A Time of Uncertainty and Opportunity: Findings from a Formative Assessment of First-Time Parents in Cross River State, Nigeria

Research Brief
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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 aims to address 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. Awarded in September 2011, this project will continue for eight years, until September 2019. The project is led by Pathfinder International, in partnership with ExpandNet, IntraHealth International, Management Sciences for Health, and PATH. www.E2AProject.org

Introduction

Over the past five years, the Evidence to Action (E2A) project has been working to understand and respond to the needs of First-Time Parents (FTP), defined as young women, under the age of 25 years who are pregnant with or have one child, and their male partners. Through an on-going safe motherhood initiative – Saving Mothers Giving Life (SMGL) – in Cross River State (CRS), Nigeria, E2A has had an opportunity to implement an intervention package that addresses the continuum of health needs and outcomes that arise during the FTP lifestage and generates much-needed evidence on effective programming for FTPs. As a first step, E2A conducted a qualitative formative assessment to understand more about these young FTPs, their specific reproductive health (RH) and maternal and newborn child health (MNCH) needs, and the underlying gender and social norms that influence their ability to take timely AYRH action. The assessment, conducted in 2017, yielded important insights drawn from the experiences shared by young First-Time Mothers (FTMs) and the critical influencers in their lives - their partners and their own mothers. This brief presents key findings on the situation of FTPs in CRS, Nigeria, as well as the emerging considerations for programs that are interested in reaching this critical population.

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

Saving Mothers Giving Life-Expanding Family Planning (SMGL-EFP) Initiative

The SMGL-EFP Initiative aims to increase the coverage and quality of maternal, neonatal, and reproductive health services, as well as improve delivery outcomes in 148 public and faith-based health facilities in all 18 Local Government Areas (LGAs) of CRS, Nigeria, from 2014 – 2019. SMGL-EFP focuses attention on the most vulnerable period for mother and baby—labor, delivery, and the first 48 hours postpartum – and applies a systems approach to strengthen existing health networks to address the three delays of maternal mortality: delays in deciding to seek appropriate services, delays in reaching those services, and delays in receiving timely, quality care. An additional component of the SMGL-EFP Initiative provides comprehensive FP services, with a focus on provision of Long-Acting Reversible Contraceptives (LARCs). Working in partnership with the Government of Nigeria and local communities to implement the SMGL-EFP Initiative until September 30, 2019, E2A expects to reduce the maternal mortality ratio by 35%, and the neonatal mortality rate by 25% from the 2014 baseline values, as well contribute to an increase in contraceptive prevalence and a reduction in unmet need in CRS.

Background to the FTP Formative Assessment

Becoming a parent for the first time marks an important milestone in the lives of women and men around the world. For young people in particular, the FTP lifestage is one of evolving needs and challenges. Faced with pregnancy, childbirth and parenting, adolescent and young parents must seek out new health services, learn how to care for a young child, and adapt to the shifts in lifestyle, responsibilities, social status and personal relationships that come with becoming a mother or father. As such, the FTP lifestage presents an important opportunity for programs interested in improving reproductive health outcomes for adolescents, especially in countries where youth are at high risk of early, unintended pregnancies.

In CRS, over 18% of adolescent girls have already begun having children, indicating that many young people are at risk of poor RH outcomes, such as sexually transmitted infections (STIs), unplanned pregnancies, and unsafe abortions.[1] Adolescent pregnancy is associated with higher morbidity and mortality for both the mother and child.[3] Young mothers are also less likely to access healthcare forantenatal (ANC) and postnatal care (PNC), as well as skilled birth attendance.[4] The limited use of FP/RH care among FTMs, including contraceptive services, reflects their lack of control over decisions regarding their FP/RH, as well as social and supply-side barriers.

Despite their vulnerabilities, few programs in CRS have reached young FTPs with interventions that encourage the healthy timing and spacing of pregnancies (HTSP) and post-partum family planning (PPFP), gender-equitable communication and shared decision-making, and positive parenting. In addition, there is little documentation of the needs of FTPs and whether they are being met. With the SMGL-EFP initiative in CRS, E2A saw an opportunity to fill this programmatic and evidence gaps, beginning with a qualitative formative assessment to better understand the current situation and needs of young FTPs.

