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E2A EVIDENCE TO ACTION for Strengthened Reproductive Health

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

TECHNICAL REPORT | E2A PROJECT

ABOUT E2A

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 health care needs of girls, women, and underserved communities around the world by increasing support, building evidence, and leading the scale-up of best practices that improve family planning services. A Cooperative Agreement awarded in September 2011, E2A will continue until March 2021. E2A is led by Pathfinder International in partnership with ExpandNet and IntraHealth International.

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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, Regional Technical Advisor, Women's Led Resilience for Eastern & Southern Africa, Pathfinder; Patrick Kinemo, Director for Advocacy and Population, Health, and Environment, Pathfinder Tanzania; Chaus Emmanuel, Clinical Services Mentor, Pathfinder Tanzania; Marcel Kato, Health Program Officer, PHE Program, Pathfinder Tanzania; Philipo Paul, Monitoring, Evaluation and Learning Manager, PHE Program, Pathfinder Tanzania; and Benjamin Mrema, mHealth Program Lead, Pathfinder Tanzania.

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On behalf of the project team, E2A the young first-time mothers, their partners, and their older women key influencers that participated in the program, as well as the program implementers that shared their experiences, for helping to advance programming for young FTPs around the world.

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Acronyms and Abbreviations

BMU	Beach management unit
CHW	Community health worker
COCOBA	Community conservation bank
E2A	Evidence to Action Project
FP	Family planning
FTM	First-time mother
FTP	First-time parent
GREAT	Gender Roles, Equality, and Transformation Project
HTSP	Healthy timing and spacing of pregnancies
LARC	Long-acting reversible contraceptive
MOH	Ministry of Health
PHE	Population, health, and environment
PPFP	Postpartum family planning

In 2019, the Evidence to Action (E2A) Project and Pathfinder International Tanzania began a new wave of programming for first-time parents (FTP) in the Greater Mahale Ecosystem of Tanzania. This work built on a 2018 FTP intervention implemented as part of the USAID/Tanzania-funded Tuungane Population, Health, and Environment (PHE) project. The new program incorporated strategies informed by insights from the first phase. These included the need for more systematic outreaches with men and older women, stronger integration with Tuungane's PHE activities, and collaboration with former peer leaders to reach young women in their communities of all parity levels.

Background

Since 2011, Tuungane has been working in partnership with the Government of Tanzania in remote, marginalized, and vulnerable communities to tackle some of their most complex development challenges, including access to voluntary family planning (FP) services. The communities in Tuungane depend on their local natural resources for their health, food, and livelihoods. However, climate change, deforestation, and unsustainable fishing practices threaten the ecosystem. Tuungane works with communities to promote positive health and natural resource management practices, including FP, which help support the long-term well-being of families and conserve the ecosystem within these communities. Tuungane strengthened access to quality FP care through health facilities, mobile outreaches, and community health workers (CHWs) in Uvinza and Tanganyika districts. Additional Tuungane approaches to promote positive PHE behaviors include the following:

- **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 nursery zones.
- **COMMUNITY CONSERVATION BANKS:** Community Conservation Banks (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:** Since most villagers do at least some subsistence farming, the Tuungane project provides training on climate-smart agriculture practices that reduce run-off into the lake and produce higher yields for farmers.
- **FOREST MANAGEMENT:** Community forest scouts are trained and deployed to protect forest reserves, including some that are habitats for chimpanzees, from threats due to agricultural expansion, indiscriminate fires, and illegal forest harvesting.

Tanzania faces significant reproductive health 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.[2] These same two zones have the highest levels of teenage childbearing in Tanzania, and modern contraceptive use in both Kigoma and Katavi regions is just 18%, among the lowest levels in the country.[3] Only 8.6% of young women ages 15 to 19 and 29% ages 20 to 24 years use a modern method of contraception.[4] Unmet need for FP among young married women ages 15 to 24 years is approximately 23% across Tanzania and reaches 27% to 28% in both Kigoma and Katavi.[5]

Noting these patterns, E2A and Pathfinder International Tanzania saw an important opportunity for the project to advance 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 partner. Specifically, the project set out to:

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

Qualitative baseline findings from Tuungane communities echo global insights into the unique challenges that limit first time mothers' reproductive health choices and actions.[6] 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. Isolation 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 they rarely make decisions about whether and when to have children or to use contraception on their own. Husbands, parents, in-laws, community members, and family elders have significant influence over decisions that involve reproductive health and use of household resources.[7] Unequal power and gender dynamics, along with contextual factors such as socio-cultural preferences around fertility, can encourage early childbearing and closely-spaced repeat pregnancies, which compromise the health of young mothers and their newborns.[8] The risks associated with early childbearing and closely spaced pregnancies are high for both the woman and her new baby, including increased risk of

[1] Tanzania Demographic and Health Survey and Malaria Indicator Survey 2015–16
[2] Ibid
[3] Ibid
[4] Ibid
[5] Ibid
[6] FTP Snapshot: Tanzania, Evidence to Action, 2018
[7] 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.
[8] 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.

both maternal and infant mortality.[9] The high incidence of pregnancy among adolescents and young women in Kigoma and Katavi and the particular vulnerabilities of young FTMs made the addition of an FTP-focused project component a priority for Tuungane and E2A.

