regular participation. Holding the small peer group sessions at the health facility made it easier for CHEWs and health providers to answer questions about health-related topics. Group leaders appreciated having the support of a health expert during the small group meetings. Holding the meetings at the health facility also facilitated access of first-time mothers to SRH and MNCH services, including contraceptive services. Small peer group sessions were generally conducted monthly and lasted about 1.5 hours. The sessions addressed various SRH and HTSP topics, guided by the project activity cards. By the end, 315 first-time mothers participated in 10 groups over a six-month period. Among the 315 participants, 273 participated on a regular basis, representing a retention rate of 87 percent.

Home visits

E2A and Pathfinder International trained 15 CHEWs[6] on how to conduct home visits with FTP using an adapted version of E2A's "Providing Reproductive Health Services to Young Married Women and First-time Parents in West Africa: A Supplemental Training Module for Community Workers Conducting Home Visits,"[7] tailored to the Akwa Ibom context. Prior to this project, CHEWs already conducted home visits to discuss MNCH and SRH issues with

[4] The title of the module is "Small Group Facilitation for Young First-Time Mothers in Akwa Ibom, Niger:ia A supplemental Training Module for Facilitators," which was adapted for the Akwa Ibom context based on Pathfinder's "Small Group Facilitation for Young Married Women and First-time Parents in West Africa: A Supplemental Training Module for Facilitators."

[5] 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.

[6] All trained CHEWs were women.

[7] Available at: http://www.pathfinder.org/publications-tools/ymw-ftp-community-workers-training.html

members of households in their health facility's catchment area. This project helped CHEWs to refine their home visits to meet the specific needs of FTP.

Following the training, CHEWs integrated home visits with FTP and their key household influencers into their routine home visit schedule. CHEWS organized meetings with community leaders to explain the project and the purpose of the home visits. When they obtained approval from the community leaders to conduct home visits, CHEWs identified households of first-time mothers below the age of 25 who were pregnant or already had one child. Throughout the project, CHEWs also identified first-time mothers who came to the health facility for MNCH, PMTCT, and SRH services and included them in their home visit schedules. Efforts were also made to include first-time mothers who participated in the small peer groups in the home visit schedule. However, CHEWs did not systematically conduct home visits for all small peer group members.

When households of first-time mothers were identified, trained CHEWs developed a schedule to conduct home visits two to three times per week and aimed to visit the same first-time mother once or twice per month. In the facilities with fewer health personnel, CHEWs were less available to conduct home visits, as they were often the primary health provider at the facility.

During home visits, CHEWs first obtained approval of key household influencers, such as mothers-in-law, husbands, parents, and others, before meeting with first-time mothers. Approval was not always possible to obtain due to reluctance or opposition of some household members, especially husbands and mothers-in-law of married first-time mothers, and parents of unmarried first-time mothers. When approval was obtained, meetings with first-time mothers were conducted in a private and confidential manner to provide counseling on FP, SRH, and MNCH with a focus on HTSP. The CHEWs also held talks with household influencers to sensitize them about the importance of FP/SRH/MNCH, with a focus on HTSP for young women. Occasionally, CHEWs conducted couples counseling, but this was not done systematically. The CHEWs kept a record of all home visits they conducted, including the main topics raised during counseling and sensitization talks.

CHEWs could also provide condoms and oral pills during home visits. Although CHEWs were trained to provide injectables and implants at health facilities, community-based provision of these methods was not yet introduced in Akwa Ibom state during the implementation period. First-time mothers who were interested in injectables or long-acting reversible contraception (LARC) were referred to the nearest health facility.

Topics covered in small 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, Lactational Amenorrhea Method
- Gender norms
- Communication and decision-making among couples
- Desired family size
- Gender-based and intimate partner violence
- HIV and sexually transmitted infections

Community Level

At the community level, several strategies were implemented to increase demand for FP services and build support for FP/SRH services for FTP among community influencers, as outlined below.

Advocacy meetings with community leaders

Trained CHEWs arranged meetings with community leaders to inform them about the "CHEWS Injectables and Implants" project and to advocate for their support for community- and facility-based FP services, including for FTP. Community leaders included village chiefs, religious leaders, cultural/traditional leaders, women's group leaders, youth group leaders, and others. The community leaders were also invited to participate in community outreach activities.

