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

**REPORT | E2A PROJECT**

# ACKNOWLEDGMENTS

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The FTP activities and results presented in this report were achieved through the efforts of a large team, including: Pathfinder and E2A staff in Tuungane project offices, Dar es Salaam, and Washington DC; other Tuungane partners and staff; and community health workers, health providers, and young first-time mother (FTM) peer leaders from project communities. Several individuals played a leadership role in the design and implementation of the Tuungane FTP component: Joseph Komwihangiro, Pathfinder Tanzania Country Director; Josaphat Mshighati, Director for Advocacy and Population, Health, and Environment (PHE), Pathfinder Tanzania; Dr. Benedict Nyiro, Health Advisor, Tuungane PHE; Chaus Emmanuel, Clinical Services Mentor, Tuungane PHE; Hiza Ally, Community Outreach Officer, Tuungane PHE; Helen Magige, former Monitoring and Evaluation Director, Pathfinder Tanzania; and Benjamin Mrema, Monitoring, Learning, and Evaluation Program Officer, Pathfinder Tanzania.

Researchers from CSK Research Solutions, Limited (Tanzania) conducted baseline and endline interviews and focus groups with project participants under the direction of Dr. Catherine Kahabuka, Principal Consultant. The collation and analysis of monitoring and service data was conducted by Allison Schachter, former E2A M&E Advisor, and Ene Anteyi, former E2A Monitoring and Evaluation Intern. Technical, editing, and design support for this report were provided by Rita Badiani, E2A Project Director, Pathfinder International; Eric Ramírez-Ferrero, E2A Technical Director, Pathfinder International; Erica Mills, E2A Program Officer, Field Support; Maren Vespia, Consulting Communications Director; Ilayda Orankoy, E2A Communications Coordinator, Pathfinder International; and Margo Young, Consulting Editor.

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# ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| **BMU** | Beach Management Units |
| **BMU-COCOBA** | BMU Community Conservation Bank |
| **CHW** | Community health worker |
| **COCOBA** | Community savings bank |
| **E2A** | Evidence to Action |
| **FGD** | Focus group discussion |
| **FP** | Family planning |
| **FP/RH** | Family planning/reproductive health |
| **FTM** | First-time mother |
| **FTP** | First-time parent |
| **HTSP** | Healthy timing and spacing of pregnancy |
| **IDI** | In-depth interview |
| **MoHCDGEC** | Ministry of Health, Community Development, Gender, Elderly and Children |
| **PHE** | Population, Health, and Environment |
| **PL** | Peer leader |
| **TNC** | The Nature Conservancy |
| **USAID** | U.S. Agency for International Development |

# INTRODUCTION

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. Implemented in a subset of project health facilities and communities, the Tuungane FTP component generated valuable evidence and insights about this vulnerable youth population and how best to respond to their HTSP/FP needs.

This report presents an overview of Tuungane's FTP component, along with the FP-related results and key implementation learnings generated. The report also provides recommendations to inform future FTP programming under Tuungane and more broadly in Tanzania.

## Background

E2A's FTP work in Tanzania, along with similar E2A efforts in Nigeria and Burkina Faso, are part of an evolving body of work to increase global awareness and evidence on programming for FTPs. E2A's focus on FTPs grew out of efforts to understand the diversity of youth reproductive health (RH) experiences and needs. A 2014 review of global data pointed to a large subset of young first-time mothers (FTMs) who are at increased risk of poor pregnancy, delivery, and child health outcomes, a situation compounded by multiple factors that limit their access to timely health information and services. Despite these vulnerabilities, young FTPs have historically been overlooked by adolescent and youth FP/RH programs. E2A has prioritized closing this global gap by reaching FTPs in multiple contexts with health and gender interventions and gathering new evidence on effective programming for this subset of youth.

The Tuungane project in Tanzania provided 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. The Western Zone has the highest

total fertility rate in the country—6.7 children—compared to the national rate of 5.2 children.[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.[2] Importantly, these same two zones have the highest levels of teenage childbearing in Tanzania, with 38% (Western) and 34% (South West Highlands) of adolescents aged 15–19 years who have begun having children, compared with 21% nationally.[3] Katavi Region (South West Highlands) leads the country, with a teenage pregnancy rate of 45.%.[4]

According to the 2015–16 Tanzania Demographic and Health Survey, 32% of married women in Tanzania use a modern contraceptive. However, modern contraceptive use in both Kigoma and Katavi regions is just 18%—among the lowest levels in the country.[5] Only 8.6% of women aged 15–19 years and 29% aged 20–24 years use a modern method of contraception.[6] Unmet need for FP among married women 15–24 years is approximately 23% across Tanzania and reaches 27–28% in both Kigoma and Katavi.[7] As a result, 57% of women in Tanzania have given birth or are pregnant with their first child by age 19.[8]

These statistics suggest that young FTMs face unique challenges that limit their RH choices and actions—challenges that are different from other adolescents and different from older married women. Young mothers often become isolated because household responsibilities and limited mobility keep them at home and away from health services and supportive social networks. This situation can be compounded for unmarried FTMs who fear real or perceived stigmatization by their families and communities for having a child outside a socially sanctioned union. For many FTMs, the choice of using contraception to plan when and if they want to have children is rarely their own. Their husbands, parents, in-laws, community and family elders, and religious leaders have significant influence over decisions that involve RH and use of household resources.[9] Unequal power and gender dynamics, along with other contextual factors such as sociocultural preferences around fertility, can influence early, rapid, and repeat pregnancies, compromising the health of young women and their newborns.[10] 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.[11] Significant evidence posits that both mother and baby are healthier if at

[1] Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) [Tanzania Mainland], Ministry of Health (MoH) [Zanzibar], National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF. 2016. *Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015-16*. Dar es Salaam, Tanzania, and Rockville, Maryland, USA: MoHCDGEC, MoH, NBS, OCGS, and ICF.

[2] Ibid.

[3] Ibid.

[4] Ibid.

[5] Ibid.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] 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), accessed June 25, 2013, http://www.popcouncil.org/pdfs/TABriefs/09_BurkinaFaso.pdf.

[10] 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.

[11] Extending Service Delivery Project. Healthy Timing and Spacing 101 Brief. Washington, DC

least 24 months passes between pregnancies.[12,13,14,15] 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.