Implemented from May to October of 2018, the first phase of the FTP component of the Tuungane project focused on advancing HTSP/FP and social support for young FTMs. E2A applied a life-course and socio-ecological lens to the design of the content and structure.[10] Given the FP focus of both E2A and Tuungane, the intervention primarily focused on postpartum family planning (PPFP) and HTSP for FTPs to facilitate access to informed, voluntary use of modern contraceptive methods. In addition, the effort aimed to address underlying gender and social norms that influence FTP relationships, choices, and actions. The initial phase of FTP programming showed promising results, including increased voluntary use of modern contraceptive methods (from 35% to 66% of peer group members), deepened understanding of HTSP and its benefits, and improved communication about FP with partners. Peer group members also reported sharing their knowledge and experiences with others in their community, suggesting a diffusion of key messages. Furthermore, through the experience of implementing FTP interventions within the larger PHE project, the team learned several important lessons about how to structure and carry out programming for young FTPs. To read more about the results, implementation learnings, and emerging recommendations from Phase 1 of the program, please consult the full report.

The Phase 2 FTP Program Component

Based on the promising results achieved in the first phase of the FTP component of Tuungane, the project decided to implement a second phase of FTP programming with new peer groups that built upon lessons learned from the initial program. The Phase 2 program was implemented over a five-month period (November 2019 to March 2020) in 14 communities within Uvinza and Tanganyika districts. Of these 14 communities, 8 were included in the Phase 1 FTP program (Buhingu, Ikola, Kalya, Karema, Kashagulu, Mchangani, Mgambo, and Tambusha) and 6 were new (Herembe, Isengule, Kapanga, Kasekese, Nkonkwa, Rukoma). Phase 2 continued with many of the key components of Phase 1, including the FTM peer group discussion sessions using activity cards, the provision of home visits by CHWs, and the support to health facilities. However, the Phase 2 program included some new components, including the following:

[9] Healthy Timing and Spacing 101 Brief, Extending Service Delivery Project.
[10] FTP Framework, Evidence to Action, 2019

- Structured small-group discussion sessions with husbands/partners and older female key influencers of FTMs
- Inclusion of PHE-related discussion sessions for all three participant groups and greater linkages to PHE champions
- Outreach by peer leaders who had been trained in Phase 1 to conduct outreach sessions and home visits with young women in their communities

TABLE 1: PROGRAMMING WITH A LIFE-COURSE AND SOCIO-ECOLOGICAL LENS

INTERVENTION	PHASE 1 ACTIVITIES	UPDATES FOR PHASE 2
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, comprised of 12 to 15 FTMs each, met for 9 sessions held every 2 weeks. Groups were supervised by CHW attached to a local health facility.	FTM small groups explored information on PHE and problem solving in addition to the original discussion topics. A total of 28 groups, comprising 12 to 15 FTMs each, met for 10 sessions held twice a month, and also went on a group visit to a model household.
OUTREACH WITH HUSBANDS AND PARTNERS	CHWs led informational sessions with partners/husbands to build awareness about contraceptive methods and build support for contraceptive use by FTPs.	CHWs led five monthly small-group discussion sessions with partners/husbands, covering PHE, HTSP, relationships, and fatherhood. They also hosted a group visit to a model household.
OUTREACH WITH OLDER WOMEN	CHWs led informational sessions with older women to build awareness about contraceptive methods and build support for contraceptive use by FTPs.	CHWs led three small-group discussion sessions with older women covering HTSP and FP, the needs of FTPs, and PHE. They also hosted a group visit to a model household.
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 methods and services. They also provided follow-up support.	The household visits by CHWs remained similar for the phase 2 program. CHWs were instructed to provide at least one home visit to each FTM. PHE champions were also instructed to provide at least one home visit to each FTM.
COMMUNITY AND FACILITY FP SERVICES AND INFORMATIONAL OUTREACH	The Tuungane program provided support and supervision to health facilities, trained health care providers, and CHWs to provide youth-friendly FP counseling and services. CHWs also provided orientations on FP and FTPs to community members.	This activity remained unchanged, with the exception of increased linkages between FTPs and PHE champions.

PHE INTEGRATION	CHWs provided and tracked referrals to FTM peer group members for different PHE activities in their communities, including agriculture groups, COCOBAs, model households, and beach management units (BMUs).	New PHE components of the Phase 2 program included: - Model household visits for FTMs, partners, and older women - PHE-specific discussion sessions for all three participant groups - Increased linkages with PHE champions, who became involved in peer group sessions and home visits
OUTREACH WITH OTHER YOUNG WOMEN	While the results from this program indicated that peer group members were informally sharing information and ideas with their communities, outreach to other young women was not included in the design of the Phase 1 program.	Fifteen peer leaders and 16 deputy peer leaders from the Phase 1 FTP program were trained to conduct outreach sessions and home visits to young women in their communities, in collaboration with CHWs and PHE champions, to provide information on HTSP, FP, PHE, and gender roles.

