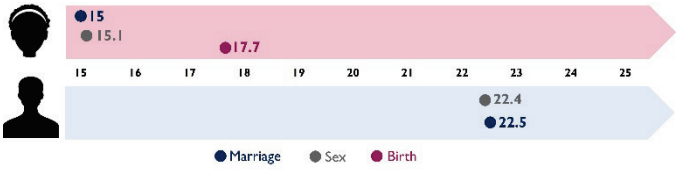
Research Brief: Highlights from Formative Research with First-Time Young Parents in Bauchi State, North East Nigeria

December 2018

www.mcsprogram.org

Background

Figure 1: In Bauchi State, girls marry before the age of 16 on average, but delay the first birth for a few years after marriage



In Bauchi State, in North East Nigeria, young people experience major life transitions in rapid succession (Figure 1). By the age of 19, 56.7% of girls in Bauchi State will have begun childbearing.[1] During this critical period, adolescents, and girls in particular, are at a disadvantage due to limited social support and knowledge about reproductive, maternal, newborn, and child health (RMNCH). In addition, these girls often have poor nutrition, limited resources, and few financial opportunities.

Adolescent girls are less likely to use essential health care than are older women. In Nigeria, 46% of mothers under 20 years received no antenatal care and only 26% delivered with a skilled provider, compared with 34% and 40% of women aged 15–49, respectively. Further, adolescents have lower knowledge and use of contraceptive than older women; while 10% of all married/in union women use a modern method of contraception, just 1% of married/in union adolescent girls do.[1]

There is a clear need for interventions to increase the uptake of health care among pregnant and parenting young people, to influence better health outcomes. Use of care will also promote healthy spacing of future pregnancies by providing knowledge of and access to family planning. However, there are few evidence-based models/practices for reaching first-time young parents (FTYPs).

Methods

The United States Agency for International Development's flagship Maternal and Child Survival Program (MCSP) conducted qualitative research in Kogi and Ebonyi States in 2016 and in Bauchi, Cross River, Ondo, and Sokoto States in 2017. The aim of the research was to understand the RMNCH needs of FTYPs, factors influencing care use, and current care gaps.

In each of the six states, two health facility catchment areas were purposively selected, one each from urban and rural areas. In the catchment areas, MCSP recruited study participants—pregnant and parenting adolescent girls aged 15–19—through youth groups, community health workers, and facility-based health providers. These participants were given vouchers to invite others to join the study, including their pregnant/parenting acquaintances, male partners, and/or a senior woman relative or non-relative whom they trusted, respected, and looked to for advice. The study team conducted a total of 72 focus group discussions (FGDs) and 140 in-depth interviews (IDIs) in all six states. In Bauchi, urban (Bauchi) and rural (Itas Gadau) areas were sampled; these sites were selected based on consultation with stakeholders at the state level. A total of 12 FGDs, which included eight to 12 participants each, and 24 IDIs were conducted. Study participants in Bauchi included:

- Adolescent mothers and pregnant adolescents who participated in an FGD or IDI (four FGDs and 24 IDIs)
- Male partners of adolescent mothers and pregnant adolescents who participated in an FGD (four FGDs)
- Older, influential female relatives or non-relatives of adolescent mothers and pregnant adolescents who participated in an FGD (four FGDs)

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

FGDs for first-time mothers and fathers explored perceptions of young couples who use RMNCH care and the support they receive from family and others throughout pregnancy and birth, and in pregnancy spacing. IDIs with young mothers used participatory influence mapping to identify the individuals who were influential during their pregnancy and their experience as a new parent.

General Findings

Across all states, FTYPs felt that health care was important, although they did not often use it. The most important barriers to seeking care were the financial burden of care, influence of individuals with power over first-time adolescent mothers' (FTAMs') decision-making, and health care that does not respond to the needs of adolescents. Specific findings for Bauchi State are outlined below.

Bauchi State-Specific Findings

Adolescents' Experiences with Pregnancy and Parenthood

Adolescents who participated in the study stated their unpreparedness for parenthood. As illustrated by the excerpts below, marriage influenced reactions to adolescent parenthood: among unmarried FTYPs, pregnancy caused distress to the couples and their families. Reactions in these cases ranged from FTYPs' being highly stigmatized in the community, being kicked out of their homes by parents, to stress and worry over what will happen; as a result, almost no one was happy about the pregnancy. Married FTAMs experienced stress related to their age; however, responses from women, partners, and older female relatives indicate that most were mainly happy about the pregnancy and parenthood.