## Tuungane Population, Health, and Environment (PHE) Project

The Tuungane project is a collaboration between Pathfinder International and The Nature Conservancy, in partnership with the Government of Tanzania and other stakeholders, aimed at strengthening PHE initiatives in communities in the Greater Mahale Ecosystems of Tanzania. The project builds awareness about the relationship between people and their ecosystems and the importance of finding approaches that lead to positive human welfare and conservation outcomes. The communities in Tuungane are highly dependent on their surrounding natural resources—for their health, their food and their livelihoods. But climate change, deforestation, and unsustainable fishing practices are impacting the ecosystem and its ability to provide the natural resources that these communities need. Tuungane works with communities to address these issues and promote positive health and natural resource management practices, including planning their families, which will help conserve the ecosystem and support the long-term well-being of families living in these areas.

As the FP/RH partner on Tuungane, Pathfinder Tanzania focuses on four main objectives: (1) increasing access to quality sexual and reproductive health (SRH) services and FP for women and youth, including first-time parents; (2) increasing knowledge and demand of SRH/ FP services; (3) improving local government and community-level institutional capacity in PHE; and (4) increasing women's and youth participation in community platforms and management of natural resources, integrating health and non-health interventions.

Under Tuungane, E2A and Pathfinder strengthen access to quality FP services through health facilities and community health workers (CHWs) in Uvinza and Tanganyika districts in Kigoma and Katavi regions, respectively. The team also provides linkages to other interventions that Tuungane supports to promote positive PHE behaviors, including:

- ***Model Households***: Families volunteer as "Model Households" to educate by example. These families model healthy and sustainable behaviors, such as using a hand-washing station, installing an upgraded latrine, using energy saving stoves, and setting their agricultural plots away from the lake.
- ***Beach Management Units***: Coastal villages have established Beach Management Units (BMUs) to enact and enforce their own sustainable fishing regulations, such as outlawing destructive beach seine nets and under-sized fishing nets and protecting fish breeding and nurseries zones.

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[12] WHO. *Report of a technical consultation on birth spacing.* (Geneva: WHO, 2005). Available at: www.who.int/maternal_child_adolescent/documents/birth_spacing.pdf?ua=1

[13] UNFPA. *How Universal is Access to Reproductive Health?* 2010. Available at: www.unfpa.org/webdav/site/global/shared/documents/publications/2010/universal_rh.pdf

[14] Conde-Agudelo A and Rosas-Bermudez A. *Effects of Birth Spacing on Maternal, Perinatal, Infant and child Health: A Systematic Review of Causal Mechanisms.* Studies in Family Planning. 2012 43[2]: 93–114

[15] Cleland J, et al. "Contraception and health." The Lancet, 2012 380: 149-156.

- ***COCOBAs***: BMU Community Conservation Banks (BMU-COCOBAs) offer villagers an opportunity to save money and access loans, including microfinance loans, to start sustainable small businesses and diversify their income.
- ***Climate Smart Agriculture Groups***: Most villagers do at least some subsistence farming. The Tuungane project is providing training on climate smart agriculture practices, which not only reduce run-off into the lake, but also produce higher yields for the farmers.
- ***Forest Management***: The forested areas of the Greater Mahale Ecosystem are under threat from agricultural expansion, indiscriminate fires, and illegal forest harvesting. Community forest scouts are trained and deployed to protect forest reserves, including some that provide important habitat for chimpanzees.

## 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 addresses the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and facilitating the scale-up of best practices that improve family planning services. Awarded in September 2011, this project ends in September 2020. E2A is led by Pathfinder International, in partnership with ExpandNet, IntraHealth International, and PATH.

## Overview of E2A's Work with First-Time Parents

**First-time parents—defined by E2A as young women under age 25 who are pregnant with or have one child, and their partners—have largely been overlooked in reproductive health (RH) programs for youth.** Over the past five years, E2A has undertaken several conceptual and programming efforts that detail the FTP experience and explore how best to respond to their complex needs. Milestones of E2A's FTP work to-date include:

**A LITERATURE REVIEW**, Reaching Young 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 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);

**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 (current).

# TUUNGANE FTP COMPONENT

Launched in 2018, the 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 Uvinza and Tanganyika Districts. Project activities, such as provider training and supportive supervision, helped to improve FP quality and capacity at these health facilities. CHWs were also working in project communities to build awareness and provide FP counseling and services.[16]

Building on this platform, Tuungane introduced the FTP component in 15 communities served by seven facilities (Buhingu, Ikola, Kalya, Karema, Kashagulu, Mwese, and Sibwesa) in the two districts. Community-based resources persons implemented all activities in partnership with the MoHCDGEC and the Local Government Authority, with supervision by Tuungane staff working and technical support from E2A/Washington, D.C. Preparations for FTP activities began in early 2018, with the main period of implementation from May through September and data collection/analysis continuing through November.

E2A applied a life-course and socio-ecological lens to determine the appropriate content and structure of the FTP component.[17] Given the FP mandate for both E2A and Tuungane, interventions primarily focused on the postpartum phase among FTPs to improve HTSP/FP outcomes and facilitate 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 FTM/FTPs, including the underlying gender and social norms that influence FTP relationships, choices, and actions.

**Four primary objectives, aligned closely with E2A's global FTP approach, guided the technical strategy for the Tuungane FTP component:**

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

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

[17] For more information on E2A's FTP Framework, see https://www.e2aproject.org/publication/ftp-framework/

To meet these objectives, the Tuungane 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. Specific activities were also included to generate fresh evidence on both the implementation experience and FP outcomes emerging from this programming effort. The table below summarizes the interventions included in the Tuungane FTP component, followed by additional information on key activities, capacity-building, and data generation.

**Table 1: Tuungane FTP Interventions**

| 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. |

## CHW Capacity Building

Tuungane was already working with a network of CHWs to conduct FP-related activities, including broader awareness raising, home visits, and referrals, in all 44 communities involved in the project. Although CHWs fell under the MoHCDGEC system, the project defined the overall scope of their activity and provided a nominal travel allowance of 15,000 Tshs. (US$7) per month. The project team screened all active CHWs from FTP communities and selected 30 women and men (two per community) to implement multiple FTP activities. As all CHWs had already been trained on FP methods, counseling, and referrals—including use of a mobile application FP counseling tool—Tuungane staff conducted orientations that focused on the situation of FTPs in project areas, the proposed FTP component and activities, and project roles and responsibilities (community awareness building, home visits, referral systems, linkages with facilities, monitoring reports, etc.). CHWs received additional trainings as interventions rolled out, including on the peer group intervention (trained along with peer leaders), and on informational outreach activities with husbands/male partners and older women. CHWs were directly supervised by their corresponding health facility supervisors. Tuungane staff also monitored CHWs' field visits and engaged with CHWs, peer leaders (PLs), and facility supervisors through monthly meetings to review progress, address any challenges, and plan forward.