Methodology

The design of the formative assessment was guided by E2A's FTP Lifestage Framework, which highlights the key health and social factors that shape the FTP experience, including: FP/RH and MNCH needs and vulnerabilities; socio-ecological factors that comprise the broader context of sexual and reproductive activity at individual, household, community and systems levels; underlying gender and social norms that affect FP/RH choices,

Key Statistics

- 1.3 million youth (10-24 years) in CRS[2]
- 18% of adolescent girls (15-19 years) in CRS have started childbearing[1]
- 48% of all young pregnant women (15-24 years) in South-South Region are expecting their first child[1]
- 27% of sexually active adolescent girls (15-19 years) in CRS currently use a modern contraceptive method (both married and unmarried)[1]
- 15% of married young women and 24% of sexually active unmarried young women in Nigeria have an unmet need for contraception[1]
- 40% of births to all women in CRS over the past 5 years were delivered in a health facility and by a skilled birth attendant[1]

decisions and behaviors. The primary objectives of the assessment were as follows:

1. To explore knowledge, attitudes, and behaviors among FTMs, their male partners, and other household and community influencers and decision-makers related to health and health-related outcomes of interest, such as experience with ANC and delivery services, child health and breastfeeding, and attitudes towards birth spacing and postpartum contraceptive use;
2. To explore the current experience of facility- and community-based health providers and resource persons in providing services to FTMs and their partners; document the levels of current use of FP/RH and postpartum care services by FTMs at facility level;
3. To explore the acceptability and interest in participating in a program targeting FTMs and their partners on the above outcomes of interest.

The assessment was conducted in communities within the catchment areas of three health facilities in Ikom and Obubra LGAs, which were already working with SMGL-EFP. Data-collection methods included:

- Focus Group Discussions (FGDs) with married FTMs aged 18-24 years and Community Health Volunteers (CHVs) who provide outreach to all pregnant women on ANC and safe delivery;
- In-depth Interviews (IDIs) with facility-based FP providers; married FTMs aged 18-24 years (both current and never users of facility-based FP services); unmarried FTMs aged 18-24 years (both current and never users of facility-based FP services); husbands/partners of FTMs; mothers of unmarried FTMs residing with them; and community leaders.

Recruitment of FTMs, male partners of FTMs, and mothers to unmarried FTMs (who live in the same household) was conducted at the household level in the designated facility catchment areas. Trained research teams moved from house to house to locate eligible respondents using a pre-determined interval of household selection (based on a quick mapping exercise of the number of residential structures in the target communities). FTMs aged 18-24 years with only one infant less than 12 months of age were the primary target. Additionally, mothers and male partners of FTMs were recruited by inquiring if an FTM with the desired characteristics lived in their residence, FTMs, male partners, and FTM mothers were interviewed in separate households; no more than one respondent was interviewed in each residence. Interviews were conducted primarily in Pidgin, with a few interviews conducted in vernacular languages.

The assessment team maintained detailed field notes and short summaries of field work observations throughout data collection. An analog or digital voice recording device was also used to capture the interviews. Recorded interviews were transcribed and translated into English. Field notes and transcripts were coded and a coding template was developed to reflect emerging themes. Analysis was conducted using NVIVO software. The protocol for this assessment received Institutional Review Board (IRB) approval from the Government of CRS, Nigeria, Health Research Ethics Committee and was exempted from IRB review by PATH's Research Determination Committee.

The qualitative research methods used during the study have several well-known limitations, such as lack of generalizability of findings, biases introduced by flawed respondent recruitment strategies, moderator biases, non-response of respondents due to sociocultural and

Two FTMs and their children

power differences, or fear of lack of confidentiality. E2A sought to reduce these limitations by selecting participants at the household level, training all moderators in ethical qualitative research, and ensuring the full confidentiality of respondents.

Key Findings

The formative assessment provided a wealth of information on the experience and needs of FTP in CRS. This research brief focuses on information shared by young FTMs, their male partners and the mothers of FTMs.

Unmarried FTMs tended to be younger than married FTMs, and their male partners were themselves young and first-time fathers. The assessment provided an important opportunity to learn more about the basic socio-demographic characteristics of FTPs. in CRS. As most available facility data does not disaggregate recorded information by both age and parity, these findings offer context to better understand their responses and also give a better sense of the potential participants for FTP programming. Table 1 presents a summary of FTM and male partner characteristics.