Question: What will her mother think of (getting pregnant so early?) 1) The mother will be scared of the safety of her delivery because she was too young to conceive, so she will worry the baby might have to pass through cesarean section. 2) The mother will not be worried because she knew that she wedded her [daughter] early. The only fear will be for her to deliver safely. (Two FTAMs, age 15–17, rural)

Individuals Who Most Influence FTYPs' Use of Health Care

People close to FTAMs may impede or facilitate their use of health care use. Partners, in-laws, and parents all enable FTAMs' use of care in Bauchi. In-laws encourage women to go to the hospital and provide money to pay for health care. Older women said they preferred health facilities over traditional birth attendants (TBAs). Some husbands provide money and facilitate the use of health care (either at a facility or with a TBA). Several FTAMs said that when they wanted to seek care, they enlisted help from relatives. Many partners hindered access to health care by not giving the FTAM permission to seek care (both family planning [FP] and maternal, newborn, and child health). As illustrated by the comments below, partners preferred that women seek local help because of distance, cost, and convenience factors.

As a head of the house, I am the one responsible for my family. I can take [my wife] to the hospital with [nobody's] (i.e., other relatives) concern. I will save some money, or I should sell something for her delivery plan. (First-time father, rural)

I would like to go to the hospital but my husband is totally against it. I don't bother anymore. (FTAM, age 15–17, rural)

Factors That Facilitate the Use of Health Care

Good experiences with care

The most commonly mentioned health system-related factors influencing the use of care were personal satisfaction with the care received, a facility's reputation for providing high-quality care, and the relative benefits of a health facility versus an alternative source for care, especially for childbirth. As illustrated by the comment below, the provision of high-quality care means that the facility offers effective treatment, is equipped with adequate supplies, and delivers care in a respectful, kind way.

When I went [to the health facility], they happily welcomed me. I was happy with the things they did to me. They told us to eat good and healthy foods. They said we should take very good care of ourselves and that we should visit the hospital for antenatal care for the unborn child … and they advised us to take very good care of our child. (FTAM, age 18–19, urban)

Perception of need for health care

Participants mentioned the need for health care—mostly maternal, newborn, and child health (versus FP). Participants from all groups commented that generally, health facilities offer the best care for maternal, newborn, and child health. However, most women do not use the health care for various other reasons.

Adolescents and their influencers desire to space pregnancies

In rural Bauchi, getting pregnant soon after marriage was important to many respondents across groups. Some urban FTAMs ideally wanted to delay their first pregnancy until their education was completed. Others wanted children soon after marriage. FTAMs spoke about waiting until the first child is weaned off breast milk before having a second.

There are some husbands [who] give their wives contraceptives after marriage because they want to rest first, but in my opinion, this is not right. The proper thing is when you get married, they should test the woman's womb to know if she can conceive or not. When she gives birth, then they can go for family planning. (FTAM, age 18–19, urban)

Although participants expressed desire for using modern contraceptive methods, they likely try traditional methods first. Respondents expressed having negative experiences due to the side effects of modern methods. Most comments about contraception referred to short-acting methods. Injectables were by far the most commonly mentioned, in any context.

Barriers to Use of Health Care

Adolescent girls lack power and social capital

There were few comments about joint decision-making for FP and maternal, newborn, and child health; FTAMs are expected to follow their male partner's wishes, as expressed by the comment below. In this sample, social capital most often took the form of participation in church groups that educated youth about marriage and family life. Few clubs were mentioned.

She should ask his permission if she has the money to go hospital. I will not allow my wife to claim that she would deliver only two children for me. She must have, to obey my opinion, six children at least. (First-time father, rural)

The financial burden of accessing health care is insurmountable for adolescents

The cost of obtaining maternal health care was identified as one of the most important barriers to care use, and this was true across all states, regardless of urban or rural residence. TBAs were noted as being less expensive to use than a health care facility, and they accepted goods instead of money. FTYPs may not have started working or were just beginning a job, thereby making the costs of care prohibitive. The financial burden is exacerbated by the fact that almost all FTAMs are dependent on their partners and/or other family members to facilitate and pay for their care during pregnancy and childbirth. Often, the people on whom they depend also lack money. Care that is free still incurs costs, such as from transport, hospital fees, maternity kits, medications, and other necessities. Preference to use TBAs over formal health care providers was often connected to the family's or couple's financial constraints.

