Research Brief: Highlights from Formative Research with First-Time Young Parents in Cross River State, South Nigeria

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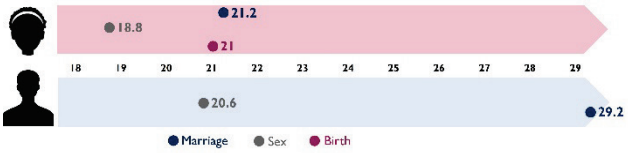
Background

In Cross River State, in South Nigeria, young people experience major life transitions in rapid succession (Figure 1). By the age of 19, 18.5% of girls in Cross River 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.

Figure 1: In Cross Rivers State, the average age at sexual debut first birth are lower than the average age at first marriage for young women



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 contraceptives 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 Cross River, urban (Calabar) and rural (Obudu) 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 22 IDIs were conducted. Study participants in Cross River included:

- Adolescent mothers and pregnant adolescents who participated in an FGD or IDI (four FGDs and 22 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 that young couples receive from family and others throughout pregnancy and birth, and for pregnancy spacing. IDIs with young mothers used participatory influence mapping to identify the individuals who were influential during their pregnancy and 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 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 Cross River State are outlined below.

Cross River State-Specific Findings

Adolescents' Experiences with Pregnancy and Parenthood

Among all groups of participants, responses to early pregnancy ranged from being shocked to being happy and excited. Older FTAMs commented about lost opportunities for schooling and employment. Most older women were happy about being grandparents. As in other states, marriage mediated reactions to adolescent parenthood: if the FTYP couple was married, people were happy; if not, respondents' reactions were mainly negative.

I feel ashamed to face even my friends. Your peer group is looking at you, seeing you pregnant when you're not supposed to be, when you're in school and you were supposed to finish. I'm a student so this is very, very bad. It's quite disappointing. (FTAM, age 15–17, rural)

A mother cannot be happy to see a daughter…carry a baby at 16 years or 17 years…no way to finish school, no way to work. It is not a happy thing for a mother with that kind of daughter. (Shakes head.) (Older woman, urban)

Individuals Who Most Influence FTYPs' Use of Health Care

People close to FTAMs may impede or facilitate their use of health care. Older female relatives were identified as being a greater barrier to care use than partners. These older women recommended using traditional birth attendants (TBAs) as they had. Apart from parents and in-laws, who gave money to seek health care, partners were considered responsible for their wives' care. Peers and friends were mentioned in the context of family planning use.

It was my mother that took me there [to the TBA], and then I discovered the woman was kind, and we don't pay money. (FTAM, age 18–19, rural)

Like my mom, she will not allow me to go and deliver with these women in the house. She would prefer that I come and deliver here in this hospital than go and deliver in the house. (FTAM, age 18–19, urban)

Factors That Facilitate Use of Health Care

Good experiences with care

The most commonly mentioned health system-related facilitators of care use were personal satisfaction with the care received and the facility's reputation for providing high-quality care. 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.

Perception of need for health care

Many comments indicated that participants perceived a need to use health care; only a few comments were to the contrary. Participants expressed that delivering in a health facility is safer for both mother and child, and that health facilities educate people.

I prefer delivering at a health facility because life is not two, it's one. [At the] TBA, there are no drugs, no oxygen. [At the] hospital, there will be injection if you cannot deliver, or [if] the baby is not coming out. (FTAM, age 15–17, urban)

Adolescents and their influencers desire to space pregnancies

Almost everyone commented about wanting to space pregnancies, with the ideal period varying from 2 to 5 years. The majority of participants commented that adolescents should wait until they are at least 20 years old to become parents.

Couples mentioned that they made family planning decisions together. Women in Cross River State seem to have more decision-making power than in some other states in Nigeria.

It's an agreement between the two of them. With time, they will have second child, when…everything is well with them. (Older woman, urban)

Barriers to Use of Health Care

Adolescent girls lack power and social capital

FTAMs are essentially powerless because of their age and sex. They are beholden to their husbands, parents, and in-laws. Many comments about gender roles pertain to a husband's duty as the family decision-maker to care for his wife and children.

Social capital is a form of social and economic power that an individual or group can leverage through social networks. Having adequate social capital can mean the difference between being marginalized and being able to exercise agency. This is especially true of young people in Nigeria, who are dependent on their families, and even more important for young women, who are the least empowered members of society. Participants made a few comments about church groups, but mentioned no other mechanisms that engage adolescents with other adolescents or with others in the community.