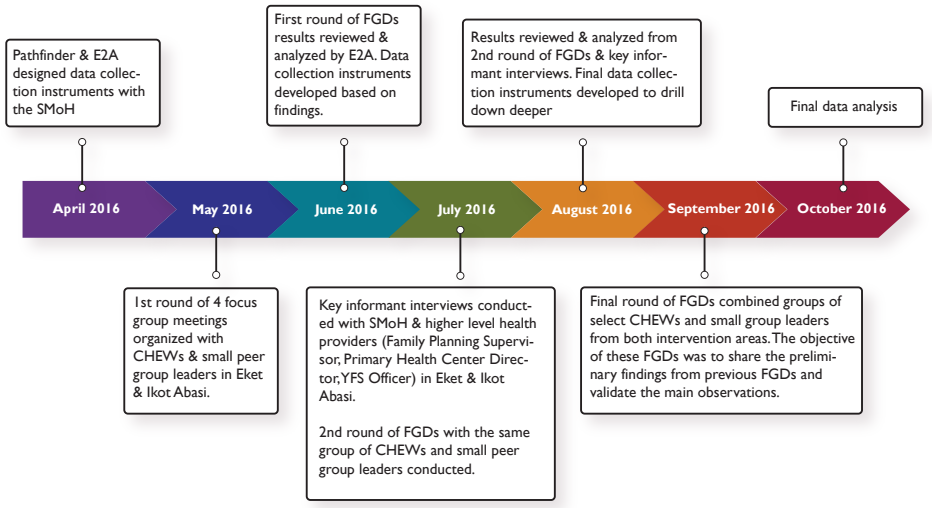
Community outreach activities

Trained CHEWs planned and implemented community-based outreach activities to sensitize community members about FP services. These outreach activities were part of the broader "CHEWs Injectables and Implants" project, but also included a focus on contraceptive needs of adolescents and young people, including FTP. CHEWs included outreach activities in their monthly workplans for the project. The outreach activities emphasized HTSP, and when possible, included counseling on all methods and referrals to services during outreach or at supported facilities. In some instances, community outreach activities were implemented with the support of local community-based organizations (CBOs). The "CHEWS Injectables and Implants" project was originally designed to leverage CBO sensitization and outreach activities funded through a PEPFAR-supported private sector PMTCT project implemented by E2A. However, new guidelines were released at the early stages of the "CHEWS Injectables and Implants" project, which prevented use of PEPFAR funds in the two intervention LGAs. Although E2A shifted its strategy to provide additional support to CHEWs to conduct community outreach activities, several facilities had very few health providers and CHEWs were often unable to take time away from facilities to implement their community outreach activities.

Sensitization activities for men and boys

Trained CHEWs and CBOs planned periodic outreach and sensitization activities that targeted men and boys; for example, sessions were organized with young men who were local youth association leaders. The objective of these activities was to sensitize men and boys in the community about the importance of HTSP, FP, and SRH, including for young women and FTP. The sessions also emphasized the importance of continued male engagement in FP/SRH. No direct links were made between the small peer groups of first-time mothers and activities with men

Figure 2. Qualitative data collection process



and boys.

Structural Level

E2A aimed to increase the capacity of CHEWs to expand provision of facility- and community-based FP services, in line with the 2014 federal policy on FP task-sharing, including a focus on reaching FTP.

Recruitment, training, and supervision of CHEWS

E2A collaborated with the SMOH to recruit 15 CHEWS from the two LGAs of Eket and Ikot Abasi. Eligibility criteria included: being a senior CHEW (not junior CHEW), some previous training on FP, working in the FP unit of a health facility or providing support to a FP unit.

The CHEWS attended a two-week competency-based training[8] on FP counseling and provision of all FP methods except permanent methods and IUCDs, as per the SMOH module. The training included a one-week pedagogical phase (classroom-based learning) and a one-week practicum phase, facilitated by SMOH Master Trainers. CHEWs were asked to conduct a pre- and post-test during the pedagogical phase and only those who demonstrated sufficient competencies progressed to the practicum phase. A post-training competency assessment was conducted within a month after the practicum phase and only those CHEWs who demonstrated sufficient competencies were certified. The training also included a one-day supplemental module on youth-friendly services, including a focus on how to conduct home visits with FTP (as described above).

In partnership with the Akwa Ibom SMOH, E2A conducted regular supportive supervision visits to all trained CHEWs to ensure the quality of FP service delivery (at facilities and in communities), including a focus on youth-friendly approaches to service delivery. E2A also joined CHEWS for quarterly review and exchange meetings.