The FTP experience proved to be a time of tremendous uncertainty for young women, their partners and their families. While it is expected that the FTP lifestage is inherently a time of transition, the assessment highlighted just how challenging the experience can be for many young people and their families. Participants across all respondent categories noted that their pregnancy fundamentally affected many other aspects of their lives – from marital or relationship status, to education, to financial support, to residence – leaving them uncertain about their immediate and longer-term situation. Some specific and inter-related points that participants noted included:

- **Pregnancies were often unplanned and unexpected, contributing to a sense of disruption and instability:** Half of FTMs, regardless of marital status, said their pregnancies were unplanned, fundamentally disrupted existing plans, and raised concerns about their ability to care for and support a child. Both married and unmarried FTMs reported that their education or financial status was negatively affected, which influenced how they felt about their situation. Male partners expressed a similar wish to have completed their education before marrying and having children. Male partners also reported concerns about their partner's health and pregnancy outcome, especially if the pregnancy was unplanned and their partner was particularly young. Across all participants, financial issues played a critical role in shaping the FTP experience, including family support, utilization of health services, and living arrangements.

"People look at you as a spoilt child and will regard you as one 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, [the family] *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

- **Pregnancy was a defining moment for their union/ relationship status:** Across all categories of interviewed FTMs, pregnancy came before marriage and influenced whether the

Table 1: Selected demographic characteristics of interview respondents, by respondent type, CRS, Nigeria

Young First-Time Mothers	*Male Partners of FTMs*
• **Age:** Unmarried FTMs tended to be younger (aged 18-22 years) than married FTMs (generally 20-24 years) • **Education:** Nearly all, regardless of marital status, had completed some or all secondary school • **Women's occupation:** Petty trade/business, hair stylist, housewife, and farming • Most respondents had a baby (either male or female) **under 6 months of age**	• **Age**: Most are in their mid- to late-20s (overall range 24-35 years old) • **Education:** Nearly all have some secondary or higher education • **Occupation:** farming, student, barber, cyclist, business, skilled trade (mason, mechanic) • Nearly all are **first-time fathers** and reported having only one wife/partner

FTM and her child

relationship resulted in continued partnership, formalized marriage, or separation. Both married and unmarried FTMs expressed uncertainties about their relationship status and partner commitment. Some male partners reported that there was pressure from the parents of the FTM to take responsibility for the child, which had implications for their relationship.

"…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

- **FTMs and their male partners experienced fluid and complex living arrangements, often related to financial needs or other forms of support:**
Many FTMs and male partners reported a wide range of living arrangements that often shifted over the course of the FTP experience, regardless of marital status or if their pregnancies were planned or unplanned. FTMs noted that they shared housing or were in temporary living situations due to financial difficulties or need for extra support with child care, especially during the postpartum period. Most FTMs, married and unmarried, received assistance with infant care from the women living with them or nearby, including their mothers, mothers-in-law, or other female relatives. While male partners participating in the study were living together with their partners or wives, several noted reliance on parents and extended family members, especially with those who are not financially independent.

- **Many FTMs reported social difficulties from the community related to becoming pregnant before marriage:**
FTMs noted that being unmarried and pregnant led to social stigma and discrimination, and that as a result, they would isolate themselves and avoid going outside of the home. Critically, FTMs and their mothers noted that this stigma can delay disclosure of the pregnancy and prevent them from seeking health care.

"Those that are married feel happy for being a pride to their family, while those who are not married are regarded as a disappointment to the family. You are looked down on because you are a single girl who is not married but pregnant."
- Married FTM FGD

- **Male partners had mixed views about their ability to be good fathers and provide for their families**:
Many men raised concerns, noting that their youth and financial instability caused them to feel some uncertainty about their futures and their ability to provide for their families. At the same time, many men, especially married men, were confident in their ability to build a home together with their wives, despite their young age, and the challenge of obtaining employment.

"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

"I had confidence since my wife and I are still young, and we are getting to our expected target. I was thinking I am capable, I was thinking the power was there to handle everything that is coming. Before my wife came, I have been a hardworking guy. I will work harder, because I know that in due time, we will be more than two."
- Male Partner IDI

- **Older women – the mothers and mothers-in-law of FTPs – provided essential support throughout the FTP experience:**
Mothers of FTMs, especially those who are unmarried, were heavily involved in ensuring that their daughters' health needs were met throughout pregnancy and delivery. They also provided childcare and financial support for the young family. Older women noted that these duties placed an additional burden on them, with responsibilities that went beyond their traditional role as mothers and grandmothers. FTMs and male partners frequently recognized the support and guidance provided by older women. FTMs

who received extended care from female relatives, especially their own mothers, felt particularly supported and less isolated. However, mothers of unmarried FTMs often expressed dissatisfaction in the attitude of the baby's father towards their daughter and the extent of financial and other support provided. This suggests underlying tensions within the core group of individuals involved and putting the young mother in a difficult situation.