CHW and PHE Champion Capacity Building and Coordination

The Tuungane project was already working with Ministry of Health (MOH) CHWs to implement FP-related activities, raise awareness, conduct home visits, make referrals, and provide pills and condoms. As part of its broader mandate, Tuungane also trained PHE champions, some of whom were also CHWs, in the project communities. The project team selected two CHWs and at least one PHE champion per community to help with the implementation of the FTP program. Before initiating interventions, Tuungane staff conducted orientations with CHWs that focused on the FTP context in the project areas, proposed FTP activities, and roles and responsibilities. CHWs also participated in the training of the peer leaders, providing support to the trainers while strengthening their own capacity. During the implementation period, CHWs were responsible for assisting FTMs with the peer groups (including recruitment, data collection, and facilitation or assistance with sessions); providing home visits and referrals of FTMs to health facilities for FP and maternal, neonatal, and child healthcare and to PHE Champions for connection with Tuungane PHE activities; leading the men's and older women's sessions; and participating in the monthly review meetings.

PHE champions and COCOBA trainers were oriented on the needs of FTPs and the FTP activities throughout the intervention. PHE champions were responsible for conducting or assisting PHE peer group sessions for FTMs, husbands/partners, and older women; providing home visits; responding to PHE referrals given by CHWs and peer leaders; and helping to arrange and conduct visits to a model household. COCOBA trainers attended peer group meetings to provide orientation on finance management and the business opportunities that are available in the project communities. Both PHE champions and COCOBA trainers participated in the monthly review meetings.

Peer-Led Small Groups with Young FTMs

As with other E2A FTP programs, FTM peer groups were a central activity for the Tuungane FTP component, providing peer networks, role models, and safe spaces for young women to learn and share. The Phase 2 peer group intervention was implemented in a subset of Tuungane communities—six in Tanganyika and eight in Uvinza districts. A total of 28 peer groups (two per village) were established and active between November 2019 and March 2020.[11]

Peer groups were led by young female peer leaders who met the pre-defined criteria established by project staff, including: (1) being FTMs (under 25 years old, pregnant for the first time or with one child); (2) living in the identified communities for the Phase 2 FTP component; (3) literate in Kiswahili; (4) possessing strong leadership and communication skills; (5) able to prepare, conduct, and report on peer group meetings; and (6) available to participate in the monthly review meetings with CHWs and supervisors. Twenty-eight young FTMs were recruited to serve as volunteer peer leaders; each was responsible for leading one peer group in her community. Project staff conducted a five-day training with the selected peer leaders in order to improve their knowledge of HTSP and contraception and their capacity to facilitate small-group activities and discussions with fellow FTMS.[12]

TOPICS ADDRESSED IN FTM PEER GROUPS

1. HTSP
2. Overview of FP Methods
3. What is PHE?
4. PHE Activities
5. Male and Female Roles
6. Implants
7. Solving Problems
8. Injectable Contraception
9. IUCD
10. Making Decisions

Following the training, peer leaders and CHWs recruited FTM group members through their community contacts and peer networks. The 28 peer groups met in their communities twice a month from November 2019 to March 2020 for a total of 10 sessions, with an additional group visit to a model household. On average, each group had approximately 12 to 15 members, with almost 400 young FTMs participating over the five-month period. Each of the 10 discussion sessions used activity cards—either adapted from the Gender Roles, Equality, and Transformation (GREAT) project toolkit or created by E2A for this project—to address health and gender issues, such as HTSP, FP, gender norms, problem solving, decision making, PHE and Tuungane activities. In addition to these 10 discussion sessions, the groups visited a model household to see PHE principles and best practices in action and think about how to begin to integrate these practices into their own lives.

CHWs and PHE champions provided support to each of the peer groups and attended select meetings to answer questions and help with facilitation and logistics. For example, one common question asked to PHE Champions was regarding what model households looked like, and whether FTPs were able to be enrolled

[11] Due to COVID-19 restrictions, the final session was not completed in 10 of the 28 groups FTM peer groups.

[12] The GREAT Activity Cards were developed under the USAID-funded GREAT project by Pathfinder International, the Georgetown University Institute for Reproductive Health, and Save the Children. In 2013, Pathfinder translated the Activity Cards into French for use in West Africa. The cards designed for married and/or parenting adolescents are found in Annex 2. The entire toolkit can be downloaded here: http://www.pathfinder.org/publications-tools/great-scalable-toolkit.html.

as a model household. Monthly review meetings were held for peer leaders, CHWs, facility-based supervisors, PHE champions, and COCOBA trainers to gather information and data on peer groups, address challenges and capacity strengthening needs, and plan activities for the next month.

Discussion Sessions with Husbands/Partners of FTMs

For Phase 2, the project expanded activities with husbands/partners of FTM peer group members to take a more systematic approach. CHW-led small groups for husbands/partners met once a month for a total of five sessions to discuss PHE, HTSP and FP, gender, relationships, and fatherhood.[13] The timing of the session topics was aligned with the FTM peer groups in order to encourage discussion within the couples. Husbands/partners also participated in a group visit to a model household so that they could also see key PHE principles in practice. The men enrolled in the program were particularly interested in the PHE education provided by the program—including information about energy saving stoves and use of the tippy tap[14]—as well as the information provided about FP and how it can allow them to meet the basic needs of their families and raise their children well.

Discussion Sessions with Older Women

Noting the influence of mothers/mothers-in-law in reproductive health decision making, including FP uptake and participation in peer groups, small groups were also convened for older female key influencers of FTMs to deepen their knowledge and build their support for FP use among FTMs. These small groups were led by CHWs and met a total of three times to cover HTSP and FP, the needs of FTPs, and PHE. As with the men's groups, the schedule of the sessions was aligned with both the FTM peer groups and the men's groups in order to encourage household discussion. The older women also visited a model household to further their education on PHE.

