



Reaching First-Time Parents IN NIGERIA

Evidence to Action (E2A) and Pathfinder International have been implementing a new program for young **First-Time Parents (FTPs)** as part of the Saving Mothers Giving Life-Expanding Family Planning (SMGL-EFP) Initiative in Cross River State (CRS), Nigeria.

SMGL-EFP has been working in partnership with the CRS MOH since 2014 to increase the coverage and quality of maternal neonatal and reproductive health (RH) services and improve delivery outcomes in 148 public and faith-based health facilities across the state. An additional component of SMGL-EFP focuses on strengthening family planning (FP) services, including the provision of long-acting reversible contraceptives (LARCs).

With 18% of adolescent girls aged 15–19 having already begun childbearing in CRS and only 27% currently using a modern contraceptive method, the SMGL-EFP team noted a particular need to reach young mothers with reproductive, maternal, newborn, and child health (RMNCH) information and services. In response, E2A designed a new FTP-focused component that

advances healthy timing and spacing of pregnancy (HTSP), FP, and gender-related outcomes for FTPs.

Informed by a qualitative formative assessment conducted in 2017, this new FTP component centers on peer group activities with young first-time mothers (FTMs) to build their FP/RH agency and facilitate access to facility- and community-based FP services. The program also includes group activities with the male partners of FTM peer group members to foster healthy relationships and promote couple communication and joint decision-making. With the launch of FTP activities in May 2018, E2A conducted baseline surveys with FTMs and male partners participating in the program to understand more about their FP/RH situation and needs.



This snapshot highlights important information on **SMGL-EFP's FTPs** and some of the factors that influence their access to informed, voluntary use of contraception.

Overview of E2A's Work with First-Time Parents

First-time parents—defined by E2A as young women under age 25 who are pregnant with or have one child, and their partners—have largely been overlooked in reproductive health (RH) 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 FTPs for the Healthy Spacing of Second and Subsequent Pregnancies (2014), which highlights the lack of programming for this vulnerable population

A TECHNICAL CONSULTATION with 30 health/gender experts to outline components, strategies, and considerations for an integrated package of interventions (2014)

DOCUMENTATION OF RESULTS & LESSONS learned from programs that reduce the social isolation of young FTMs and increase knowledge of/access to FP/RH services in Burkina Faso (Pathfinder 2013), Nigeria (E2A/Pathfinder 2014) and Tanzania (E2A/Pathfinder 2014)

THE DEVELOPMENT OF A CONCEPTUAL FRAMEWORK, which applies a lifecourse and socio-ecological lens to explore the FTP experience (2017)

NEW PROGRAMS IN BURKINA FASO, NIGERIA & TANZANIA that expand FTP programming with FTMs, male partners, and other influencers to gather evidence on health and gender outcomes (current)

Who Are Our First-Time Parent Participants?



338

FIRST-TIME MOTHERS (FTM)
COMPLETED BASELINE SURVEY

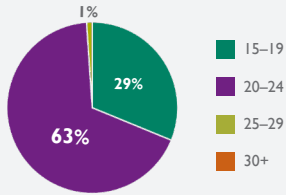


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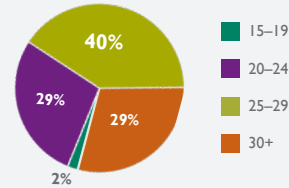
MALE PARTNERS
COMPLETED BASELINE SURVEY

AGE

By design, most program FTMs were **UNDER 25 YEARS**, with the majority (63%) between the ages of **20-24 YEARS**



Male partners, who were identified by the FTMs, were also young, with the majority **UNDER 30 YEARS (71%)**

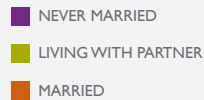


RELATIONSHIP



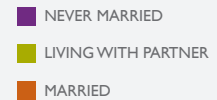
63%

The majority of FTMs reported being **NEVER MARRIED**

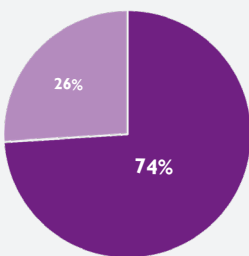


58%

The majority of male partners reported **LIVING WITH PARTNER**



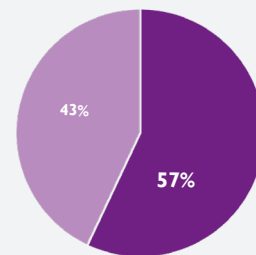
FAMILY PLANNING



74%

The majority of FTMs were **NOT** currently using FP

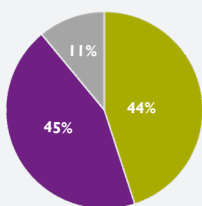
Of the 26% who are current users, the majority reported using implants, followed by male condoms