"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

*"I am not happy with the way the father of this child is treating everybody. I am not happy with the way he is treating my daughter, because even when I was…pregnant, I received a lot of care from my husband and my pregnancy expenses weren't [*the responsibility of*] my mother, like what is happening to my daughter now. He impregnated my daughter in school. It was so painful. I wanted to do bad to him because of my anger, but people said I shouldn't do it. I do advise him but he doesn't take my advice, he does anything he likes."*
- Mother of FTM IDI

FTMs did not make important decisions about their lives and healthcare independently. Parents and/or partners played critical roles. A majority of FTMs (both married and unmarried) mentioned that they tend to make day-to-day childcare and feeding decisions, with advice from their mothers, mothers-in-law, or the baby's father. However, more important decisions were often driven by others, especially when financial resources were involved. For married FTMs, male partners and partners' families played a critical role in making decisions. For unmarried FTMs living with one or both parents, parent(s) were the ones to make key decisions. Male partners generally felt that they made decisions about healthcare, largely driven by their responsibility to pay and assist with their wife/female partner's care, or care of their infants. FTM mothers and male partners reported conflicts about care and decision-making, particularly when the male partner was young and unemployed, with the FTM mother reporting that she made most of the decisions.

Unmarried and married FTMs differed in their healthcare use, reflecting financial concerns and broader social stigma. Unmarried FTMs, who reported experiencing more stigma related to their pregnancies than their married counterparts, attended ANC later in their pregnancies, made fewer visits, and were less likely to deliver at a clinic or hospital than married FTMs. Unmarried FTMs reported not visiting the hospital after a home delivery, while most married FTMs reported visiting the hospital within a few days after a home delivery for medical checks. Cost and proximity to healthcare determined the use of health facilities by all FTMs interviewed. Almost no FTMs mentioned wanting or preferring to deliver at home, but did so due to lack of planning or resources. These views were echoed by many male partners as well.

"That fateful day, I wasn't at home, I was with one of my friends. I was called that my wife had given birth, she was cooking, and she just gave birth. She was already in labor at home and she could not get to the health center because she couldn't walk to the clinic. It was the way God wanted it to be. God knew that I did not have money to get her to deliver at the hospital, so he made her deliver peacefully."
- Male Partner IDI

While there was broad support for breastfeeding, exclusive breastfeeding was not practiced. All respondents agreed that breastmilk helps a baby grow and develop, and that it would be taboo not to breastfeed. FTMs had uneven knowledge about the benefits of breastmilk, especially regarding the benefits of colostrum and exclusive breastfeeding. FTMs who accessed facilities for ANC and/or deliveries reported receiving information and support with exclusive breastfeeding from providers. However, practice of exclusive breastfeeding was limited. Many FTMs began complementary feeding a few weeks after delivery because they thought that breastfeeding alone was insufficient nutrition for the baby. Several participants attributed the crying of babies to hunger, and therefore initiated water and foods, such as pap (cornmeal porridge) or instant custard (commercially made of cornstarch, colors, and flavorings, mixed with water or milk and sugar). This practice was usually influenced by FTMs' mothers, mothers-in-law, or male partners.

"I am giving my baby exclusive breastfeeding because we were told in the hospital that it makes the child stronger and it prevents the baby from [getting] sicknesses."
- Married FTM IDI

"…if she wants your attention, she will begin to cry and you will feel that the child is crying, let me go and carry her. If it is hunger and if you give her breast milk, she will stop. If she continues to cry, you give her pap and she will keep quiet, and if the crying stops, you will know that she was hungry."
- Male Partner IDI

Across the board, there was strong understanding and support for spacing the birth of the next child: Nearly all respondents – across FTMs and male partners - reported that they preferred to wait three to five years before having a second child. Most respondents could

Male partners of FTMs

easily name several benefits of birth spacing, including improved health of the mother and child, and improved chances of resuming education and being financially prepared for the next pregnancy.