Provision of FP/SRH services for first-time mothers

Trained CHEWs offered facility- and community-based FP services to first-time mothers, among other clients of reproductive age. At the facilities, trained CHEWs offered counseling and a full range of modern contraceptive methods (excluding permanent methods and IUCDs) to first-time mothers. In communities, trained CHEWs offered counseling, re-supply of oral contraceptive pills, and female and male condoms in their respective catchment areas.

When possible, the community-based FP services were offered in an integrated manner with community-based immunization and/or HIV services (including HIV counseling and testing and PMTCT). Special attention was placed on ensuring confidentiality, privacy, and a non-judgmental approach for provision to first-time mothers. Communities that did not have a Primary Health Center and those that were hard-to-reach (e.g., bad roads, water crossing) were prioritized.

Project Monitoring and Documentation Methods

The FTP component of the "CHEWS Injectables and Implants" project sought to enhance knowledge on effective strategies to reach first-time mothers with FP information and services in Akwa Ibom state. Data collection for project monitoring and process documentation included quantitative and qualitative methods. Quantitative data were collected by gathering baseline and endline service statistics and regular monitoring data. Qualitative data were collected through focus group discussions (FGDs) with trained CHEWs and small peer group leaders, as well as key informant interviews (KIIs) with local and state government officials, higher level health providers, and E2A staff.[9] The qualitative data collection process is outlined in Figure 2.

A qualitative end-of-project assessment was conducted at ommunity and facility levels for the broader "CHEWs Injectables and Implants" project. It aimed to assess changes in awareness and attitudes within the community and determine the project's effects. Seventy-six respondents participated in the community assessment, including: women of reproductive age; men; young men/women (15-24 either married or cohabiting); first-time mother peer group leaders; elderly women (e.g., mothers-in-law, grandmothers); traditional leaders (head of council of chiefs or prominent chief); and religious leaders. At health facilities, KIIs were held with health facility heads and two FGDs were held with CHEWs (these interviews and FGDs were in addition to the process documentation data collection described above).

[8] Full details about the training, supervision, and certification of CHEWS can be found in the E2A technical brief that describes the "CHEWs Injectables and Implants project," to be available on the E2A website in June 2017.

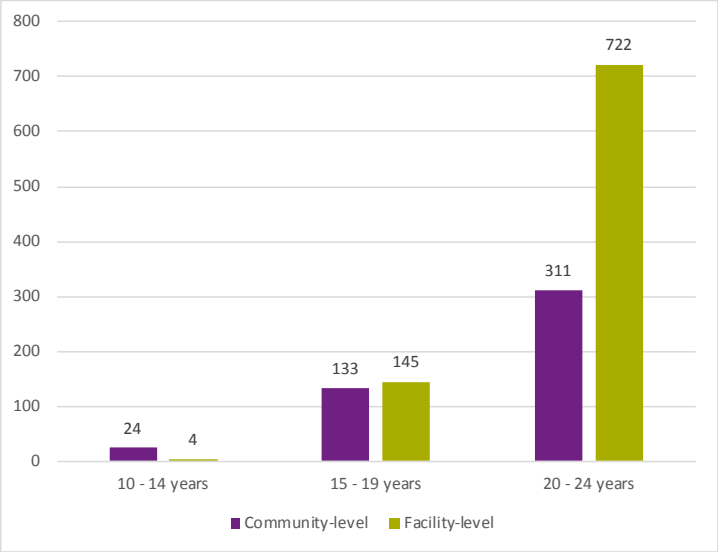
[9] Due process was done to ensure ethical clearance for this data collection. E2A submitted a research determination application to the PATH Research Determination Committee, which deemed that the activity was not research. The data collection was conducted as part of project monitoring and quality improvement. As such, IRB approval was not required.

Project Results

Quantitative Results

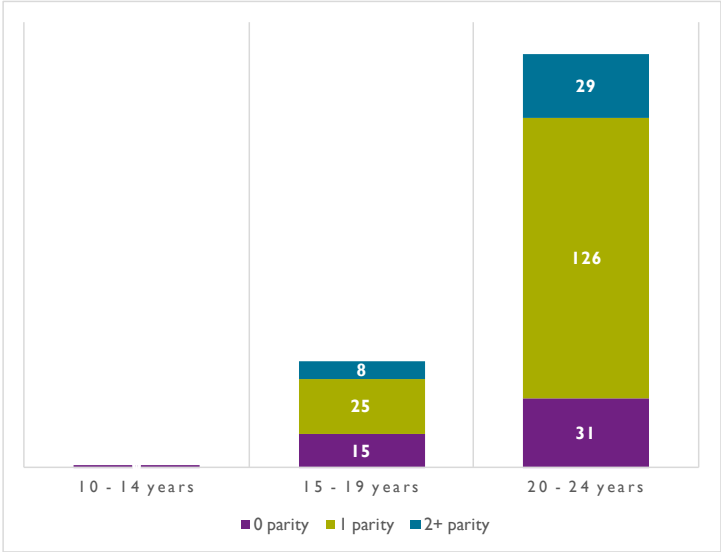
Through the project, 1,339 adolescent girls and young women received FP counseling by trained CHEWs at the community and facility levels.[10]