57%

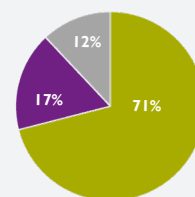
The majority of male partners were **NOT** currently using FP

Of the 43% who are current users, the majority reported using implants, followed by male condoms



55%

FTMs believed or are unsure that contraceptive use can **JEOPARDIZE FUTURE FERTILITY**

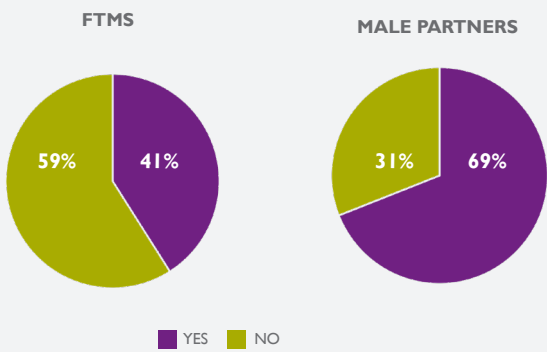


29%

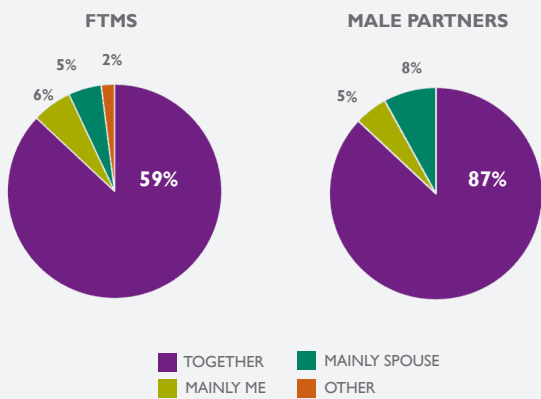
male partners believe or are unsure that contraceptive use can **JEOPARDIZE FUTURE FERTILITY**



41% of FTMs and 69% of male partners reported having discussed FP with their partner in the past three months

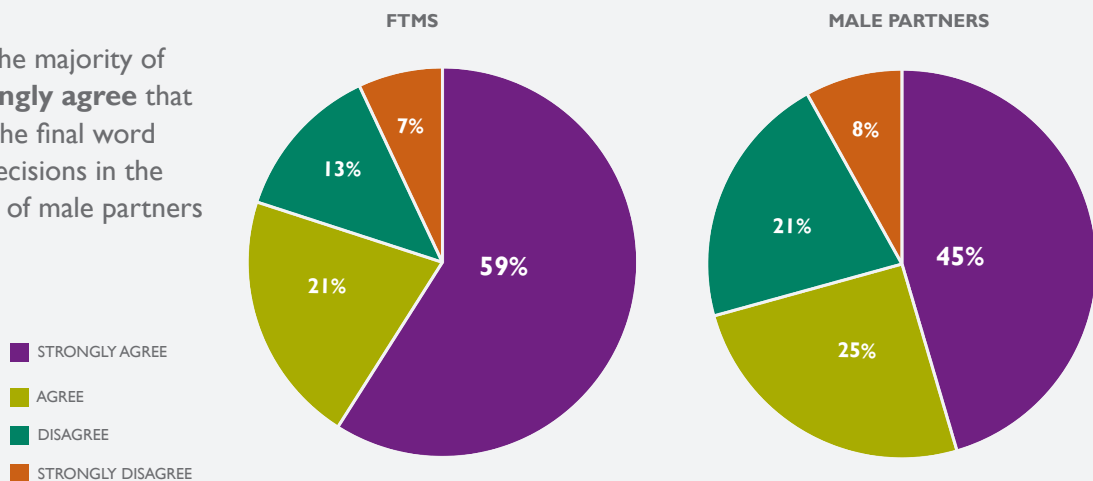


Both FTMs and male partners overwhelmingly reported that they make FP decisions together

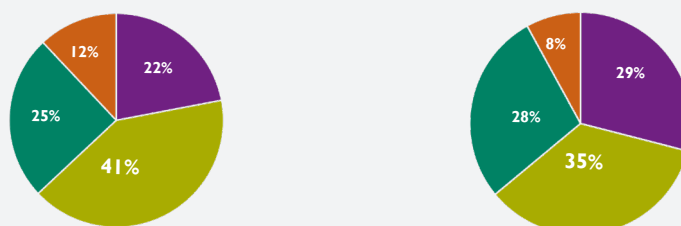


How do the projects's first-time parents make decisions?