CHWs were the primary implementers of FTP activities in communities, and each CHW:

- Coordinated with health facility staff/supervisors on community activities, contraceptive supplies, and referrals;
- Liaised with community leaders and members regarding activities under the FTP component;
- Supported two FTM peer groups in his/her community, including collecting specific data and conducting FP orientations;
- Facilitated informational outreach with key influencers (husbands/partners and older women);
- Conducted home visits with FTM peer group members to provide counseling, select contraceptive methods (condoms and oral contraceptives), and provide referrals;
- Provided information and referrals to FTM peer group members for PHE activities under Tuungane;
- Tracked FP use by peer group members through the use of the mobile application tool;
- Completed project management tasks, including providing input for monitoring reports and attending monthly review meetings.

## Orientations on New FTP Component

The FTP component was implemented in facilities and communities that were already involved in the broader Tuungane project and, as such, were familiar with the key interventions and messages, including the promotion of quality FP services. Therefore, new orientations centered on raising awareness about FTP needs and circumstances and upcoming FTP activities. Prior to the start of activities, Tuungane staff conducted orientations at each participating facility and CHWs held meetings with community leaders and members. These orientations also provided an opportunity to begin the process of identifying potential young FTM PLs.

## 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, encouraging young women to learn and share. The peer group intervention was implemented in a subset of 15 communities and seven facilities in Uvinza and Tanganyika districts, with a total of 29 FTM peer groups established and active over a five-month period (May-September 2018).[18]

Peer groups were led by young women (PLs) who met the criteria set by project staff, including: (1) being FTMs (under 25 years with one child, and not pregnant with second child); (2) living in the localities identified for peer groups (and intending to stay at that location for at least six months); (3) literate in Kiswahili; (4) having demonstrated leadership skills, including strong communication skills; (5) able to prepare, conduct, and report on peer group meetings; and (6) available to participate in monthly review meetings. CHWs shared these criteria with community and women leaders, as well as participating facilities, to identify potential PLs. Thirty young FTMs were recruited to serve as volunteer PLs, with each responsible for one peer group in her community. Project staff trained PLs on multiple topics including: basic HTSP/FP information; facilitation skills; the use of six activity cards, adapted from the GREAT Project,[19] with their peer groups; and broader project tasks (e.g., maintaining group attendance records). Importantly, the CHWs also participated in this training, allowing PLs to begin building a connection with their primary resource person and also ensuring that CHWs were fully aware of the technical content and gender/social issues being addressed in peer groups.

**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

[18] Due to the low numbers of FTMs in one village in Tanganyika, two peer groups were combined into one single group, which was active throughout the intervention.

[19] 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.

Following the training, PLs and CHWs began recruiting FTM group members through their community contacts and peer networks. The 29 peer groups met in their communities every two weeks from May to September 2018 to conduct seven sessions. On average, each group had approximately 12-15 members, with almost 400 young FTMs participating over the five-month period. Using activity cards adapted from the GREAT toolkit, each session addressed a priority health and gender issue, such as HTSP, specific modern contraceptive methods and problem solving within relationships. PLs facilitated one card per session, with each meeting lasting approximately 1.5 hours on average. During one session, CHWs provided an overview of all modern contraceptive methods to ensure FTMs were oriented on all FP options. Many CHWs attended sessions throughout the intervention to answer questions and help with facilitation and logistics.

CHWs were responsible for daily supervision of PL activity, and project staff conducted visits to review progress and help troubleshoot any issues. Monthly meetings also provided an opportunity for PLs, CHWs, and staff to gather information and data on peer groups, address capacity building or informational needs, and plan activities for the next month.

## Informational Outreach with Key Influencers and Communities

The Tuungane FTP component sought to engage FTM key influencers—namely husbands/male partners and older women (especially the mothers and mothers-in-law of FTMs)—in a one-time informational outreach session to increase awareness of HTSP/FP and modern contraceptive methods and build support for FTP FP use. CHWs led the implementation of these sessions, working with PLs and peer group members to identify their influencers and invite them to attend. Sessions with key influencers were conducted in August 2018, toward the end of the peer group activity.

## Household Visits by CHWs

As part of the larger Tuungane project, CHWs were already conducting home visits to provide tailored FP counseling, initiate use of/resupply condoms and oral contraceptives, and refer clients to nearby facilities for the full range of FP methods/services. Importantly, CHWs were provided with a mobile application to guide FP counseling and track contraceptive use. The new FTP component prioritized home visits for young FTMs, and each peer group member received at least one visit (at her request) over the course of the intervention. In addition, CHWs were encouraged to identify and visit other young women under age 25 (regardless of parity level). In total, CHWs reached and registered 345 FTM peer group members and 810 additional young women in the 15 FTP communities.

## Facility-Based FP Services

Tuungane's PHE approach included a specific focus on FP, and project staff had worked with participating facilities since 2017 to strengthen contraceptive service delivery for all modern methods and provide ongoing supportive supervision. The FTP component ensured that young FTM/FTPs were also connected to facilities for access to the full range of modern contraceptive methods and services.

## FTP Component Data Collection

Multiple forms of data collection and analyses took place over the course of the Tuungane FTP component. Two main data sources inform the main implementation learnings and FP-related results presented in this report:

- CHW Mobile Application Tool: All CHWs participating in the Tuungane project were provided with smartphones equipped with an application to support quality FP counseling, service provision, and referrals. While the tool's primary purpose is to guide CHWs in providing tailored counseling/services for clients, it also collects and tracks FP-related information for each client the CHW registers, which is then available for analysis and use. 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 obtain their FP status at the end of the project —or "exit."