Graph 1: Young women who received FP counseling by trained CHEWs (n=1,339)



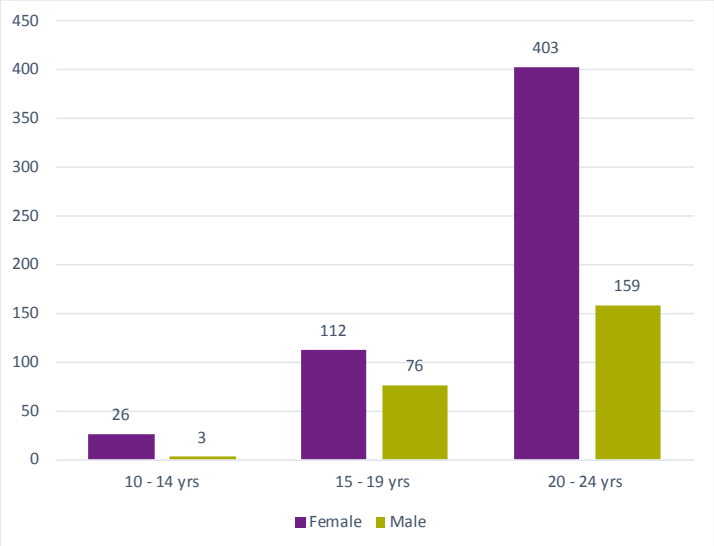
The FTP interventions resulted in 315 first-time mothers participating in regular small peer group meetings in the two intervention LGAs. Trained CHEWs reached 235 adolescent girls and young women through home visits to provide counseling on HTSP and community-based access to select contraceptive methods; 151 of these young women were first-time mothers.

Graph 2: Adolescents and young women reached through home visits (n=235)

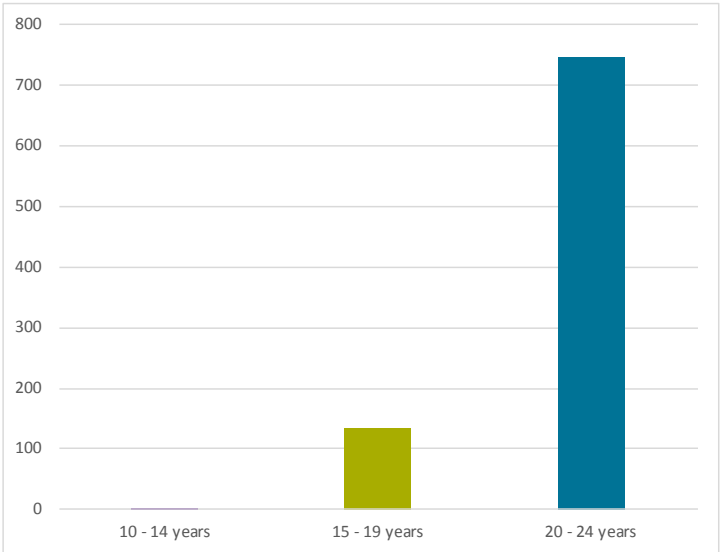


Through the "CHEWs Injectables and Implants" project, 125 community outreach activities were conducted to provide HTSP information, counseling on all FP methods and referrals to supported facilities. These activities reached 779 adolescents and youth; the majority (70%) were female.[11]

Graph 3: Adolescents and youth reached through community outreach activities (n=779)



Graph 4: Adolescents and young women who received FP methods (n=881)



Of the 881 adolescent girls and young women who received contraceptive methods, 385 were first-time mothers. Although all first-time mothers were younger than age 25, monitoring data did not disaggregate the age range of the first-time mothers who accessed FP methods.

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[10] Monitoring data on the number of people who received FP counseling were not disaggregated by parity, so it is not possible to ascertain how many of these adolescents and young women were FTPs.

[11] Monitoring data on the number of people reached through community outreach activities were not disaggregated by parity, so it is not possible to ascertain how many of these adolescents and youth were first-time mothers.