However, the majority of FTMs **strongly agree** that men have the final word about all decisions in the home. 45% of male partners concur.



Similarly, the majority of FTMs and male partners share the opinion that, in a disagreement, the man "gets his way," suggesting that joint decision-making may be a challenge for many FTPs.



What are the key findings from the qualitative formative assessment with FTPs in CRS?



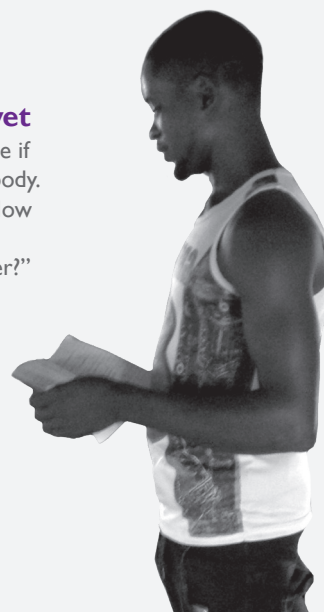
The FTP experience is a time of tremendous uncertainty for young women, their partners, and families, affecting all aspects of their lives—union/relationship status, living arrangements, education, financial needs, and social stigma/isolation

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

—MARRIED FTM, FGD

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

—MALE PARTNER, IDI



FTMs do not make important decisions about their lives and healthcare independently. Partners and parents—especially the mothers of FTMs—play critical roles

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

—UNMARRIED FTM, IDI

“If my child gives birth to a baby, I don’t need to abandon the child but take care of the child and take decisions. I treat my grandchild as my direct child. I care and provide for her.”

—MOTHER OF FTM, IDI



Unmarried and married FTMs differed in their healthcare use, reflecting financial concerns and broader social stigma

Despite high acceptance for delaying next birth, participants did not always see contraception as a safe tool to space subsequent pregnancies

“...Our economy is not good

at all, and I want to be financially stable to care for them and look after the baby and the mother properly ...and to send her to school from the nursery to secondary and be ready for the next child.”

—MALE PARTNER, IDI

“She came to tell me about what they told [her] about family planning

at the health centre. I advised that the FP is good so that she would not make any mistake and it is left to her to decide if she wants to do it or not.”

—MOTHER OF FTM, IDI

“No, [I have never used family planning].

Some say it's not good and spoils a woman's womb. That is why some of us are afraid to use it.”

—UNMARRIED FTM, IDI



Parenting and childcare roles and responsibilities fell along clear gender lines



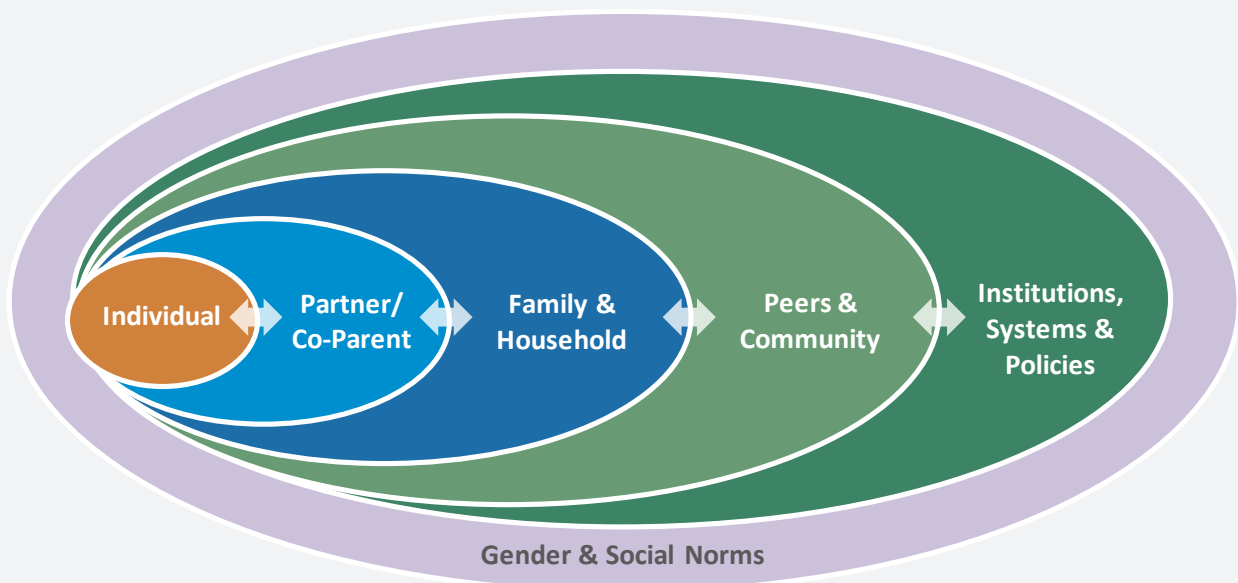
Findings from this formative assessment provide important insights for stakeholders, programmers, and communities interested in reaching young FTPs in CRS.


