Improving Family Planning Outcomes for First-Time Parents in the Greater Mahale Ecosystem of Tanzania

In 2018, the Evidence to Action (E2A) Project and Pathfinder International/Tanzania launched an initiative focusing on young first-time parents (FTP) in the Greater Mahale Ecosystem of Tanzania as a new component of the Tuungane Population, Health, and Environment (PHE) project.

Since 2011, Tuungane has been working in partnership with the Government of Tanzania in extremely remote, marginalized, and vulnerable communities to tackle some of their most complex development challenges, including access to voluntary family planning (FP) services. Noting patterns of early childbearing and low contraceptive use among young people in the Kigoma and Katavi regions where Tuungane operates, E2A and Pathfinder Tanzania saw an important opportunity for the project to add a new component that advances healthy timing and spacing of pregnancy (HTSP), FP, and social support for FTPs—defined as women under 25 years who are pregnant with or have one child and their partners. Specifically, the project set out to:

- **Increase voluntary contraceptive use**
- **Improve HTSP/FP knowledge, attitudes, and intentions**
- **Increase support from partners, families/households and communities to create an enabling environment for FP use by young first-time mothers (FTMs)**

THE TUUNGANE PROJECT: AN OPPORTUNE SETTING FOR FTP PROGRAMMING

Tanzania faces significant RH challenges, particularly in the areas where Tuungane operates—Kigoma Region in the Western Zone and Katavi Region in the South West Highlands Zone.[1] Sexual activity starts early in these two zones, with a median age at first sexual intercourse of 17.1 in Western and 17.2 in South West Highlands. Importantly, these same two zones have the highest levels of teenage childbearing in Tanzania, with 38% (Western) and 34% (South West Highlands) adolescents aged 15–19 years who have begun having children, compared with 21% nationally.[2] Katavi Region leads the country, with a teenage pregnancy rate of 45.1%.[3] At the same time, modern contraceptive use in both Kigoma and Katavi regions is just 18%, among the lowest levels in the country.[4] Only 8.6% of young women aged 15–19 years and 29% aged 20–24 years use a modern method of contraception.[5] Unmet need for FP among married young women 15-24 years is approximately 23% across Tanzania and reaches 27-28% in both Kigoma and Katavi.[6]

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Qualitative baseline findings from first time mothers (FTMs) in Tuungane communities echo global insights into the unique challenges that limit their reproductive health choices and actions.[7] Most FTMs lack accurate information on FP, as they often cannot access trusted sources of health information. Household responsibilities and limited mobility keep them at home and away from health services and supportive social networks. This situation can be compounded for young unmarried FTMs who fear real or perceived stigmatization by their families and communities for having children outside a socially sanctioned union. Many FTMs also report that decisions to plan when and if they want to have children and use contraception are rarely their own. Their husbands, parents, in-laws, community, and family elders have significant influence over decisions that involve reproductive health and use of household resources.[8] Unequal power and gender dynamics, along with other contextual factors, such as sociocultural preferences around fertility, can influence

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THE TECHNICAL STRATEGY FOR THE TUUNGANE FTP COMPONENT WAS GUIDED BY FOUR PRIMARY OBJECTIVES, ALIGNED CLOSELY WITH E2A'S GLOBAL FTP APPROACH

1. Improve the capacity of CHWs to provide FP counseling, services, and referrals for FTMs/FTPs at the community level
2. Strengthen the capacity of FTMs/FTPs to access FP information and services at the facility and community level
3. Create an enabling environment for the provision and use of FP by FTMs/FTPs
4. Contribute to the global evidence-base on effective strategies to reach FTMs/FTPs with community-based FP information and services

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e2aproject.org/FTP

early, rapid, and repeat pregnancies, compromising the health of young women and their newborns.[9] The risks associated with early childbearing and closely spaced pregnancies are high for both the woman and her new baby, including increased risk of both maternal and infant mortality.[10] Given the high levels of pregnancy among adolescents and young women in Kigoma and Katavi and the particular vulnerabilities of young FTMs, adding an FTP-focused component became a priority for Tuungane and E2A.