Table 1: Amount of commodities provided by type

Type of FP commodity	# of commodities provided to women of reproductive age (15 – 49 yrs.)
Male condom	16,724
Female condom	5,821
Pills	1,238
Implants	406
Injectables	1,989

The project provided a range of contraceptive commodities to women of reproductive age (15 – 49) as outlined in the Table 1, above.[12]

Qualitative Results

In addition to the quantitative results, the FTP interventions also achieved several qualitative results, outlined below.

Improved understanding of specific needs of FTP among CHEWs

This was the first FTP-focused initiative in the two intervention LGAs. Prior to the project, CHEWs were not aware of FTP's specific needs and considerations in relation to SRH services. Through the youth-friendly services training and involvement of CHEWs in the FTP small peer groups, the project helped to improve CHEWs' understanding about the importance of reaching FTPs with HTSP information and services.

> *"Family planning helps the FTP because some of them, when they get pregnant, they are unable to further their education or find employment like handwork." - CHEW*

> *"What made me to focus greatly on FTP is that they are the future of tomorrow and I don't want them to meet what our parents have met before. Some of our parents, they have so many children that they cannot educate, they cannot care for, they cannot feed the children. And the FTPs, they are our future of tomorrow, I focus on them very greatly so that they will have a child at the time they need and not the time that the child needs them." - CHEW*

Greater acceptance of contraceptive use by FTP through relationship-building with household influencers

The project contributed to increased acceptance of HTSP and FP for young people, including FTP.

> *"People's reaction to family planning, in the past, was on the negative side, because they felt that if they use family planning they will not be able to get pregnant again…but now because of the awareness in family planning, a lot of people have come to embrace it, both husbands and wives." - First-time mother group leader*

CHEWs found that it was useful to build relationships with household influencers, especially mothers-in-law and male partners, over time through home visits and outreach activities. Frequent home visits allowed them to gain their trust and respect, and increase household influencers' openness to discussing the benefits of FP.

Frontline implementers noted that young married women in Akwa Ibom often feel the need to consult with husbands and partners about FP decisions. Mothers-in-law and fathers-in-law also hold significant influence over young married women, particularly about the desired number of grandchildren. If a CHEW discovered that a young woman's mother-in-law was opposed to contraception, the CHEW would arrange a one-on-one discussion with the mother-in-law to build rapport and share information about HTSP.

> *"The old women are now accepting it [FP]. They are encouraging their daughter-in-laws, some of them. Through the explanation from the [health] provider they now accept." – CHEW, Ikot Abasi*

While polygamy is rare in Akwa Ibom, co-wives can play an important role in decision-making about contraceptive uptake within polygamous households. Senior co-wives usually have a closer relationship with the mother-in-law and can yield more power. Therefore, in situations where mothers-in-law oppose contraceptive use, first-time mothers may want to ensure that older co-wives are not aware she is seeking contraceptive information or services, for fear of backlash from the mother-in-law. CHEWs noted that this kind of relationship further emphasized the importance of gaining the trust and respect of a mother-in-law.

> *"One of my clients was afraid of taking family planning, because she did not want her co-wife to know and then tell her mother-in-law who is against it. As I was counseling her, she heard the co-wife's son's voice and quickly asked me not to let the co-wife know what we were discussing, so she would not tell their mother-in-law." – CHEW, Eket*

For unmarried first-time mothers, CHEWs noted that the young woman's parents, especially her mother, were the most important household members with influence over contraceptive choices.

A general observation by CHEWs was the importance of taking time for relationship-building. In many cases, CHEWs needed to gradually introduce the topic of FP services, and would start with discussions about other health services offered at the facilities, such as immunization, before addressing FP in later discussions. CHEWs found that persistence through frequent home visits was key to reaching key influencers. It was also helpful to engage with several respected community leaders, such as

[12] Data on commodities were not disaggregated by age, so it was not possible to know how many of each commodity was provided to young clients.

church leaders and village heads, to create a more supportive environment and help to increase acceptance of FP services. In some cases, CHEWs shared their own experiences of using FP to earn trust. It was useful to state that the program was supported by the government, as it helped lend credibility and trust.

Improved knowledge and understanding of contraception among FTP

CHEWs noted that the small peer groups with first-time mothers and outreach activities with young men helped to improve knowledge and understanding of contraception, especially as a means of birth spacing, achieving desired family size, and keeping families healthy.