"The benefit for me and his father is that we will be able to make more money before the next child comes, and the first child will be in school."
- Married FTM IDI

"*If you look at our economy, it 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

Despite high acceptance of delaying their next birth, participants did not always see contraception as a safe tool to space subsequent pregnancies. Some FTMs and male partners were able to name at least one modern contraceptive method, but most had limited knowledge of how to use any method or how they worked. Myths and misconceptions about modern contraceptive methods were common, especially fears about causing infertility and 'spoiling the womb.' Married FTMs who had never used a method of contraception generally said family planning is safe and beneficial, but unmarried FTMs who had never used contraception were less likely to agree. Several men mentioned that they prefer "the local method" of spacing (i.e., extended postpartum abstinence). While most male partners do not believe that modern contraceptive methods are safe, they said they would approve of their wives/partners using a method if they wished. Mothers of FTMs largely agreed that they would approve of their daughters using contraceptives, as this would allow them to fully recover from their previous pregnancies and would offer them opportunities two return to school or continue a relationship with the baby's father.

"No [I have never used a method of 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

"It affects the womb and sometimes when one later needs babies, the woman will not be able to take-in [get pregnant] again, that means the womb may have been destroyed."
- Male Partner IDI

"Yes, *I do advise her, she will do FP, we have it in our plans. She came to tell me about what they told them about family planning at the health centre. I advised that FP is good so that she would not make any mistake. It is left to her to decide if she wants to do it or not."*
- FTM Mother IDI

For FTMs, concerns related to financial instability and lack of security influenced FP use and choice of contraceptive method. In general, respondents who were in more stable unions and less worried about their financial stability seemed less likely to use a modern contraceptive method. Several unmarried FTMs who were current contraceptive users mentioned that they would use a method until they got married or wished to become pregnant again. Married FTMs using contraception mostly relied on condoms, which were

often given for free upon discharge after delivery. Unmarried FTMs reported using either an implant or injectable obtained during a specific FP counseling visit to a facility. While men suggested they would support their partners if they wished to use FP, FTMs were less clear on this, even indicating that secret use of FP could occur.

*"Some [*husbands*] will support [*their wives to use FP*], some don't support, some women will hide and do it [*FP*] without the knowledge of the man."*
- Married FTM FGD

Parenting and childcare roles and responsibilities fell along clear gender lines. In general, FTMs reported having primary responsibility for daily care of the household and child, often with the assistance of other women in the household or extended family. Many men reported caring for, and providing support to, their wives with a variety of childcare tasks, despite norms-driven negative perceptions that say a man must have been "charmed" or "bewitched" to do so. For most men, however, direct handling of the baby (e.g., holding, soothing, playing) only occurred after the infant was a few months old. Men consistently stressed their role as being the provider for the family, and less on daily care of their partners and children. Given the spectrum of relationships and living arrangements, FTMs varied regarding their own feelings about the father's support and engagement with the child.

*"He spends time [*with the baby*] as he is supposed to do. He will stay with the child for some hours. Right now, I don't have anybody apart from him, so he will help me do anything I need before he goes out."*
- Married FTM IDI

"My wife does virtually all the activities, I only assist her when the baby cries."
- Male Partner IDI

*"…the father takes care of the children. When they are born, you will buy him medicine, give him treatment, and when a child is not well, he keeps embracing the child so that the child will be happy. And when the woman herself cries about food at home saying there is no food today, the father will go out to buy food - if he is a real father. But if [*he*] is not a real father, he will just go his way not having time, his own [*role*] is just to come and see the woman and go back. He does not even have time for the child."*
- Male Partner IDI

Across the board, respondents interacted with their infants and young children, and had some understanding of child development. All respondents understood that babies communicate from a very early age, even through crying. Both male and female respondents played, sang, and talked to their infants, even before they could talk or sing in return. FTMs and male partners said they occasionally became angry with their babies; few reacted by scolding or physically punishing the infant.

FTMs, male partners, and older women expressed interest in programs for FTPs. Most FTMs expressed a willingness to participate in a program for FTMs, male partners, and FTM mothers. Married FTMs noted that they would be willing only with the permission of their husbands. Nearly all men mentioned that they would be eager to participate, and several mentioned the desire to participate in home visits specifically. Most men supported their partner's participation in the program as long as childcare duties were met. FTM mothers said participation may be beneficial for their daughters and that they could convince them to participate, especially since they have been the main person supporting their daughters during pregnancy through childbirth and child care.

Program Considerations

The findings from this formative assessment provide important insights for stakeholders, programmers and communities interested in reaching young FTPs in CRS. The experiences shared by FTMs, their male partners, and their mothers point to the complexity of the FTP lifestage and the multiple people and factors that influence how pregnancy, childbirth and child raising occur. Based on the study findings, a program targeting FTMs, their male partners, mothers, and mothers-in-law should consider the following points.