BRINGING AN FTP-FOCUS TO THE FAMILY PLANNING ELEMENTS OF TUUNGANE

Launched in 2018, the new FTP component of the Tuungane Project focused on advancing HTSP/FP and social support for young FTMs. As part of its broader PHE approach, Tuungane had already been working with the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) to strengthen FP service delivery at 23 health facilities and 44 surrounding villages in the Uvinza and Tanganyika Districts. Project-supported activities, such as provider training and supportive supervision, helped improve FP quality and capacity at these health facilities. Community Health Workers (CHWs) also worked in project communities to build awareness and provide FP counseling and services. Building on this platform, E2A and Tuungane implemented the FTP component in a sub-set of the larger project and included 15 communities served by seven facilities (Buhingu, Ikola, Kalya, Karema, Kashagulu, Mwese and Sibwesa) in the two districts. All activities were implemented through community-based resources persons, in partnership with the MOHCDGEC and the Local Government Authority, with supervision by Tuungane staff and technical support from E2A/Washington DC. Preparations for FTP activities began in early 2018, with the main period of implementation in communities occurring from May through September and data collection continuing through November.

In designing the FTP component, E2A applied a life-course and socio-ecological lens to determine the appropriate content and structure of the FTP component.[11] Given the FP mandate for both E2A and Tuungane, interventions primarily focused on the post-partum phase of the FTP lifestage to improve HTSP/FP outcomes and facilitate the informed, voluntary use of modern contraceptive methods. In addition, the effort aimed to strengthen the support of multiple influencers and systems for voluntary contraceptive use among young FTMs/FTPs, including the underlying gender and social norms that influence FTP relationships, choices, and actions.

1–6 Tanzania Demographic and Health Survey and Malaria Indicator Survey 2015–16.

7 FTP Snapshot: Tanzania, Evidence to Action, 2018.

8 Anna Engebretsen and Gisele Kabore, Addressing the needs of girls at risk of early marriage and married adolescent girls in Burkina Faso, Population Council, May 2011.

9 Stephenson, Rob et al. "Contextual Influences on Modern Contraceptive Use in Sub-Saharan Africa" American Journal of Public Health July 2007, Vol 97, No. 7.

10 Healthy Timing and Spacing 101 Brief, Extending Service Delivery Project.

11 CHWs in Tanzania can provide male condoms, initiate and resupply oral contraceptives, and give referrals for all contraceptive methods.

12 FTP Framework, Evidence to Action, 2019

PROGRAMMING WITH A LIFE-COURSE AND SOCIO-ECOLOGICAL LENS

To meet its objectives, the team implemented a package of interventions straddling multiple levels of the FTP socio-ecological model to improve FP-related knowledge, attitudes, communication, decision making, and use by young FTM/FTPs.

INTERVENTION	DESCRIPTION
FTM PEER GROUPS 	FTM small groups, facilitated by peer leaders, explored information on HTSP and FP, contraceptive choice, decision-making, and gender dynamics. A total of 29 groups, composed of 12–15 FTMs each, met for seven sessions held every two weeks. Groups were supervised by CHWs attached to a local health facility.
OUTREACH WITH KEY INFLUENCERS 	CHWs led informational sessions with key influencers, including partners/husbands, mothers, and mothers-in-law to build support for contraceptive use by FTPs.
HOUSEHOLD VISITS 	CHWs visited FTM households to provide tailored services. With the aid of a mobile application, CHWs provided information to women and their partners, delivered condoms and oral contraceptives, and made referrals for other FP methods and services. They also provided follow-up support.
COMMUNITY AND FACILITY FP SERVICES AND INFORMATIONAL OUTREACH 	Tuungane provided support and supervision to health facilities, and also and trained health care providers and CHWs to deliver youth-friendly FP counseling and services. Through the FTP component, CHWs also provided orientations on FP and FTPs to community members.
PHE LINKAGES 	CHWs provided and tracked referrals to FTM peer group members for different PHE activities in their communities, including agriculture groups, Community Conservation Banks (COCOBAs), model households, and Beach Management Units (BMUs).
DATA GENERATION 	The project team generated data on both implementation and FP-related results, including a qualitative baseline/endline, FP data collected via CHW mobile application tool, health facility data, and monitoring reports.