> *"[FTP] are well informed, before maybe they did not have the knowledge, they were ignorant but now they are well informed about the services they now accept it that is why you see them coming to access the services." - CHEW*

CHEWs relayed that first-time mothers who participated in both home visits and peer group discussions had more knowledge and understanding than participants who benefited from only one activity and this may have led to an increase in uptake of FP services.

> *"For the past 18 months I have seen those that are below 25 years, the first-time parents, have come to access services in the facility because of the work being done by the trained CHEWs. They go on home visiting … and Pathfinder has also trained first-time parents [peer leaders]. So, they now come to the facility to access this family planning services and we have increased client flow especially in respect to first-time parents." - CHEW*

Lessons Learned and Recommendations

Implementation of the FTP interventions highlight several lessons and recommendations, with relevance for other efforts to reach FTP with contraceptive information and services.

Ensure confidentiality and privacy for first-time mothers.

The project reaffirmed the importance of engaging household influencers to increase support for first-time mothers accessing FP/SRH services. At the same time, the experience in Akwa Ibom highlighted the imperative of ensuring privacy and confidentiality for first-time mothers.

> *"In some homes that I visit, if I meet the husband, mother and other members, the women do not accept to take services in front of other members, they either take my number or come and meet me privately. Most women strictly warn me not to let their mother-in- law know about their choices" – CHEW*

CHEWs noted that during home visits many first-time mothers were interested in FP, but were often afraid to talk openly in front of elders or other household gatekeepers. CHEWs found that the best way to earn the trust of first-time mothers during home visits was to ensure privacy and confidentiality. CHEWs employed context-specific strategies depending on the setting and who was present.

At health facilities, CHEWs also ensured privacy and confidentiality for first-time mothers and noted that one-on-one counseling at the health facility helped first-time mothers open up about contraceptive use and other SRH issues.

> *"Some first-time mothers, at the initial stage when they come in and especially in the immunization session … When you give a health talk about family planning, they will be shy because of the adult women that are there. But, when they come closer to you and you tell them, 'this family planning, if you need it, you will not be counsel there immediately, that we will have a private talk one-on-one,' they will be happy and accept the services." - CHEW*

Tailor approaches to young women's different life stages.

Marked differences were observed among young women in their contraceptive choices and attitudes depending on their life circumstances. For example, young married women with one or more children were more open to discussing contraceptive use compared to young married women without children. The latter group often feared that contraceptive services could have negative effects on future childbearing. CHEWs and small peer group leaders noted that some married first-time mothers became more open to FP after understanding how birth spacing could put less strain on and improve the relationship with their husbands.

With regard to method choice, CHEWS observed that many married young women preferred implants, because they were dealing with stresses related to having a first child and did not want to get pregnant again soon. Unmarried first-time mothers generally preferred short-acting methods, such as condoms and injectables, which they may have deemed more reversible and less likely to affect their long-term ability to have children. Since many unmarried first-time mothers were not in stable relationships, they were less concerned about a rapid repeat pregnancy. CHEWs also found an association between choice of contraceptive methods and levels of education. For example, unmarried first-time mothers who were in school were more likely to choose LARC to finish schooling. Unmarried women without an education preferred short-acting contraception.

Future programs should include tailored approaches for addressing the needs of first-time mothers in different life circumstances. Further, programs should emphasize dispeling common myths that LARC has negative consequences for future fertility, while also emphasizing reversibility and choice.

Ensure a balanced focus on facility-based and community-based strategies to reach first-time mothers.

As described above, the "CHEWs Injectables and Implants" project was designed to increase uptake of injectables and implants via CHEWs at health facilities. As such, the FTP component of the project had a strong focus on facility-based interventions. The fact that CHEWs were the only health

provider at several of the intervention sites also contributed to a focus at the health facility level. For example, the small peer group members were primarily identified by CHEWs and health providers through ANC, PMTCT, and immunization services, rather than through community mapping as during Pathfinder's FTP projects in Burkina Faso[xii] and Tanzania. Small peer group meetings took place at health facilities, often in the presence of CHEWs or other health providers.

Small peer group leaders noted that the facility-focused approach helped them feel more comfortable leading discussions with their peers, since they could easily ask CHEWs or health providers to answer questions or address concerns raised by first-time mothers. The small peer group leaders also noted that hosting the meetings at the health facility made it easier for first-time mothers to access FP and other health services (ANC, SRH, and MNCH) before or after meetings. CHEWs noted that recruiting first-time mothers through ANC services allowed them to identify young women early in the pregnancy, which is harder to do at community level.