- 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, using in-depth interviews (IDIs) and focus group discussions (FGDs) at baseline (May/June 2018) and endline (September/October 2018). The key objectives of the qualitative evaluation were: (1) to assess behaviors and attitudes related to HTSP and voluntary postpartum contraceptive use among FTMs peer group participants and their partners; (2) to understand and explore experiences, barriers, and facilitators in relation to HTSP/FP communication, access and use among FTM peer group participants, partners, and other social influencers: and (3) to assess the process and approaches used in implementing the FTP program from the perspectives of program participants, PLs, and CHWs.

  A trained research team collected data at the health care facilities serving communities participating in FTP programming. All project participants were directly or indirectly involved in Tuungane FTP component activities and consented to participate in this qualitative evaluation. The following table presents the in-depth interviews and focus group discussions conducted:

**Table 2: Tuungane FTP Qualitative Baseline and Endline Participants**

| RESPONDENT TYPE | RESPONDENT CATEGORY | BASELINE | ENDLINE |
|---|---|---|---|
| FTM Peer Group Members | Unmarried FTMs | 6 FGDs | 6 FGDs |
| | Married FTMs | 6 FGDs | 6 FGDs |
| | Married/unmarried FTMs who completed five or more sessions and adopted a FP method during/after intervention (regardless of prior FP use) | | 5 IDIs |
| | Married/unmarried FTMs who completed five or more sessions and did not adopt FP | | 5 IDIs |
| | Married/unmarried FTMs who attended four or fewer sessions | | 6 IDIs |
| Male Partners of FTM Peer Group Members | Did not attend any outreach sessions | | 11 IDIs |
| | Attended outreach OR partner of FTMs who completed all sessions and accepted FP | | 11 IDIs |
| Mothers/Mothers-in-law of FTM Peer Group Members | Did not attend outreach sessions | | 6 IDIs |
| | Attended outreach OR mother of FTMs who completed all sessions and accepted FP | | 6 IDIs |
| PLs | All PLs | | 6 FGDs |
| CHWs | All CHWs who supervised a peer group | | 6 FGDs |
| Supervisors of CHWs | Supervisor of participating CHWs | | 5 IDIs |

The study protocol and other required documents were submitted to the Medical Research Coordinating Committee of the National Institute for Medical Research in Tanzania, which provided approval for the study in April 2018. E2A also submitted documents to PATH's research determination committee in the United States, which determined this to be "not research" and therefore not necessitating any additional review (April 2018).

- Monitoring and Health Facility Data: In addition, routine monitoring reports and health facility FP service data were collected to ensure that activities were carried out as planned, address any challenges, and track overall progress. This included monthly meetings with PLs, CHWs, and facility providers to monitor the status of FTP activities as well as review FP service data, disaggregated by age and parity, from the seven health facilities involved in the FTP component.

## TUUNGANE FTP FP-RELATED RESULTS

One of the objectives of the Tuungane FTP component was to generate fresh evidence on effective programing for young FTPs. In addition to analyzing the implementation experience and distilling lessons learned, E2A and Tuungane collected quantitative and qualitative data that would provide insights into the specific FP-related outcomes of interest, including uptake of modern contraceptive methods and the underlying issues—such as attitudes, communication, and decision making—that influence informed, voluntary FP use. Specifically, data that CHWs collected via the mobile application tool on FP service

provision, together with the qualitative baseline and endline discussions with FTMs and key influencers, point to several results that highlight if and how such FTP programs can influence positive FP behaviors and outcomes.

**Summary of Tuungane FTP FP-Related Results**

1. Voluntary use of modern contraceptive methods increased from 35% to 66% of FTM peer group members over the course of the intervention.
2. Voluntary FP use by FTM peer group members increased across the range of modern contraceptive methods available through community and facility-based providers.
3. The majority of peer group members who adopted FP during the course of the intervention were new FP users.
4. Understanding of HTSP and its benefits seems to have deepened over the course of the intervention for FTMs and their key influencers.
5. While participation in FTP activities has improved knowledge and attitudes about FP, fundamental concerns about safety and return to fertility persist among FTMs and their key influencers.
6. Peer group FTMs noted improved communications about FP with partners, although decision making about FP use remains a complex process for many.
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.
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.

**Result 1: Voluntary use of modern contraceptive methods increased from 35% to 66% of FTM peer group members over the course of the intervention.**

Using the mobile application tool, CHWs collected FP information from each of the 345 registered FTM peer group members at the start of the intervention and also tracked subsequent FP uptake and use during the intervention period (exit data was captured in November 2018). Overall, FP use increased significantly, from a baseline level of 35% (n=119) to 66% (n=228) by the end of the intervention—almost doubling the number at intake. The table below illustrates FP status at intake and exit based on different characteristics such as age and marital status. Despite the relatively short five-month intervention period, there were increases in FP use by registered FTM peer group members of all age and marital status categories. Importantly, the largest improvement in FP use was among younger FTMs aged 15-19 years, with a 145% change by the end of the intervention.

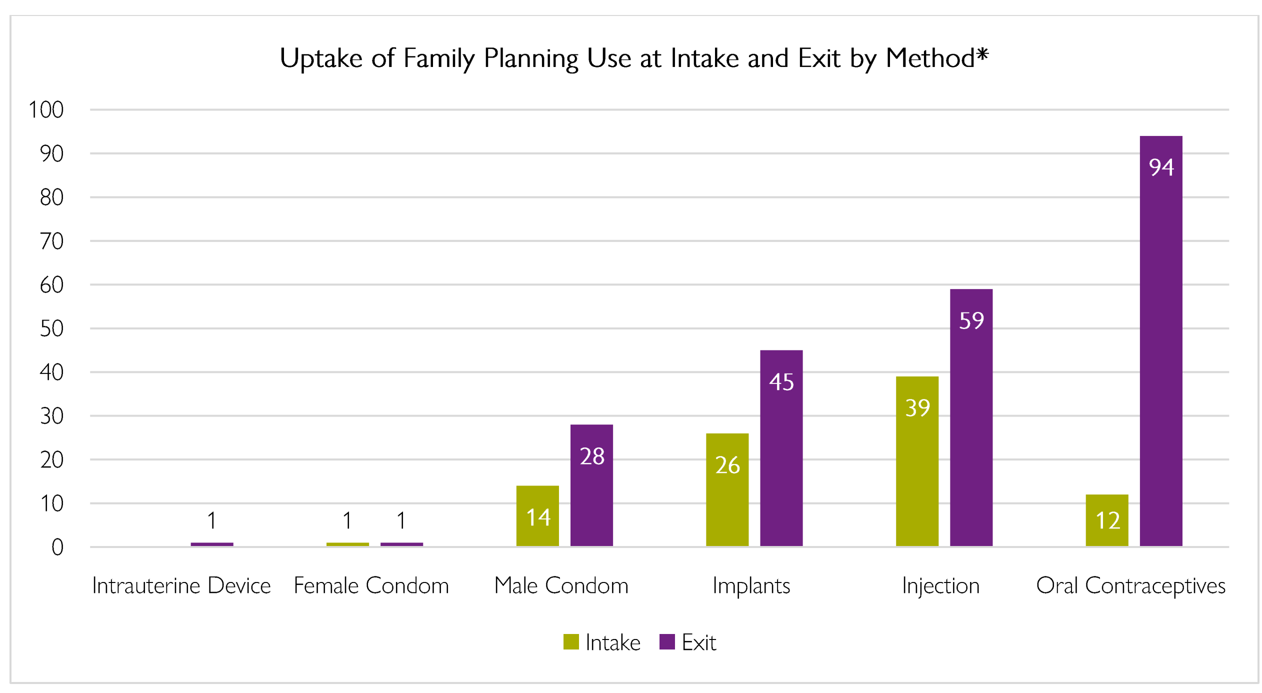
**Table 4: Voluntary Contraceptive Use by Registered Peer Group Members at Intake vs. Exit by Background Characteristics**