I will quietly [use family planning] after giving birth to two children, because there is no way I will stay and see my children crying for food. I will take the injection and hustle, work for my children and their school fees; I will not let [my husband] know. [My husband] will be there thinking of another pregnancy, and it will not come. (FTAM, age 15–17, urban)

The financial burden of accessing health care is insurmountable for adolescents

Participants mentioned lack of finances to cover the various costs of maternal health care more frequently than any other barrier. Although such care is supposed to be free in Nigeria, participants cited related costs such as transport, hospital fees, maternity kits, medications, and other supplies. Often, a respondent's preference to use a TBA over formal health care was phrased in connection with the family's or couple's financial constraints; TBAs are less expensive and they accept goods, such as cola nuts and soap, as payment. Participants reported that programs that provide financial relief or the logistics needed to visit a facility—as well as having good experiences with facility-based care—motivated their use of health care.

When a woman is in labor, you go to a TBA; they will just receive you and make sure that you are safe and your baby [is] safe. But when you go to the hospital, if your bill is $550, they will tell you, "Give us $275 before we start the work." And what if the money is not there? You will just die. (FTAM, age 18–19, urban)

There's this new system that the government just started. They will give you a voucher if…you want to deliver if somebody is not there with you. They will give you a phone number [to] just call and the…person will take you to [a health facility]…even if it is in the night…the cyclist will come and [bring you] where you are registered. (FTAM, age 18–19, rural)

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

The most common health system-related barrier mentioned was staff attitude. Staff at health facilities, including providers, were generally described as rude, mean, and disrespectful to patients. Across the study states, FTAMs stated that they felt staff treated them differently than they did women over age 20. Staff attitudes induced shame and embarrassment related to the young ages of FTAMs. FTAMs, especially those aged 15–17 years, also stated that they are not taken seriously at health facilities because of their age. Some FTAMs commented that when they went for antenatal care services, staff and others at the clinic made fun of them because of their age. This sentiment was reported by respondents regardless of their marital status, but unmarried FTAMs suffered the most stigma. Other barriers included facilities lacking supplies, drugs, and staff.

The first day I attended antenatal [care clinic], the pregnancy was still 3 months and did not show. So when I said I came for antenatal, everybody was amazed… "You [are] pregnant?" I said, "Yes I'm pregnant; I came for antenatal and to register." Even though they didn't say it to me directly, I know very well that they will go say, "Look at this girl. She is not yet at the age of getting pregnant [and] she's coming for antenatal." (FTAM, age 18–19, rural)

Stigma around pregnant and parenting adolescents

Participants reported that upon becoming pregnant, their community shamed them and treated them as children. Marriage mediated this community reaction: married women did not face the same kind of stigma as unmarried pregnant adolescents did.

You'll face a lot of things [if you have an early pregnancy]. From friends. Your friend will cut short; they'll feel maybe you've committed one sin. From your parents. I know it's normal, they have to talk, they have to quarrel, they have to get angry, because of the age. Then from community, it's almost the same thing. (FTAM, age 18–19, urban)

Recommendations

The formative research reveals that initiatives need to include partners and family. The financial burden of health care is an important barrier in Cross River State. For example, respondents in this state named two financial relief programs as enabling their attendance at health services for pregnancy and delivery. Health system factors (such as consumable supplies and provider attitudes toward FTYPs) and community stigma against adolescent pregnancies, together, have the strongest impact on care use in the state. Sustaining success will require ongoing stewardship of FTYPs' needs and data at all levels. Key recommendations to the Cross River State Ministry of Health and partners include the following.

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

- Develop state-tailored strategies to address **financial burden of care** through vouchers or special funding streams for FTAMs to reduce the transport and cost barriers that limit care use.
- **Strengthen the capacity of health workers/providers** to provide high-quality, adolescent-responsive health care so FTYPs know they will be taken seriously and treated with respect. Support efforts to mainstream adolescent-responsive health care across all service areas and 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 facilitate tracking of FTYP care use.

Foster Demand for Health Care among FTYPs and Their Families

- **Increase perceived need** for care among FTYPs and their families through education on the benefits of both family planning and maternal, newborn, and child health care.
- **Address social norms and stigma** related to adolescent pregnancy and that limit women's decision-making power, particularly unmarried adolescents, with family, community, and health system stakeholders.
- **Leverage the desire for pregnancy spacing** that was expressed by FTYPs, and improve FTYPs' and their families' understanding of the role of family planning and contraceptive choice, including what to expect from each contraceptive method, through 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 soccer league with adult coaches).
- **Connect FTAMs to educational and income-generating opportunities** to mitigate cost-related barriers to health care use and provide leverage when negotiating decisions with partners and family.
- This study's findings reinforce the importance of **tailoring programs to adolescents' age and life stage**, highlighting the need for care use promotion efforts before, during, and after pregnancy.

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/

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