Household Visits

As part of the larger Tuungane project, CHWs were already conducting home visits to provide tailored counseling, initiate use or resupply of condoms and oral contraceptives, and refer clients to nearby health facilities for the full range of FP methods and services. CHWs were provided with a digital application to guide FP counseling and track contraceptive use. The Phase 2 FTP component continued to prioritize home visits for young FTMs, ensuring that each peer group member received at least one home visit over the course of the intervention to provide counseling and referrals tailored to their stage of pregnancy or early parenthood on topics such as PPFP. In addition, the program added at least one home visit by a PHE champion for each FTM peer group participant and her household in order to increase their knowledge about PHE practices and connect them with the broader Tuungane PHE activities.

[13] Due to COVID-19 restrictions, the final session was not completed in 2 of the 14 husband/partner groups.

[14] The tippy tap is a hands-free handwashing system, often used where running water is not available. It is operated by a foot lever, minimizing the risk of person-to-person bacteria transmission, and requires less water than other handwashing means, such as using a bucket. https://www.tippytap.org/the-tippy-tap

Community and Facility FP Services and Informational Outreach

Tuungane's PHE approach included a specific focus on FP, and project staff have worked with participating facilities since 2017 to strengthen contraceptive service delivery for all modern methods and provide ongoing supportive supervision. Mobile FP outreaches were also conducted at project-supported facilities in order to increase access to contraceptives, including long-acting reversible contraceptives (LARCs). The FTP component ensured that FTMs/FTPs had access to facilities offering the full range of modern contraceptive methods. CHWs were trained to provide youth-friendly counseling and short-acting contraceptive methods (condoms and pills) and orient the community on HTSP, FP, and FTPs.

Integration with Tuungane PHE Activities

There were several new PHE-related components to Phase 2 of the FTP program. The program aimed to integrate PHE into the FTP program and link FTPs to the broader Tuungane PHE activities. Two PHE-specific discussion sessions were added for the FTM peer groups. The first provided an overview of what PHE is. The second introduced participants to Tuungane's various PHE activities and was presented by a PHE champion. An "Understanding PHE" session was also added for the men's and older women's groups. These PHE small-group discussion sessions sought to increase the knowledge of the three groups and encourage discussion about PHE within the household. Visits to a model household were arranged for FTMs, husbands/partners, and older women to demonstrate key PHE principles in practice and encourage participants to think about which components they could begin implementing in their own lives.

Outreach to Other Young Women

The results of the Phase 1 FTP component indicated that there was diffusion of information from FTM peer group participants to others within their communities, including other young women who did not meet the FTP recruitment criteria. The Phase 1 evaluation also found that once peer leaders' capacity had been built, several young FTMs took on additional tasks and roles, often reaching out to other FTMs and young women to share information and encourage FP use. During Phase 2, the project sought to structure this peer-to-peer sharing of ideas and information by tapping into the capacity and energy of Phase 1 peer leaders. The project continued to strengthen the capacity of these peer leaders—as well as newly selected deputy peer leaders—from the Phase 1 groups, training them to conduct outreaches and home visits to other young women within their community. Reaching more young women of all parity levels is especially important in rural, remote areas where young women face multiple barriers to accessing FP/RH information and services.

The trained peer leaders and deputy peer leaders conducted one outreach session per month, covering HTSP, FP, PHE, and gender roles, as well as a home visit to eight other young women per month. These peer leaders also worked closely with CHWs and PHE champions, connecting them to the young women for counseling, services, and referrals. Once connected to the young women through the peer leaders, CHWs were able to provide a range of information and services related to FP, ANC, and child health. Similarly, the PHE Champions were able to provide information on PHE concepts and connect these

young women to Tuungane PHE activities. This included information on better farming practices and household improvements for the benefit of themselves and their families.

Data Collection

Three main data sources were used to inform the results from the Tuungane FTP component that are presented in this report.

INTAKE/EXIT DATA: At the first FTM peer group session, CHWs collected intake data for all participants, including basic demographic characteristics, current participation in Tuungane PHE activities, FP use and method choice, and key knowledge and attitudes related to FP. CHWs collected the same data after the conclusion of the peer groups to determine if there were any changes in FP use, knowledge and attitudes, and participation in PHE activities over the course of the intervention.[15] The completed paper questionnaire forms were mailed to the Pathfinder office in Dar es Salaam, where the data was compiled into two databases, one for intake and one for exit, from which the data were analyzed.

ATTENDANCE-TRACKING FORMS: Peer leaders, with support from CHWs, completed attendance-tracking forms at each FTM peer group meeting. CHWs also completed attendance-tracking forms for the men's and older women's groups. These attendance forms were also sent to the Pathfinder office in Dar es Salaam. The FTM peer group-attendance information was added to the exit database, and a separate database was created for the men's and older women's attendance data.

DISCUSSIONS WITH PROGRAM IMPLEMENTERS: At the end of the FTP intervention, project staff conducted discussions on the implementation experience with program implementers, including peer leaders, CHWs, and PHE Champions. The discussions focused on the new interventions involving PHE, men and older women, and outreach to other young women. Initially, the project and Washington, DC-based E2A staff had planned to hold an implementers workshop in order to discuss and document these lessons learned. However, this workshop was canceled due to COVID-19, and phone interviews were conducted instead. In total, E2A interviewed nine CHWs, nine peer leaders, and three PHE Champions across the two districts.