Work with young FTMs to ensure positive health and gender outcomes throughout pregnancy, delivery, childbirth, and the early life of their child. Regardless of their individual characteristics and situations, FTMs are generally uninformed and unprepared for the health journey of becoming a mother – especially as so many are coping with unplanned pregnancies and unexpected motherhood. Given the fluid nature of relationships, living situations and support, all FTMs would benefit from programs that build their FP/RH/MCH knowledge and related lifeskills and access to quality health care. An essential part of this must focus on gender norms and roles, including helping FTMs build the planning, decision-making, communication, and negotiation skills they need to take more control of their personal situations and options. With the stigma and isolation that some FTMs experience, there is also great value in creating a safe space where young women can come together to learn and build new connections with others in their same situation.

Systematically engage the key influencers – the male partners of FTMs and the mothers of FTMs – to build support for FTM action and

foster more gender-equitable roles and responsibilities. Although male partners and older women may be most influential with different FTMs – male partners within marriage, and mothers for unmarried FTMs – they consistently have a say in critical choices and decisions for all FTMs. Many male partners are themselves young First-Time Fathers also coping with unexpected fatherhood. Older women are taking on roles and tasks as mothers and grandmothers that push beyond traditional boundaries. As such, these key influencers also need basic FP/RH/MCH information and access to services to support healthy decisions and actions throughout the FTP lifestage. In addition, programs should build understanding of gender norms and power dynamics, as well as encourage influencers to reduce relational barriers to better health and life options for themselves and their partners/daughters.

Address community attitudes and norms that can lead to isolation and stigmatization of young FTMs. Many FTMs reported feeling condemned for being young, unmarried and pregnant. Given that marital status is so fluid, it is likely that many FTMs face the emotional and mental toll of stigma, as well as the very real health consequences of not seeking timely health services for themselves and their child. Programs should engage with community leaders and members – especially parents and gatekeepers responsible for the well-being of adolescents and youth – to build their understanding of the FTP lifestage and the complex situations of FTPs in CRS, including the negative social and gender norms that limit FTP choice and timely use of healthcare.

Tailor FP/RH/MCH information and service delivery to better reach and serve young FTMs and influencers. Experiences shared by FTMs, male partners, and older women indicated several gaps in knowledge and access that increase risks of poor pregnancy, maternal, and child health outcomes. Given that so many FTPs are dealing with unplanned pregnancies, it is essential to find health information and service delivery access points that link young mothers to care in a timely manner.

The assessment suggested several opportunities to reduce the social, physical and financial barriers that FTPs in CRS face:

- Create systems that identify and link young FTMs (especially unmarried FTMs) to a continuum of care that begins with timely ANC and continues through child health services, such as home visits by trained community-based resource persons and community-based health and service outreaches;
- Promote birth preparedness of FTMs, couples, and other key influencers (e.g., mothers of FTMs) by working with them to recognize potential risk factors and complications and plan for delivery;
- Support financing options that reduce costs for FTPs to travel to and deliver at health facilities; such as delivery vouchers/subsidies and emergency transport systems;
- Expand on positive norms related to breastfeeding to strengthen practice of exclusive breastfeeding, focusing on the nutritional "completeness" of breastmilk for young infants, timing of weaning, and importance of colostrum;
- Build on support for birth spacing to improve acceptance of modern contraceptive methods as a tool to achieve spacing goals by improving knowledge of contraceptive methods (including side effects), addressing myths and misconceptions; and exploring values related to contraceptive use.

Promote positive parenting and gender-equitable roles in caring for homes and children. While both FTMs and male partners valued interacting with their infants and children, caretaking responsibilities fell along clear gender lines. FTMs or other female relatives took responsibility for all daily tasks (e.g., feeding, bathing, washing, etc.), while men focused on the provider role. Programs should work with FTPs to challenge and change gender norms that limit fathers' engagement with their families and reduce the burden of care placed on FTMs.

I***ncorporate program elements (or link to other ongoing programs) that address educational and economic opportunities for FTMs and their families.*** Across the board, FTMs, male partners, and older women flagged how unexpected parenthood disrupted educational plans and raised financial concerns. Programs that support continued education, vocational/entrepreneurship training and income generating activities would address significant non-health needs of FTPs.

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