TOPICS ADDRESSED IN FTM PEER GROUPS

Healthy timing and spacing of pregnancy

Life aspirations and desired family size

Overview of all contraceptive methods, with specific activities on implants and IUDs

Gender norms

Healthy intimate relationships

Peer-led Small Groups with Young FTMs

FTM peer groups—a core element of E2A's approach to working with this youth population—formed the central activity for the Tuungane FTP component, providing safe spaces, peer networks, and role models, which encouraged young women to learn and share. A total of 29 FTM peer groups were established and remained active over a five-month period (May–September 2018). All participating FTMs, including Peer Leaders, met the age (under 25 years) and parity (pregnant with or having one child) criteria, and lived within the peer group community. Groups met every two weeks in their communities to conduct seven sessions that focused on HTSP/FP and related topics. For each session, peer leaders used an activity card adapted from the GREAT Project to explore a specific topic. For each content session, peer leaders used an activity card, adapted from the Gender Roles, Equality, and Transformations (GREAT) project,[12] to explore a specific topic. On average, each group had approximately 12–15 members, with over 400 young FTMs attending sessions over the intervention period.

"We have seen tremendous changes in the peer groups. Most of them had no idea of the modern FP methods, and did not have the knowledge. They have adapted these new ways after getting the education on the modern FP methods." —CHW, KALYA

CHW Activities

CHWs were the primary implementers of FTP activities in communities. Under Tuungane, the project team was already working with a network of CHWs to conduct FP-related activities, including broader awareness raising, home visits, and referrals. For the new FTP component, the project worked closely with 30 CHWs in 15 villages to implement multiple activities:

- **Coordinating with health facility staff/supervisors on community activities, contraceptive supplies, and referrals**
- **Liaising with community leaders and members regarding activities under the FTP component**
- **Supporting two FTM peer groups in his/her community, including collecting specific data and conducting FP orientations**
- **Facilitating informational outreaches with key influencers (husbands/partners and older women)**
- **Conducting home visits with FTM peer group members to provide counseling, select contraceptive methods (condoms and oral contraceptives), and provide referrals**
- **Providing information and referrals to FTM peer group members for PHE activities under the Tuungane project**
- **Tracking FP use by peer group members through the use of the mobile application tool**
- **Completing project management tasks, including providing input for monitoring reports and attending monthly review meetings**

Photo Sala Lewis

12 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.

GENERATING FAMILY PLANNING-RELATED RESULTS

One of the objectives of the Tuungane FTP component was to generate fresh evidence on effective programming for young FTPs. Along with the implementation experience and lessons learned, E2A and Tuungane collected quantitative and qualitative data that provided insights into FP-related outcomes of interest, including uptake of modern contraceptive methods and the underlying issues—such as FP attitudes, communication, and decision-making—that influence informed, voluntary FP use.

METHODOLOGY

Two main data collection efforts yielded important FP-related results and findings from participating FTMs, their influencers, and program implementers:

1. CHW Mobile Application Tool

All CHWs participating in Tuungane were provided with smartphones equipped with an application to support quality FP counseling, service provision, and referrals. The tool also collects and tracks FP-related information for each client registered by the CHW. For the FTP component, CHWs were asked to register all interested FTM peer group members, with their consent, at the start of the intervention—or "intake." Once registered, the peer group FTM could receive FP counseling, services, and referrals at any point during the intervention, and her data was updated after every interaction the CHW. In November 2018, the project extracted data for all registered peer group members to understand their FP status at the end of the project—or "exit."