| | INTAKE | | EXIT | | PERCENT CHANGE |
|---|---|---|---|---|---|
| | N-Value | Percentage | N-Value | Percentage | |
| **FTM Age** | | | | | |
| 15–19 | 40 | 24% | 98 | 60% | 145% |
| 20–24 | 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%** | **228** | **66%** | **92%** |

**Result 2: Voluntary FP use by FTM peer group members increased across the range of modern contraceptive methods available through community and facility-based providers.**

CHWs also collected data on contraceptive methods used by FTM peer group members. This information was available for 102 of the 119 FTM peer group members who reported using a method at intake and for all 228 peer group members whose FP status was tracked at exit.

The graph below illustrates the number of FTM peer groups using FP by method at intake and exit. 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.



*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.**

The CHW mobile application data show that 114 FTM peer group members adopted an FP method over the course of the implementation. Almost all of these —97%—were new users of FP. 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.**

Through their participation in the peer groups program, FTMs reported learning about how to space their pregnancies and the benefits of HTSP. Several peer group members highlighted the session on HTSP as being one of their favorites, and several noted that this was their most useful session. Qualitative findings indicate that the FTP intervention helped some FTMs deepen their understanding of the benefits of child spacing/HTSP among married and unmarried FTMs. Many FTMs participating in this evaluation could mention several benefits of HTSP for themselves, their baby, their partner, and the family as a whole.

Discussions on the benefits of HTSP and use of FP commonly included an economic element that supported important life goals for FTPs and their children. FTMs noted that being able to space and plan their children allowed more time and energy to "hustle"—to invest in work and build something that will be "helpful in life." Many FTMs felt that economic issues also resonate well with partners, because with fewer and well-spaced children, male partners would be better able to support their families. Participants also noted that a longer waiting time could be especially beneficial for very young unmarried women who have no partners and are still living with their parents/caregivers.

> *"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**

> *"He [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 and return to fertility 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. Participants and implementers noted that FTMs valued having specific questions about methods and side effects addressed through the groups or home visits. The FTP intervention was also helpful in addressing concerns about the safety of contraceptives, especially with regards to return to fertility after FP use. Baseline findings highlighted the deep fear across FTMs that FP use could permanently affect a woman's fertility and leave her unable to conceive in the future. Input from FTMs at endline showed a shift in this thinking, with almost all participating FTMs (both married and unmarried) reporting that they now feel FP is safe to use—even by women with just one child. Several noted that accurate information provided through the peer groups helped to alleviate fears and allowed them to "feel free" to use FP.

However, at the endline a few married FTMs reported that they were still concerned about safety of some of the FP methods. As they explained, there are widespread myths about FP and different methods in their communities, and despite the information received in peer groups, they were still not sure what to believe. 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.**

During the qualitative endline discussions, FTMs reported that the peer group intervention played a role in opening up/improving partners' communication about FP. Many noted 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 communicate about FP—sometimes for the first time.

*"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**

Several FTMs reported using what they learned through participating in the peer groups on the benefits of FP methods to initiate discussions with their partners on FP use.

*"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**

The above quote highlights the complexities involved when making decisions about FP use. While many FTMs, both married and unmarried, felt that the decision to use FP ultimately lay with them, they also noted that other individuals—especially male partners/husbands and mothers—play an important role in these decisions. As the quote illustrates, even in cases of improved communication and information/idea-sharing between couples, FTMs may need (or feel they need) permission from a partner or parent to use FP.

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 husbands/partners 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.

***Who is involved in FP decisions?***

*"They [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."* **—Unmarried FTM, KAREMA**

**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.**

While endline qualitative participants largely noted improved FP-related outcomes, they also noted that many FTM face critical barriers to FP use. Lack of partner support came out strongly as a barrier for both married and unmarried FTMs, echoing some of the results on communication and decision making presented above. FTMs gave various reasons for their partners not agreeing to FP use, including lack of education on FP benefits, concerns about FP safety, and fears that FP use would lead to promiscuity by their wives. Without partner support, FTMs noted they face the difficult choice of using FP without his knowledge or not using FP at all. Many married FTMs also felt that their in-laws would not be supportive of FP use because they want them to have many children.

Throughout the discussions, FTMs also 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 married FTMs could more easily access FP than unmarried women, for whom FP use was linked to promiscuity and thus discouraged many from seeking services. At the same time, some FTMs (both married and unmarried) felt that married women may also find it challenging to access FP because they would typically need to consult their spouses, who may refuse and prevent them from seeking FP 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.**

During endline discussion, 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. This included their friends, parents, and partners—extending exposure to key information and messages (largely HTSP/FP-related) beyond the defined scope of the FTP component. 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**

# FTP IMPLEMENTATION LEARNINGS

For E2A and Tuungane, this was the first experience implementing FTP interventions within the larger PHE project. Prior to this effort, little was known about young FTMs and their key influencers in project communities, including their potential engagement in different Tuungane activities. From initial orientation and capacity building steps through the main period of implementation, several important learnings emerged on how to structure and carry out programming for young FTPs. These learnings were informed by monitoring reports and project team experiences, as well as qualitative baseline/endline input from implementers and participants.