[15] Initially, the exit data collection was planned to for the final peer group session. Because of COVID-19 restrictions, CHWs collected this data individually from FTMs in the groups that were unable to have their final session and from any other peer group participants who were not in attendance for their final session.

Results

Based on analysis of the intake/exit and attendance data, as well as a review of the experiences described by program implementers, we identified the following key findings from implementation of Phase 2 of the FTP program component.

SUMMARY OF RESULTS

1. Overall, the FTP program was successful in attracting and retaining FTMs, husbands/partners, and older women for project activities.
2. FP use increased from 50% to 73% among FTM peer group members throughout the course of the intervention.
3. Knowledge and attitudes related to FP use improved among FTM peer group members throughout the course of the intervention.
4. The program fostered increased couple communication about FP and shifts in attitudes related to couples' decision making.
5. Partner support and attitudes related to their involvement in HTSP/FP have improved since the start of the FTP program.
6. The FTP program exposed FTMs and their households to new PHE ideas and participation in Tuungane PHE activities increased among FTMs, their husbands/partners, and other members of their households.
7. Peer-to-peer outreaches reached a wider range of young women and built the capacity of previously trained peer leaders.

Finding 1: Overall, the FTP program was successful in attracting and retaining FTMs, husbands/partners, and older women for project activities.

There was strong program participation and interest among FTM peer groups, and husbands/partners and older women were generally interested and easy to engage.

FTM PEER GROUPS

In Phase 2, the project identified and attracted 375 FTMs for the peer group intervention. Of the 375 FTMs who were enrolled in the project and provided intake data, 367 provided exit data and had their attendance tracked. Table 2 shows the breakdown of marital status, pregnancy status, and age at the time of data collection, illustrating the project's success in reaching FTMs across a range of ages and marital status.

TABLE 2: CHARACTERISTICS OF THE FTMS WHO COMPLETED INTAKE AND EXIT QUESTIONNAIRES, TANZANIA 2020

CHARACTERISTIC	INTAKE (N=375)		EXIT (N=367)	
	n	%	n	%
Age				
15-19	149	39.73%	82	22.34%
20-24	220	58.67%	272	74.11%
25+	1	0.27%	7	1.91%
Missing Data	5	1.33%	6	1.63%
Marital Status				
Single	174	46.40%	153	41.69%
Married or Cohabitating	192	51.20%	201	54.77%
Divorced or Separated	5	1.33%	8	2.18%
Other	1	0.27%	0	0.00%
Missing Data	3	0.80%	5	1.36%
Pregnancy Status				
Currently Pregnant	15	4.00%	21	5.72%
Not Currently Pregnant	346	92.27%	332	90.46%
Unsure of Pregnancy Status	4	1.07%	5	1.36%
Missing Data	10	2.67%	9	2.45%

Project implementers expressed that prior to recruitment, FTMs were interested in participating because they had heard about previous project activities in neighboring villages. CHWs also conducted visits with influencers of interested FTMs prior to intervention to pave the way for their participation.

> *"I can say there was no challenge [in recruiting participants]. Since in 2018 we were told to enroll all FTM in our village, but the program had not started, this time was easy because the information was known to the community. Furthermore, this program was already happening at our neighboring villages (Buhingu and Mgambo) so FTM were interested to join and attend."*
> **—CHW NKONKWA**

Once enrolled, FTMs were generally able to consistently attend the peer group sessions. Of the 367 FTMs who completed the endline data collection and had their attendance tracked, 85% attended at least 7 of the 11 peer group sessions and 84% received at least one home visit from a CHW. Attendance rates were similar across the age groups, with 83% of 15- to 19-year-olds and 85% of 20- to 24-year-olds attending at least seven sessions, and across marital status, with 83% of married FTMs and 87.5% of single FTMs having attended at least seven sessions. This indicates that neither age nor marital status was a significant barrier to participation.

While all topics seemed to be useful for the FTMs, implementers indicated that the peer group members' favorite topics included HTSP and specific FP methods. Peer group members were also interested in the newly added PHE-related topics.

"FTM are excited with the program. It seems it was an opportunity for them to meet and learn. There were topics they had not heard before, like decision making and problem solving. But they also enjoyed learning in detail about family planning methods."

—CHW KAPANGA

"PHE overview was a wonderful session for first-time parents, and many loved the model household visit. In our village, people are fined if they are found with no toilets or have no waste dumping places, so giving them this education and information opened the door for them to join model household. After the visit, many young mothers started with tippy tap, using family planning and setting up waste disposal sites."

—PEER LEADER ISENGULE

FTMs did face some challenges to regular participation, including farming priorities, heavy rains, and, in some instances, resistance from husbands/partners. CHWs and peer leaders made diligent efforts to minimize these barriers by rescheduling meetings as needed, visiting peer group members at home to let them know about any changes, and visiting partners to try and gain their support.

"A challenge came when two groups members were restricted by their husband to attend the meetings. I tried my best to talk to their partner unsuccessfully. I reported to CHW, and we conducted home visit and spoke to their husband but rejected even welcoming us. We told one respected elder in the community, and he talked to them and they allowed their wives to continue attending the meetings."