2. Qualitative Baseline/Endline Data Collection

E2A and Tuungane worked with a local research firm, CSK Research Solutions Ltd., to conduct two rounds of qualitative data collection at baseline (May/June 2018) and endline (September/October 2018). The key objectives of the qualitative evaluation were to: (1) assess behaviors and attitudes related to HTSP and voluntary postpartum contraceptive use among FTM peer group participants and their partners; (2) understand and explore experiences, barriers, and facilitators for FTPs in relation to HTSP, communication, access to, and use of modern contraceptives among FTM peer group participants, partners, and other social influencers; and (3) assess the process and approaches used in implementing the FTP program from the perspectives of program participants, peer leaders, and CHWs. Data collection was conducted by a trained research team at six health care facilities serving communities participating in the FTP programming. All participants were directly or indirectly involved in Tuungane FTP component activities and consented to participate in this qualitative evaluation. The study protocol and other required documents were submitted to the Medical Research Coordinating Committee (MRCC) of the National Institute for Medical Research (NIMR) in Tanzania, which provided approval for the study in April 2018.

RESULT 1

Voluntary use of modern contraceptive methods increased from 35% to 66% of FTM peer group members over the course of the intervention. Despite the relatively short five-month intervention period, there were increases in FP use by registered FTMs across age and marital status categories. Importantly, the largest improvement in FP status was amongst younger FTMs aged 15–19 years, with a 145% change by the end of the intervention.

TABLE 1: Voluntary Contraceptive Use by Registered Peer Group Members at Intake vs. Exit by Background Characteristics*

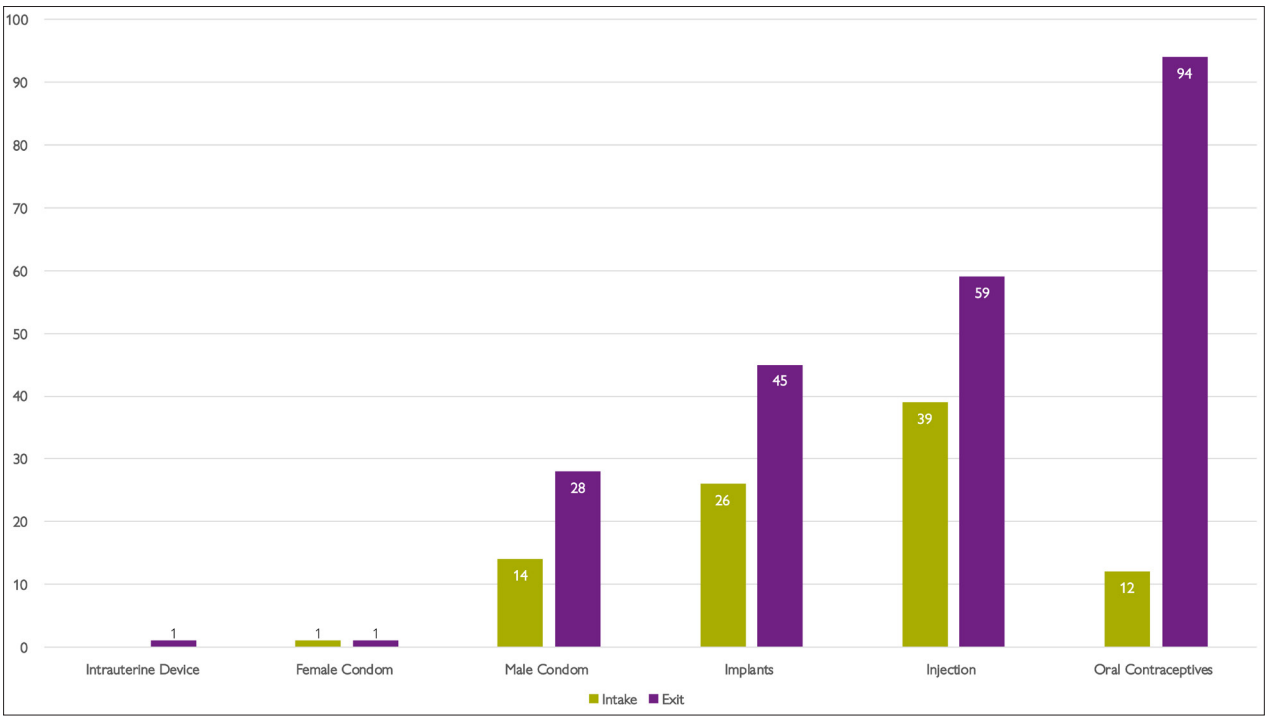
	INTAKE		EXIT		PERCENT CHANGE
	Number	Percentage	Number	Percentage	
FTP Age					
15–19 years	40	24%	98	60%	145%
20–24 years	79	44%	130	72%	65%
Marital Status					
Never Married	72	36%	141	70%	96%
Married or Cohabitating	42	32%	79	60%	88%
Separated or Widowed	5	45%	8	73%	60%
TOTAL FTMS	119	34%	288	66%	92%

*345 FTM peer group members were registered by CHWs.