**Summary of Learnings about Tuungane FTP Component**

1. The peer group activity attracted young FTMs across age and marital status categories.
2. FTMs had good levels of attendance and exposure to critical HTSP/FP-related content through peer group sessions.
3. While peer-led groups were effective convening and access points for young FTMs, PLs needed continuous support from CHWs and project teams to execute activities.
4. Key influencers—male partners and older women—expressed interest in FTP activities but were often difficult to identify and engage.
5. Additional activities to address fears regarding the safety of FP and FP use by young people were needed across the community to build support for FTPs.
6. Community health workers were the "lynchpin" of the Tuungane FTP component, providing critical support for FTP activities, as well as access to FP counseling and services.
7. While access to services has improved, stronger linkages with facility-based providers would ensure that young FTMs can obtain the full spectrum of FP and other services.
8. FTMs are interested in participating in other aspects of the Tuungane project, especially those that relate to livelihoods and economic opportunities.

### Learning 1: The peer group activity attracted young FTMs across age and marital status categories.

Over the course of the program, 398 young FTMs attended at least one of the seven peer group sessions. At the start of the intervention, CHWs collected basic demographic and health information from peer group members, as part of 'intake' registration using the mobile application tool. A total of 345 FTMs were registered, which is approximately 87% of the 398 FTMs who attended at least one peer group session.

**Table 3: Summary of Key Characteristics for 345 FTM Peer Group Members**

| | | FTM PEER GROUP MEMBERS | |
|---|---|---|---|
| | | N-Value | Percentage |
| AGE | 15–19 | 164 | 48% |
| | 20–25 | 181 | 52% |
| | TOTAL | 345 | |
| EDUCATION | No Education | 41 | 12% |
| | Primary | 276 | 80% |
| | Secondary | 28 | 8% |
| | TOTAL | 345 | |
| MARITAL STATUS | Never Married | 202 | 59% |
| | Cohabitating or Married | 132 | 38% |
| | Separated or Widowed | 11 | 3% |
| | TOTAL | 345 | |

Based on the data above, peer group participants included a relatively even mix of younger and older FTMs. The peer group activity did, however, attract more never-married than married FTMs. When marital status is broken down by age, a higher percentage of FTM peer group members between 15-19 years old were never married compared to those aged 20-24. Eighty percent of FTMs have some primary level education, and 12% reported no education, perhaps underscoring the relative remoteness of these communities. Importantly, participant characteristics indicate that diverse FTMs are interested in and able to participate in this type of small group activity.

**Learning 2: FTMs had good levels of attendance and exposure to critical HTSP/FP-related content through peer group sessions.**

The FTM peer group intervention consisted of seven sessions that focused on content related to HTSP and FP. PLs kept attendance records for each session, which capture a total membership of 398 FTMs who attended at least one session over the course of the intervention. As groups were not closed, there was some fluidity to group formation and participation. Anecdotal feedback suggests that a few married FTMs dropped out due to opposition from husbands or family members or moving away from the area. However, overall attendance levels were relatively steady over the course of the intervention, with each session attended by an average of 68% of the total membership (n=398, ranging from 65–76% attendance per session).

Attendance data tracked participation by each individual FTM group member, providing a sense of program exposure and engagement across all sessions—critical information for Tuungane, given the limited information available about FTPs in project communities prior to this experience. Eighty-one percent of the total 398 peer group members attended five or more peer group sessions, and 45% essentially participated in the full program. This suggests that the majority of peer group members—including

younger and unmarried FTMS - were interested in the intervention and had reasonably good exposure to program content. It also suggests support from key influencers to continue attending sessions.

> *"When I started going to the group and they started teaching us and educating us, my mind got an understanding that 'If I go for FP, my child will grow up and I will become healthy and I will have enough energy to go and look for something to take care of that child and s/he will study more comfortably'."* **—Unmarried FTM, BUHINGU**

> *"Frankly speaking, I am so thankful for her to join in, because it [early pregnancy] has been a challenge to women … I told her that if you have joined the Tuungane peer group, you should not be lazy, and you have to keep going, because there are a lot of challenges."*
> **—Older Woman, IDI-KASHAGULU**

**Learning 3: While peer-led groups were effective convening and access points for young FTMs, PLs needed continuous support from CHWs and project teams to execute activities.**

Attendance records and feedback from FTP peer group members highlighted that the peer-led, small group structure worked well as a forum to meet, learn, and share experience for diverse FTMs. At the same time, PLs sometimes struggled with their tasks—from leading specific activities, to finding an appropriate venue for meetings, to time-keeping. Across all groups, CHWs were more involved than initially planned, often working with PLs ahead of each session to help them prepare and then being at the group meetings to answer technical questions and occasionally assist with logistics. Both PLs and CHWs reported on this during the qualitative endline, noting the need for additional training and support for PLs on activity card content and facilitation skills. CHWs also suggested improving the recruitment process for PLs to ensure that more FTMs are identified and that they are fully informed and able to take on the roles and tasks assigned.

> *"I was reading an [activity] card before the session date and there were issues that I was not able to explain. Then I used to go to the CHW who taught me what it meant. If things were still difficult, I could invite her to the session to explain to the members in detail."* **—PL, KALYA**

> *"It came to a point where they [PLs] wanted us to be present in their sessions even if we [CHWs] are not scheduled to give a session. Therefore, for them to benefit from us, they had to participate and hear the questions from the participants and our answers. They needed our guidance on many occasions. So, whenever they needed us we would go and help where we could."* **—CHW, KALYA**

**Learning 4: Key influencers—husbands/partners and older women—expressed interest in FTP activities but were often difficult to identify and engage.**

Planned activities for key influencers centered on FP-focused outreach sessions and home visits conducted by CHWs. CHWs relied on FTM peer group members to help identify these influencers and notify them of activities. In general, the response of both men and older women who participated in these activities was positive, and they appreciated having access to a trained resource person who could provide information on FP and related issues. FTMs also appreciated having CHWs reach out to husbands/partners and older women, especially when they themselves did not feel comfortable discussing such issues with them or even being part of a discussion where they were also present (e.g., at a home visit).