—PEER LEADER TAMBUSHA

An additional challenge in some villages was that demand outweighed program capacity.

"A challenge was that we found more than 30 FTMs that were interested to join the group. This created a difficult time for us, because even if 30 are included, there were many more people who wanted to join."

—CHW HEREMBE

SESSIONS FOR HUSBANDS/PARTNERS

Overall, the partners of FTMs were interested in the program and continued to participate throughout the intervention period. FTMs' husbands/partners were identified by the FTMs themselves and recruited by the CHWs. Project monitoring data shows that 155 husbands/partners participated in the program. To put this number of husbands/partners into context, at the time of recruitment, 179 of the 375 FTMs enrolled reported being single, indicating that they may not have a partner to invite for program participation. This high degree of men's participation was somewhat surprising to project implementers who thought that time constraints and gender norms might pose significant barriers to their participation.

"We didn't expect that the men's recruitment would be easy compared to older women. Usually men are busier with fishing and agricultural activities. Also, calling men for meetings to discuss specific topics is not common to our areas, but men accepted straight away. Those we invited, they came. We had thirteen men. I think this was an opportunity for them to learn especially family planning since they have been missing this information and instead were hearing from women and social media."

—CHW HEREMBE

Implementers also mentioned that men expressed that they often felt left out of interventions that only engaged their wives. Men were curious about what was happening in the FTM peer groups and wondered what the women were learning. This made them receptive to joining a group of their own.

"Men wanted to know what topics their wives were discussing and also what will happen after the meeting. This attracted men to come. Once they come, they enjoyed the session and kept coming. They especially enjoyed the fatherhood session. It surprised them how they should behave as a good father like helping their wives with home responsibilities."

—CHW NKONKWA

When men were resistant to joining the groups, an explanation of the purpose and format of the groups helped to encourage their participation. The findings of this program indicate that by engaging male partners from the onset, and by following up with them to address their concerns and explain the benefits of this type of programming for men, programs can attract and retain a substantial number of male participants.

"For men, we faced challenges with recruiting them at the beginning. Men asked what the benefit will be. They said that if the groups just provided education, they could learn this information from their wives. Men heard they will only be taught about family planning and that's why they were not participating. We spoke to them and said that they will learn different things which are important for their families. We also clarified that men groups are different from their wives— that they as men will have their own groups and will not be mixed with their wives during meeting. Afterwards they started to come."

—CHW KASEKESE

SESSIONS FOR OLDER WOMEN

Similarly, 152 older women who were key influencers of FTMs participated in at least one session. Older women were typically supportive of the program and easy to engage. While a few were not certain at first why they would need to attend, CHWs addressed their concerns, which were not a significant barrier to their participation.

"Older women asked, "Why are you inviting us to join and attend group meeting while our daughter and sister-in-law are there already?" We told them, "You will have your own group separate from the first-time parents, also you will learn different things which will help you in supporting your sister-in-law and daughter to make decisions and choices relating to sexual and reproductive health issues including spacing of pregnancy and use of family planning."

—CHW ISENGULE

Finding 2: FP use increased from 50% to 73% among FTM peer group members throughout the course of the intervention.

FP use among FTMs who were not pregnant increased from 50% to 73% over the course of the intervention. Women in these communities may have had exposure to FP information and messages prior to the intervention, since CHWs have been active and encouraged to focus on FTMs and other young women. This might explain why the baseline FP use is higher than it was for the Phase 1 FTP program (Phase 1: baseline 35%, endline 66%).

As table 3 shows, the change in FP use from intake to exit was somewhat similar across age ranges and marital status. However, there was a greater percentage increase among single FTMs than among those who were married. More research is needed to fully understand the difference and how to encourage FP uptake among married FTMs. Furthermore, while the numbers are small, a high percentage of program participants ages 25+ (83%, 5 out of 6) were using an FP method at exit.

TABLE 3: CURRENT FP USE AT INTAKE AND EXIT AMONG NON-PREGNANT FTMS, BY AGE AND MARITAL STATUS, TANZANIA 2020

	INTAKE			EXIT			PERCENT CHANGE
	All FTMs EXCEPT those that said they were currently pregnant (N)*	Currently using FP (n)	%	Did not report currently pregnant (N)*	Currently using FP (n)	%	
AGE							
15-19	138	70	50.72%	78	55	70.51%	**39.01%**
20-24	207	102	49.28%	246	179	72.76%	**47.67%**
25+	1	0	0.00%	6	5	83.33%	**---**
Missing Data	4	3	75.00%	5	4	80.00%	**6.67%**
MARITAL STATUS							
Single	166	86	51.81%	146	116	79.45%	**53.36%**
Married or Cohabitating	175	83	47.43%	177	116	65.54%	**38.18%**
Separated or Divorced	5	4	80.00%	8	7	87.50%	**9.37%**
Other	1	0	0.00%	0	0	---	
Missing Data	3	2	66.67%	4	4	100.00%	**50.00%**
TOTAL	**350**	**175**	**50%**	**335**	**243**	**72.54%**	**45.07%**