RECOMMENDATIONS

- 1 WORK WITH YOUNG FTMS TO ENSURE POSITIVE HEALTH** and gender outcomes throughout pregnancy, childbirth, and the early life of their child.
- 2 SYSTEMATICALLY ENGAGE KEY INFLUENCERS**—male partners and mothers of FTMs—to build support for FTM action and foster more gender-equitable roles and responsibilities.
- 3 ADDRESS COMMUNITY ATTITUDES AND NORMS** that can lead to isolation and stigmatization of young FTMs.
- 4 TAILOR FP/RH/MCH INFORMATION AND SERVICE DELIVERY** to better reach and serve young FTMs and influencers, especially community-based approaches.
- 5 PROMOTE POSITIVE PARENTING** and gender-equitable roles in caring for children and the home.
- 6 INCORPORATE PROGRAM ELEMENTS** or link to other ongoing programs, that address educational and economic opportunities for FTMs and their families.

Building on the broader SMGL-EFP initiative in CRS, the added FTP component includes a package of interventions, implemented in two LGAs—Ikom and Obubra—to increase FTP’s FP/RH agency and link them to facility- and community-based services.






Applying a socio-ecological lens, FTP interventions aim to strengthen the support of multiple influencers and systems for voluntary contraceptive use among young FTMs/FTPs, and address the underlying gender and social norms that influence FTP relationships, choices, and actions.



 **E2A APPLIES A SOCIO-ECOLOGICAL LENS** to examine the experience of young women and men as they move through the FTP lifestage. Discover our full FTP Framework at e2aproject.org/FTP

How is E2A addressing the barriers FTP face?



INTERVENTION	DESCRIPTION	LEVELS
FTM PEER MOTHER PEER GROUPS 	<p>Peer groups are led by young FTMs and are intended to explore decision-making processes related to HTSP, contraceptive choice, and gender dynamics. Groups are supervised by community volunteers (CVs), who are attached to a local community-based organization and linked to nearby health facilities. FTM peer groups meet for 14 sessions held weekly and typically include 10–15 members.</p>	<p>Individual Peers & Community Gender & Social Norms</p>
MALE PARTNER GROUPS 	<p>CVs facilitate group activities with male partners of FTM peer group members. As with the peer groups, these activities are intended to explore couple communication and decision-making processes related to HTSP and contraceptive choice, and also foster more gender-equitable attitudes and relationships. Male partner groups meet for six sessions held weekly and typically include 10–15 members.</p>	<p>Partner/Co-Parent Peers & Community Gender & Social Norms</p>
OUTREACH WITH OLDER WOMEN 	<p>CVs conduct a series of three outreaches with older women influencers of FTM peer group members—typically their mothers and mothers-in-law. The outreaches provide information on HTSP and modern contraceptive methods, and also explore the FP needs of young FTPs, including gender and social barriers that limit FTP choice and action.</p>	<p>Family & Household Gender & Social Norms</p>
HOUSEHOLD VISITS 	<p>CVs conduct 4–6 home visits with each FTM peer group member over the course of the intervention to provide tailored counseling and referral services for ANC, safe delivery, FP, breastfeeding, and child health issues. Home visits also provide an opportunity to engage with male partners and household influencers to foster support for FTP health actions.</p>	<p>Individual Partner/Co-Parent Family & Household Gender & Social Norms</p>
COMMUNITY- AND FACILITY-BASED INFORMATION AND SERVICE DELIVERY 	<p>CVs and facility-based health providers conduct informational and service delivery outreaches to build community support for young FTPs' access to FP/RH/MCH services. Outreaches bring services closer to all community members and strengthen links to 16 nearby health facilities with enhanced capacity to provide safe delivery and voluntary FP services.</p>	<p>Systems & Policies Gender & Social Norms</p>

The Evidence to Action Project (E2A) is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project addresses the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and facilitating the scale-up of best practices that improve family planning services. E2A is led by Pathfinder International, in partnership with ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.



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