> *"The sessions were good as they were beneficial especially to the communities like ours which are in remote region and most of us aren't aware of the family planning methods, so these sessions are needed very much. I can personally say that they were beneficial, and they bring a different attitude."*
> **—Male Partner, KAREMA**

> *"Yes, it was good to educate the mothers-in-law as one of us has said. This is because they are the ones who influence their sons on some issues…Therefore, it is good to educate them because they would be in the front line to advise their sons."* **—PL, KAREMA**

At the same time, overall participation of key influencers in home visits and informational outreach efforts was low. With so many unmarried FTM peer group members, it was sometimes difficult to identify or locate male partners. And with married FTMs, CHWs flagged just how difficult some influencers could be:

> *"It's true there are challenges especially on the side of men and mothers-in-law. When you go there and if they [partners and mothers in-law] have understood what you want to do there, they will ask you 'you people from Tuungane, you are like coming to make people unable to give birth again, and those groups are just wasting time and destroying people's direction in their families.' We try to talk to them nicely."*
> **—CHW, BUHINGU**

Notifications about outreach provided by FTMs and CHWs were not always effective in reaching or motivating key influencers to participate, perhaps due to competing priorities or lack of interest. Men noted that scheduling conflicts also limited attendance and suggested that multiple activities with advance notification would allow more to participate. This initial FTP effort and qualitative research underscored the critical role that key influencers—especially male partners—play in FP-related choice and actions and their general interest in learning more about these topics. More deliberate and structured engagement from the outset would improve both their own participation in activities and their support for the young FTMs. The program should also incorporate specific activities that foster more equitable gender and social dynamics between key influencers and young FTMs.

**Learning 5: Additional activities to address fears regarding the safety of FP and FP use by young people were needed across the community to build broader support for FTPs.**

Over the course of implementing FTP activities, several underlying attitudes and norms emerged as barriers to FP choice and use by young FTMs, especially fears about the long-term safety of FP use (return to fertility) and norms against FP use by young women (especially those who are unmarried). While peer group and key influencer activities addressed these topics, broader community outreach would have been helpful in tackling these barriers and reinforcing positive FP behaviors. Peer group members suggested having testimonials from satisfied FP users—especially women or couples who had successfully used FP to space their children—to help allay these fears. Key FTP-related information and messages, including testimonials, should be integrated across Tuungane PHE activities to build a more supportive environment for informed, voluntary FP use by young FTMs.

> *"Before they understood the FP education, they were concerned they will never give birth. I used success stories as examples about people who use FP and still give birth. I would tell them 'I am also using it and I am totally fine.'"* **—PL, MWESE**

**Learning 6: Community health workers were the "lynchpin" of the Tuungane FTP component, providing critical support for FTP activities, as well as access to FP counseling and services.**

As noted throughout the above learnings, CHWs played a critical role, both as FTP activity implementers and in their role as community-based providers of FP counseling and services. In addition to supporting PLs and conducting outreach with key influencers, CHWs took on other tasks – from hosting peer groups in their homes to escorting FTMs to facilities to receive services. Home visits were particularly valued by FTMs and their key influencers, who appreciated the tailored counseling and support provided. CHWs routinely visited all peer group members, but also noted that they were sometimes asked to conduct visits to help with specific issues and engage influencers. While CHWs largely appreciated the important role they played with FTPs, the noted the need for additional capacity building (especially related to FP) and the added demands on their time. Some CHWs also noted that their age and/or sex sometimes was a disadvantage, for example, if husbands/partners wanted to speak with a male CHW.

**Learning 7: While access to services has improved, stronger linkages with facility-based providers would ensure that young FTMs can obtain the full spectrum of FP and other services needed.**

Overall, FTMs reported reliable access to FP services through CHWs and health facilities, though they noted that they could do so more readily through CHWs, who move regularly in their communities. They also appreciated that the counseling and referrals received through CHWs prepared them to obtain their preferred methods at a health facility. FTMs did raise several concerns in interacting with facility-based providers, from receiving no or inadequate counseling to negative attitudes due their young age, including biases against some method choices for young women. Other concerns, such as a fear of being seen at a facility, also created barriers to facility use. With increased access to CHWs, it may be that FTMs had less exposure to facilities. However, their concerns are important to note, and additional activities are needed

to ensure that all providers—including CHWs and staff at facilities—are fully prepared to offer youth-friendly services and that efforts are made to build linkages and trust with young FTPs.

> *"For the unmarried ones, they (care providers) will say that she wants to use it because she is promiscuous, and she wants to be free from pregnancy. They normally have certain accusations which makes her step backwards. She feels shy to come here [health facility]."*
> **—Unmarried FTM, BUHINGU**

> *"They [FTMs] prefer to be given services with us because of one reason. She understands that she uses the method in private and she understands that if she receives the referral letter and go to the health center, there are a lot of people there. And if there are many people, she would be worried of meeting the mother's friend, brother-in-law or any other person. So, it becomes very difficult for her in such a case. Most of the times when we talk to them, they would say, 'I want the implant, but I need you to put it, I don't want to go there [to the health facility].'"*
> **—CHW, BUHINGU**

**Learning 8: FTMs are interested in participating in other aspects of the Tuungane project, especially those that relate to livelihoods and economic opportunities.**

While FTP activities largely focused on FP-related outcomes, the project also tried to create linkages between FTM peer group members and other (non-FTP or FP) ongoing Tuungane PHE interventions in their communities, such as Model Households and COCOBAs. CHWs were the main resource persons who, in addition to providing FP-related counseling and services, could also refer interested FTM peer group members to different Tuungane interventions. Of the 345 FTM peer group members that CHWs registered through the mobile application tool, just over a quarter (25.5%) were referred to a PHE intervention. Of these, almost 65% completed at least one referral, indicating a high level of interest in participating in other aspects of the larger PHE project. Importantly, 83% of all referrals made directly or indirectly address economic/financial issues, including agriculture groups (climate-smart farming) and COCOBAs (savings groups). FTMs across all peer groups mentioned the need for income-generating activities and training. Through Tuungane's broader PHE mandate, there is an opportunity to connect FTPs to other activities that can enhance their economic activity.

> *"The strategies to be implemented are to continue providing education like vocational training, animal keeping, and gardening. It is better to provide such education to members and the project can benefit from it."* **—PL, KALYA**

# EMERGING RECOMMENDATIONS

The Tuungane FTP component generated a wealth of new experience and evidence on both the "how to" of programing for young FTMs and their key influencers, and the potential FP impact that can be achieved through such efforts. Looking across the implementation results and learnings from Tuungane, several broader conclusions and recommendations emerge to inform and advance future programs for this important youth population in Tanzania and across the globe.