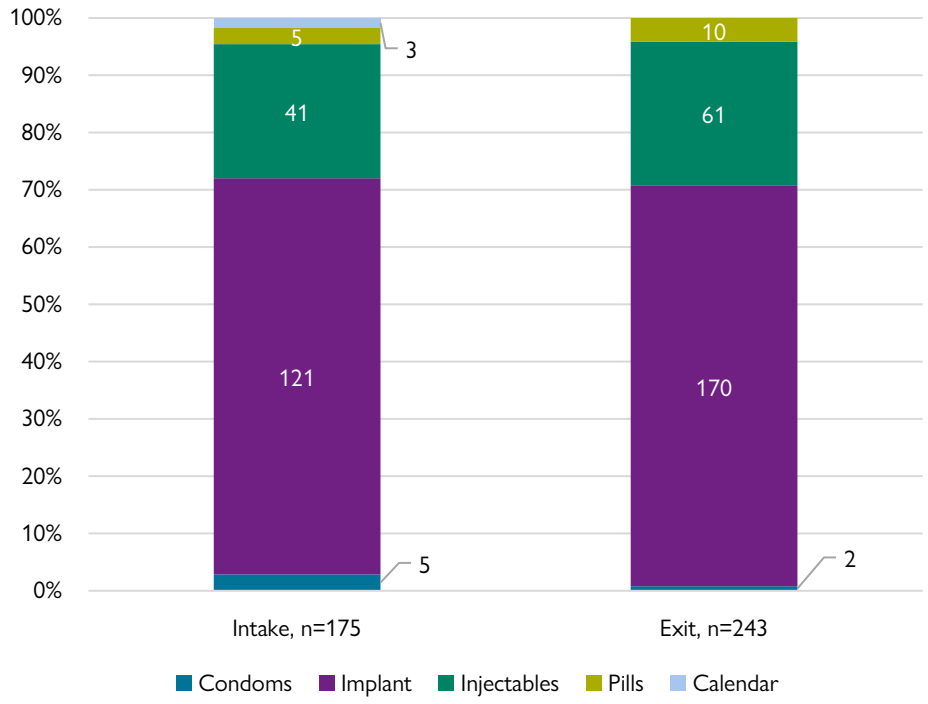
*These results are only for those for which data on current FP use was available.

One potential factor contributing to the increased FP use seen during the intervention period is improvements in access to FP information, as reported by program implementers. The peer groups also provided regular interactions with CHWs—who were able to provide pills and condoms and referrals to health facilities for other methods—during the group sessions and through home visits.

> *"You know, our village is far from a health facility. It is about three walking hours to the dispensary, so six hours to go and return. A nurse always comes for immunization and family planning once monthly. Even when he comes, there are many people waiting for him, so young women cannot access services easily unless you connect her, but these groups bring an opportunity for them to learn family planning widely. During the small-group session about IUCD and implant, our supervisor came and led the session to help the FTMs learn and ask as many questions as they can. They received a lot of information, which cleared their doubt and concern. He also talked about injection and other methods. Currently we receive many requests from other young women that want to join groups."*
>
> **—CHW KAPANGA**

The method mix among FTM peer group participants was similar at intake and exit, with the vast majority of FTMs using either implants or injectables. Importantly, the high proportion of implant use indicates that LARCs are an acceptable and accessible contraceptive method for young FTMs in these project areas.

FIGURE 1: METHOD MIX AMONG FTM PEER GROUP PARTICIPANTS THAT WERE CURRENTLY USING AN FP METHOD AT INTAKE AND EXIT



Among FTMs who previously used FP but were not using a method at the end of the intervention, 70% indicated that they stopped using FP because they wanted to get pregnant. This indicates that the majority of those who stopped using a method did so voluntarily rather than due to barriers like side effects, opposition, or lack of access. Furthermore, the majority of those who indicated that they stopped using a method because they wanted to become pregnant were married (72%), which might help explain why we saw a smaller increase in FP use among married FTMs. A minority of respondents, 16% of FTMs who stopped using FP, indicated that they stopped using due to side effects. This shows that some FTMs were not able to find a method that they felt was suitable for them in the long term. However, the FTP program, and the broader Tuungane project, made considerable efforts to ensure that all women, including first-time mothers, had access to a wide range of methods from which to choose. This included FP training for health providers under the Tuungane project, including training on PPFP provision and provision and removal of LARCs. Furthermore, findings from a recent qualitative study conducted with Phase 1 FTP program participants showed that the information provided through the FTP program small groups and home visits broadened participants knowledge of FP methods and in some cases led to participants switching to a different method, when their current method was not meeting their needs.[16] The study showed that method switching was often, but not always, from short-acting to long-acting methods.

Finding 3: Knowledge and attitudes related to FP use improved among FTM peer group members throughout the course of the intervention.

The FTP component of the Tuungane project provided information and discussion about FP with the aim of improving FTM's knowledge about and attitudes towards its use. At exit, almost all FTMs (97%) believed that it is acceptable for a young woman to use FP to prevent pregnancy, compared with 77% at intake. Furthermore, at exit, 96% of FTMs said they did not believe that FP leads to infertility, compared with 75% at intake.

Discussions with program implementers also indicated that the FTP intervention improved FTMs knowledge about HTSP and FP, which subsequently increased their comfort level in speaking about FP to their partners, family members, and community leaders.