However, the facility-based approach to recruiting small peer group members meant that participants already had some contact with the health system. Thus, first-time mothers who were not already in contact with the health system—and who often have the highest SRH needs—were less represented in the small peer group meetings. In addition, without project support, transportation costs would likely impede regular participation by first-time mothers in facility-based meetings.

Home visits were one mechanism used by CHEWs to reach more FTP at the community level. However, not all first-time mothers who benefitted from home visits also signed up to join one of the small peer groups.

For future FTP programs, it will be important to design a strategy with a more balanced focus on facility-based and community-based activities. This will allow the project to reach a more diverse group of first-time mothers and could also contribute to improved results, especially since CHEWs observed that first-time mothers who participated in both home visits and peer group discussions were observed to have gained greater knowledge and understanding than participants who benefited from only one activity.

Enhance community sensitization and outreach strategies.

The qualitative endline assessment of the "CHEWs Injectables and Implants" project suggested that awareness about FP is high in the two intervention LGAs. Nevertheless, there is need for continuous sensitization and demand-creation efforts in order to sustain the increasing acceptability of FP for FTP. This project highlighted the challenge of CHEWs' limited time to conduct community-based activities, especially when they work in health facilities with very few staff. Given CHEWs' limited availability, future programs should design a community outreach and sensitization plan in partnership with CBOs. Strategies to reach specific critical influencers, such as religious and traditional leaders, as well as community and youth groups, should be prioritized. More robust strategies for tracking and assessing the contribution of community outreach activities to FP uptake among FTP would also be helpful for future programs.

Expand structured activities for young men and boys.

All implementers agreed that it was important to engage men and boys to increase support for and uptake of FP services. Male engagement was part of the technical strategy; however, it was not implemented at all project sites. CHEWs used different methods to discuss contraception with men, including organized discussions with youth groups, churches, or other gathering places. An analysis of FP registers at the mid-point of the project highlighted that many men (both young and older) were seeking male condoms at the health facilities. This presented an opportunity for CHEWs to provide counseling on the full FP method mix available and issues related to couples communication about FP.

For older men, CHEWs found that using the local language helped to build rapport, whereas younger men responded positively to the use of English. In general, women and men who were younger and/or educated were more open to discussing and considering using FP.

> *"One man I met uneducated. He was like trying to ask me everything, when I talk on this one, he will want to know about this one before he could accept. Unlike the educated people they will understand everything you are saying and they will readily accept a method."- CHEW*

It is important to note that none of the male-engagement efforts were designed specifically to reach first-time fathers or partners of first-time mothers. For future FTP efforts, it would be important to introduce and monitor a more structured strategy for engaging male partners of first-time mothers—for example, exploring the possibility of creating small peer groups for male partners or organizing facilitated discussions between first-time fathers and first-time mothers. Strategies could also be developed to engage men and boys more purposively to increase support from community and household influencers. In addition, efforts should be made to strengthen CHEWs' capacity to counsel male clients on the full range of contraceptive methods when they come to the health facility to obtain male condoms.

Link with other youth development efforts.

When small peer groups were created, participants were asked to complete a form that included questions about their desired life plans. Many included aspirations related to education and employment. In order to better meet these needs, the SMOH—with support from E2A—met with five other line ministries to discuss how to align various services and programs for adolescent girls (e.g., support to return to school, vocational training, literacy training). These meetings identified opportunities to provide multi-sectoral support for first-time mothers.

Future FTP programs could consider planning this multi-sectoral approach at the design phase. Collaborating with other governmental and non-governmental bodies involved in youth development and empowerment efforts could increase outreach and impact the lives of FTP.

Continue to build the capacity of CHEWs to offer a full range of contraceptives as part of youth-friendly services.