RESULT 2

Increases in voluntary FP use by FTM peer group members were seen across the range of modern contraceptive methods available through community- and facility-based providers. The numbers of individual users increased across all methods, including long-acting reversible contraceptives. As the graph illustrates, the greatest increase was with oral contraceptives use, perhaps due to increased access to CHWs who can initiate and resupply this method.

FIGURE 1: Number of FTM Contraceptive Users at Intake and Exit by Method Type*



*102 FTMs were using modern contraceptive methods at intake and 228 at exit

RESULT 3

Of those peer group members who adopted FP over the course of the intervention, the vast majority were new FP users. Interestingly, there is a noticeable difference in method choice for these new users (largely oral contraceptives), versus those who were already using FP at intake (mostly injectables and implants). It is likely that increased contact with CHWs via peer groups and home visits created important access points for young women and also influenced initial method choice.

"We see the results, and the difference is evident in the community. Many [FTMs] have agreed to use FP and are continuing to change their lifestyles. Our statistics show that we had many FTMs who had not been using FP [before]. But after educating them about FP, they embraced our teaching and they are now using it."

—CHW, KAREMA

RESULT 4

Understanding of HTSP and its benefits seems to have deepened over the course of the intervention for FTMs and their key influencers. Qualitative findings indicate that the FTP intervention helped both married and unmarried FTMs deepen their understanding of the benefits of child spacing/HTSP. Many specifically pointed to the economic benefits of spacing their children—something they felt also resonated well with their partners. FTMs noted that by being able to space and plan their children, there was more time and energy to "hustle"—to invest in work and build something that will be "helpful in life."

"If I put in the FP method, I will have enough time for hustling to earn something that will be helpful in life. I think that if I put in the FP method, I can work freely, because what I am going to do is important to me."

—Unmarried FTM, KAREMA

"[My male partner] will be able to take care of the child and save money for his or her education. But if you are giving birth without spacing, the man will fail even to look for wealth. He will be overloaded in his mind."

—Married FTM, IKOLA

RESULT 5

While participation in FTP activities has improved knowledge and attitudes about FP, concerns about safety persist among some FTMs and their key influencers. The majority of FTMs participating in the endline reported having improved their knowledge of FP and different contraceptive methods through their participation in FTP activities. The FTP intervention was also helpful in addressing concerns about the safety of contraceptives, especially with regards to return to fertility after FP use. Several noted that accurate information provided through the peer groups helped to alleviate fears and allowed them to "feel free" to use FP. However, a few married FTMs reported that they were still concerned about the safety of some of the FP methods. Key influencers—especially male partners—also expressed continued concerns about future fertility after using a contraceptive method, with this often being the reason they would not agree to FP use by the FTM.

"…A large percentage of people believe that when you use FP you won't be able to conceive, and you won't get a child. Therefore, when I got into that group and became knowledgeable, I understood that even if you use FP, you will also be able to give birth."

—Married FTM, IBUHINGU

"Most say that FP isn't good because the injections or the tablets have a character of destroying the uterus. It disrupts the uterus, and so, you find that you are blocking the reproductive eggs [...] So, most are frightened through these sayings. But it's not true that FP can make you like that, because many are using it and when it's time, they remove it and by the time they want to get a child, they continue with their process."

—Male Partner, IKOLA

RESULT 6

Peer group FTMs noted improved communications about FP with partners, although decision-making about FP use remains a complex process for many. Many FTMS said that, prior joining the program, they did not feel free to speak to their partners about FP issues, but that peer group activities helped open the door to communication about FP—sometimes for the first time.