**Recommendation 1: Invest in community-based interventions that provide HTSP/FP information, address related gender issues, and build local capacity for implementation to increase informed and voluntary use of FP with diverse FTMs.**

The Tuungane experience demonstrated that community-based interventions can reach young FTMs to educate them and support their choices with respect to HTSP/FP. The program successfully engaged both married and unmarried young women and younger (15-19 years) and older (20-24 years) FTMs—groups that typically face different, but equally limiting, barriers to voluntary FP use. Creating safe spaces for these FTMs to access information and services through peer groups and especially through home visits facilitated their ability to choose and use contraceptive methods. By bringing tailored services to the young FTMs, CHWs were able to address some of the health care inequities present in Tuungane communities, and they reached many FTMs who had never used FP before. Community-based activities require an investment in building local resources persons and systems to deliver accurate information, facilitate skill-building, and provide quality services. But the results emerging from Tuungane indicate that such investments can be an effective approach to advance HTSP/FP outcomes, particularly in areas with high rates of early childbearing.

**Recommendation 2: Strengthen community and facility-based FP service delivery provision that can provide the full range of contraceptive services in an FTM/FTP-friendly, non-judgmental manner.**

Having access to trusted health care providers was a critical element of the Tuungane FTP effort. Young FTMs particularly appreciated linkages to CHWs, and these community-based resource persons were an important first point-of-contact for many young women who might otherwise not have engaged with the health system. At the same time, the Tuungane experience underscored the importance of connecting FTMs to facility-based services and providers, so that their access to health care does not begin and end with the CHW. FTMs voiced concerns about health facilities and facility-based providers, from judgmental attitudes to biases on contraceptive method choice to insufficient counseling/care. Whether real or perceived, these negative views of facility-based services hinder FTMs' access to the range of FP services and to other critical health information and care. Working with the full health system to ensure positive, non-judgmental provider attitudes, strong knowledge of country- and local-level guidelines on adolescent and youth FP/RH service provision, and more systematic linkages between providers and catchment communities are all needed to create a more holistic and continuous health support system for these young FTMs.

**Recommendation 3: Address underlying fears about FP and specific contraceptive methods, as well as negative attitudes regarding FP use by young women, to reinforce positive messages about HTSP/FP and build support for FTM/FTP health action.**

Across Tuungane communities, there were strong fears about FP and contraceptive use, particularly perceptions about impact on long-term fertility. Norms against FP use by young women, especially those who are unmarried, were also common. Such attitudes and beliefs are widespread—not just in Tuungane areas, but throughout Tanzania and globally—and create many barriers for FTMs to choose and use FP as they would like. While the project did address these issues within peer groups and home visits, these barriers need to be tackled systematically at individual, family, and community levels, including with health providers. Tuungane participants suggested that discussions with satisfied FP users and their partners (especially those who have successfully spaced births) could be useful in addressing fears about return to fertility. Addressing norms around young FTM/FTPs' access and use of FP is also a critical element of any FTP program, and the Tuungane experience suggests that messages and information on HTSP—with its benefits for the fundamental health and well-being of the family—are important tools in building positive attitudes for FP use by young FTPs.

**Recommendation 4: Systematically engage key influencers—especially husbands/male partners and the mothers/mothers-in-law of FTMs—from the outset, so that they understand the importance and relevance for their families.**

The Tuungane experience highlighted both the necessity and the challenge of engaging key influencers of young FTMs. Qualitative and anecdotal input from young women showed just how important husbands/partners and the mothers/mothers-in-law of FTMs are in determining FP/RH options, from contraceptive use to method choice to participation in activities, such as peer groups. Like the FTMs, these influential individuals needed to receive accurate information from a trusted source, have their misconceptions and questions addressed, and be encouraged to form more positive and supportive attitudes towards HTSP/FP. However, the project found it challenging to reach these influencers, especially the men. Their overall participation was low for many reasons, including a lack of awareness about the activities and competing priorities. But for those men and older women who did attend informational outreach sessions and/or home visits, their feedback was largely positive, suggesting potential for greater involvement. Early and systematic engagement of key influencers to build their understanding about FP/RH and its relevance for couples and families should be built into FTP programs like Tuungane, taking advantage of other (non-FP) project activities to broaden reach.

**Recommendation 5: Use FTMs to reach other young mothers and women with key HTSP/FP messages and links to services.**

The Tuungane FTP component applied a strategy of cultivating young FTMs to serve as PLs and role models for other young women in their peer groups. As noted above, it required training and ongoing support from CHWs to ensure PLs were able to fulfill their responsibilities. But once their capacity had been built, several of these young FTMs took on additional tasks and roles, often reaching out to other FTMs and young women to share information and encourage FP use. Tuungane, recognizing the potential

to further cultivate this local capacity, is now considering opportunities to guide FTMs in reaching more young women of all parity levels. Especially in rural, remote areas where young women face multiple barriers to accessing FP/RH information and trusted resource persons, these young FTM leaders carry tremendous potential to expand and sustain their influence beyond their peer group leader role. While this process occurred organically over the course of the Tuungane FTP intervention, other FTP projects can capitalize on this lesson learned by developing a deliberate strategy in the program design to build the capacity of FTMs as local resource persons in a realistic and context-appropriate manner.

**Recommendation 6: Link FTM/FTPs to appropriate programs and activities that will enhance their economic potential.**

FTM/FTPs repeatedly noted the financial concerns that come with the new responsibilities of raising a child, especially in such economically strained communities. Peer group members mentioned their need for economic opportunities—from livelihoods training, to entrepreneurship support, to savings groups/mechanisms—a need that has consistently been raised in all E2A FTP projects globally. As noted in this report, Tuungane includes economically oriented activities under its broader PHE mandate, such as COCOBAs and agriculture groups. While Tuungane did connect FTM peer group members to such groups, many were not necessarily structured to include young women. Many FTMs lack the assets (e.g., land, financial resources) needed to join or fully benefit from such interventions. For Tuungane or other projects interested in providing a more holistic, multi-sectoral response to FTP needs, creating or finding links to good economic programs designed for young people should be a priority.

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