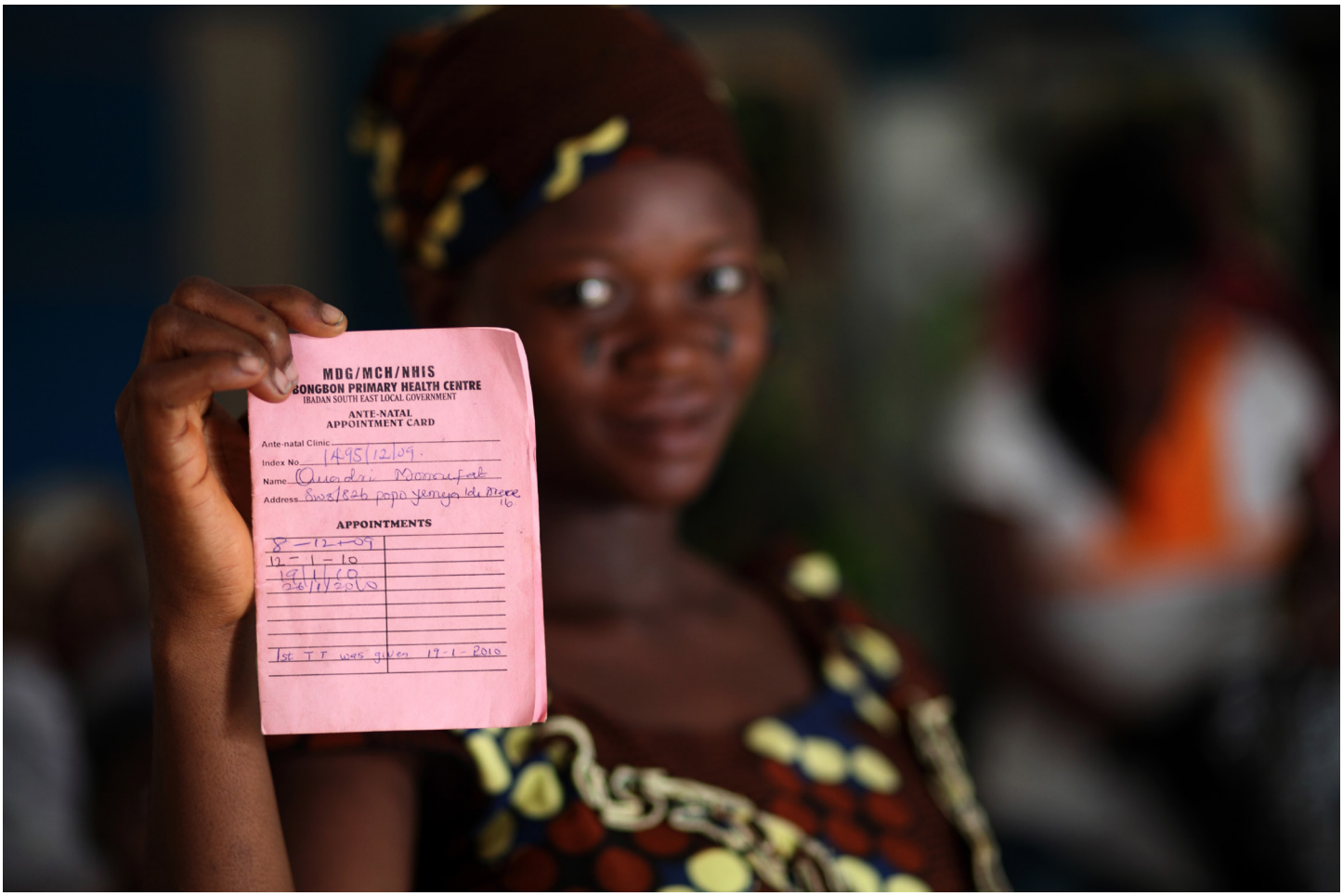
The "CHEWs Injectables and Implants" project demonstrated that training and supporting CHEWs to provide a full range of contraceptive methods (except for permanent methods) and integrated youth-friendly SRH services can contribute to increased access and uptake of contraceptive services for FTP. It will be important to scale up efforts to build the capacity of CHEWs to deliver a full range of contraceptive methods and youth-friendly services in additional sites across Nigeria.

Ensure that FTP are taken into consideration in national and state-level family planning and adolescent sexual and reproductive health policies.

The FTP component of the "CHEWS Injectables and Implants" project demonstrated that targeted interventions for specific groups of adolescents and young people can contribute to improving SRH for sub-populations that are often overlooked. For these targeted programs to be sustainably scaled up, it will be important to prioritize them in national and state policies related to FP and adolescent health. The findings from this project can be used to inform advocacy efforts to strengthen polices and ensure they meet FTP needs.

Conclusion

FTP have long been neglected in FP/SRH programs. There is increasing recognition about the imperative to increase FTP access to contraceptive information and services for HTSP. Research shows that pregnancies spaced at least 24 months apart provide best outcomes for mother, child, and family, but contraceptive use remains low for married young women in Akwa Ibom and other states across Nigeria. The FTP component of the "CHEWs Injectables and Implants" project demonstrated that a package of targeted activities for FTP—with components at health facilities and in communities—has the potential to increase awareness, acceptance, and uptake of contraceptive services among first-time mothers and their partners. While the project has ended, it will be important to seize opportunities to scale up the approach in additional sites to help achieve national and international development goals.



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