The young FTMs sometimes contradicted themselves when describing how decisions about FP use were made and acted upon, making it difficult to pull out clear patterns across the FGDs and IDIs. While most agreed that married FTMs generally consulted their partners (husbands) when making decisions on FP use, patterns were less clear with unmarried FTMs and seemed to be more situation-specific. That said, the different responses from FTMs are valuable, as they highlight the key influencers and situations that these young women navigate over FP use.

"I did not use family planning [before] because I had not yet spoken to my partner about it. I got the opportunity to talk about family planning when the peer groups were introduced. It was a golden opportunity to me."

—Married FTM, KALYA

"I told him that I had joined the peer group that was teaching about FP. I told him that, 'At first, I did not know the meaning of FP, but now I know. I'm therefore asking for your permission so that I can go and use FP. It is the thing that will help us in the future to cope with life challenges and be able to advance in some aspects. He permitted me to use FP from that point."

—Married FTM, BUHINGU

WHO IS INVOLVED IN FAMILY PLANNING DECISIONS?

"[Married FTMs] consult their husbands so that they can allow them to use family planning; although there are some husbands who would refuse to let their partners use family planning, and others agree. But most of us consult our husbands." —Married FTM, MWESE

"I am the one with the final decision because I might become pregnant while I have another child. I will be suffering myself while my husband is not around. Therefore, I have the final decision." —Married FTM, MWESE

"I involved my partner in this because I am about to live with him. That is why I told him, and he permitted me. I told him that our child is still so young, what shall we do? He said to me go and use FP, then I went for it." —Unmarried FTM, KALYA

"I will take the responsibilities myself, because he has rejected it and I don't live with him. I am the one who will suffer and not him. I will take the responsibilities and I will use it. I will do it secretively." —Unmarried FTM, KAREMA

Photo Sala Lewis

RESULT 7

Despite improved FP outcomes for peer group members, they noted that many FTMs face several barriers to FP access and use, including partner/family opposition and social stigma or restrictions. FTMs raised some of the underlying social barriers that limit access to FP services—especially at facilities—for both unmarried and married young women. Some FTMs felt that it was easier for married FTMs to access FP, as FP use among unmarried women was linked to promiscuity, which discouraged many from seeking for the services. On the other hand, some FTMs (both married and unmarried) felt that it is difficult for the married women to access FP because they needed to consult their spouses who may refuse and prevent them from seeking for the services.

"For the unmarried woman, if you educate her properly, and get her to understand well about FP methods, she is free to take the method of her choice without consulting anybody. The married woman cannot directly accept using a certain method before she has consulted her husband, and it will take more time for her to start using contraception than the one who is not married."

—CHW, IKOLA

RESULT 8

FTM peer group members reported sharing their knowledge and experiences with others in their communities, suggesting a diffusion of key messages and ideas beyond those directly engaged in the program. FTMs reported that they were open about their participation in the peer group program and shared what they were learning with others in their communities. Importantly, FTMs were able to share their experiences with other young women who might not otherwise have had access to such information and ideas.

"I talked to my friends, neighbors, and to others who might have planned even to have three children, but they deliver them continuously, they are supposed to space them."

—Married FTM, IKOLA

"I have spoken with people and some of them have started to understand me about what we learn in the peer group. Others come and ask you. You explain it to them and they understand and start to use those methods. Although we also have received a little education, they say, 'if you get [information], don't withhold it from your fellow.'" —Married FTM, KAREMA

"I thought it was good, because she tells me about what they are informed about there and I also become aware even though I am an adult. Something I found interesting was when she told me that they advised them to take care of their children so that they can grow up, and so that they can have good health for themselves first, that 'Giving birth continuously isn't good, we won't be healthy', and I told her 'Have you understood and heard? So, adhere to what they tell you.'" —Older Woman, KAREMA

This work was made possible by USAID through E2A and Tuungane in close collaboration with the Ministry of Health. The Evidence to Action (E2A) Project 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. The project is led by Pathfinder International, in partnership with ExpandNet, IntraHealth International, and PATH.

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