Since he [the husband] doesn't have the money, I would call the TBA for her because she can take a small amount of money. She may collect even soap. (First-time father, rural)

Health systems and care are not responsive to the needs of adolescents

The leading health system-related barrier mentioned was staff behavior. Staff at health facilities, including providers, were generally described as rude, mean, and disrespectful to patients. FTAMs stated that staff treated them differently than they did women aged over 20 years, and this different treatment included shame and embarrassment about their younger age.

In the health facility, sometimes they scold and even slap the woman. That is why we prefer to deliver with a TBA. (FTAM, age 15–17, rural)

Despite generally positive views about pregnancy spacing, experiences with FP methods were often negative, which then influenced an FTAM's decision to not pursue FP. Poor quality of care, including stock-outs and the inattention of staff, characterizes the responses in this area.

You will find that sometimes when people come looking for family planning methods, some hospitals will say it is not available, or they will have to order more, so what we need is methods available. (FTAM, age 18–19 urban)

Traditional practices

Participants who did not use facility-based health care said that they are accustomed to traditional medicine. Among these individuals, no particular benefit of formal care was perceived, and it was considered less convenient. There were many

comments about the need to continue doing what has always been done in families; such commenters had no plan to turn to facility-based care during this period.

I have not been to any hospital because I feel I can deliver at home safely. Growing up, I have seen my mother giving birth at home, and I have never seen any complication in childbirth; she will be healthy, and she has no complications. Because of that, I was convinced that I can also wait and see what God will do with us. (FTAM, age 18–19, urban)

Recommendations

MCSP's qualitative research to understand the RMNCH needs of FTYPs reveals that initiatives to influence this population's use of health care should include partners and kin, and such efforts also need to address issues of financial burden, health system factors (e.g., consumable supplies and provider attitudes toward FTYPs), and community capacity for making the strongest impact. Sustaining the successes will require ongoing stewardship of FTYPs' needs and data at all levels of the health system. Key recommendations to Bauchi State Ministry of Health and partners include the following.

Strengthen Health System Capacity to Address Barriers to FTYPs' Use of Health Care

- FTAMs and their kin, particularly their male partners, are reluctant or refuse to use family planning and reproductive health care provided by male providers. **The government must assure that female practitioners** are available in maternity facilities.
- Develop state-tailored strategies to address the **financial burden of care** by using vouchers or special funding streams for FTAMs, particularly to reduce transport and other cost barriers that limit care use.
- **Strengthen the capacity of health workers/care providers** to provide high-quality, adolescent-responsive health care so that FTYPs know they will be taken seriously and treated with respect. Support efforts to mainstream adolescent-responsive practices in all facility areas and among all facility staff, including clinicians and support staff, rather than investing in separate care for adolescents.
- **Include age-specific disaggregation** of RMNCH care use indicators to track FTYP care use.

Foster Demand for Health Care among FTYPs and Their Families

- **Increase perceived need for health care** among FTYPs and their families through education on the benefits of both FP and maternal, newborn, and child health care.
- **Address social norms and stigma** related to adolescent pregnancy and women's power to make decisions, particularly among unmarried adolescents, with family, community, and health system stakeholders.
- **Improve FTYPs' and their kin's understanding of the role of FP and contraceptive choice**, including what to expect from each method, via community organizations, schools, churches, and other partnerships.
- **Create opportunities to empower adolescents and build their social capital** by developing extracurricular youth programs that involve adult mentors (e.g., a sports league with adult coaches).
- **Connect FTAMs to educational and income-generating opportunities** to mitigate cost-related barriers to health care use and to enable them to have leverage when negotiating decisions with partners and family.
- This study's findings reinforce the importance of tailoring programs to an adolescent's **age and life stage** and highlights the need for care use promotion efforts before, during, and after pregnancies.

A comprehensive report detailing the study methodology and findings is available at: https://www.mcsprogram.org/resource/factors-influencing-use-of-health-services-by-first-time-young-parents-findings-from-formative-research-in-six-states-in-nigeria/

This brief is made possible by USAID and the Maternal and Child Survival Program and does not reflect the views of USAID or the United States government.