[16] Read E2A's report on exploring contraceptive use histories in Western Tanzania here: https://www.e2aproject.org/publication/tz-contraceptives-report/

"In my experience working with this program, I came to realize that young women in our community are discouraged by men and older women to seek reproductive health information and knowledge, including utilization of family planning. In our community, women and men believe having many children brings worth and respect, so older women have been speaking to their daughter to give birth to many children. After they joined the first-time parent program, young women are very happy since they have received great education, and now they can talk to their elders and husband regarding sexual and reproductive health including spacing of pregnancy."

—CHW KASEKESE

"I found that first-time parent now are competent to express themselves in front of people, including their partners, compared to previous time we started this program. Additionally, they understand more things related to their life—like PHE, family planning, and gender issues—than before. That's my experience in working with first-time parents."

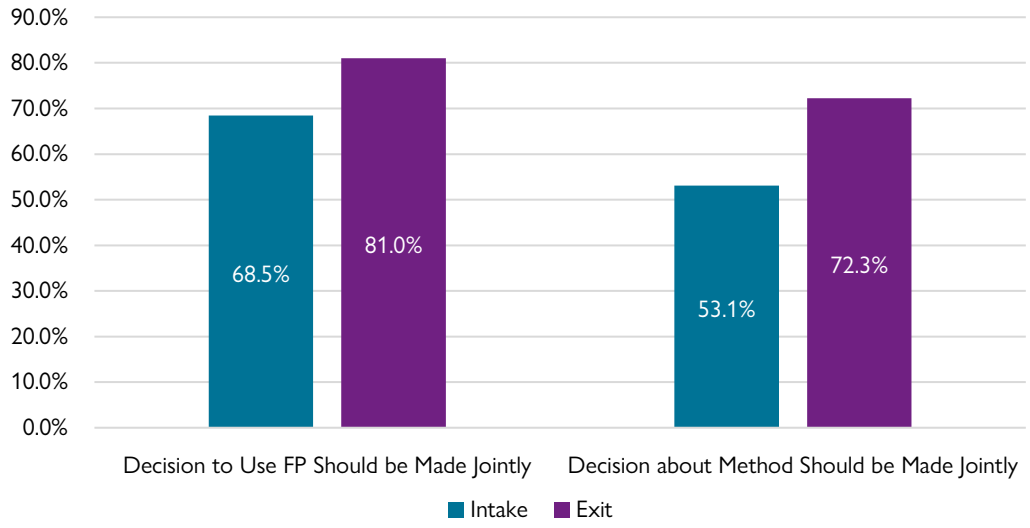
—CHW ISENGULE

Finding 4: The program fostered increased couple communication about FP and shifts in attitudes related to couples' decision making.

According to the exit data, 93% of FTMs reported discussing FP with someone—including husbands/partners and older women who were key influencers in their lives—in the past three months. This was a substantial increase from intake, when only 54% of FTMs reported speaking with someone about FP in the past three months. This indicates that the FTP component opened opportunities for discussing FP and increased FTMs comfort and ability to do so.

FTMs were also asked about their attitudes related to decision making (who should make the decision to use a method and who should make the decision about which method to use) at intake and exit. A larger proportion of FTMs at exit noted that couples should make decisions together about whether to use FP and about which method to use. Implementers, and FTMs themselves, also noted improvements in decision making among the FTM couples who participated in the program.

FIGURE 2: PERCENTAGE OF FTM PEER GROUP PARTICIPANTS THAT INDICATED THAT THE DECISION TO USE FP AND THE DECISION ON METHOD SHOULD BE MADE JOINTLY, AT INTAKE AND EXIT



Finding 5: Partner support and attitudes related to their involvement in HTSP/FP improved since the start of the FTP program.

Phase 2 of the FTP program made a concerted effort to engage FTMs' husbands/partners on topics related to HTSP/FP, PHE, gender, relationships, and fatherhood. By the end of the intervention, implementers reported seeing greater support and involvement of partners related to HTSP and FP.

> *"It was interesting that men are now supporting their wives' view on spacing of pregnancy and number of children they need to have. Supporting their wife to use a modern family planning method was impossible in our village, especially for young boys to allow their wife to attend a meeting and join family planning contraceptive use. I didn't expect [this reaction]."*
> **—CHW NKONKWA**

The program addressed misconceptions commonly held by partners/other influencers related to FP use and explained the benefits of HTSP/FP, minimizing barriers to FP uptake by FTMs. These experiences show the importance of an approach that engages both men and women, as well as older women key influencers, in a way that is beneficial for all.

> *"Resistance came from men and older women, especially mother-in-law. Men believed modern contraception has many effects including causing cancer in reproductive organ and infertility to women. We cleared all doubt among men that family planning doesn't cause infertility or cancer. We told them why family planning is important to themselves as fathers and their families, because men traditionally they believe that big family size is wealth."*
> **—CHW KASEKESE**

While men were generally interested in learning more about issues related to their relationships with their partner and child—including fatherhood, household roles, and support for their spouse/partner—some men still felt constrained by traditional social and gender norms about being in control and not needing to support their spouse with household responsibilities. In some cases, adherence to traditional gender norms prevented men's involvement in these activities. In others, men did not want others to know about the ways that they were supporting their partners. This highlights the strong influence of gender norms and expectations on men in these communities, and the potential stigma they face by challenging these norms as they move along the milestones in their life-course—from adolescence to becoming a spouse/partner and a parent.

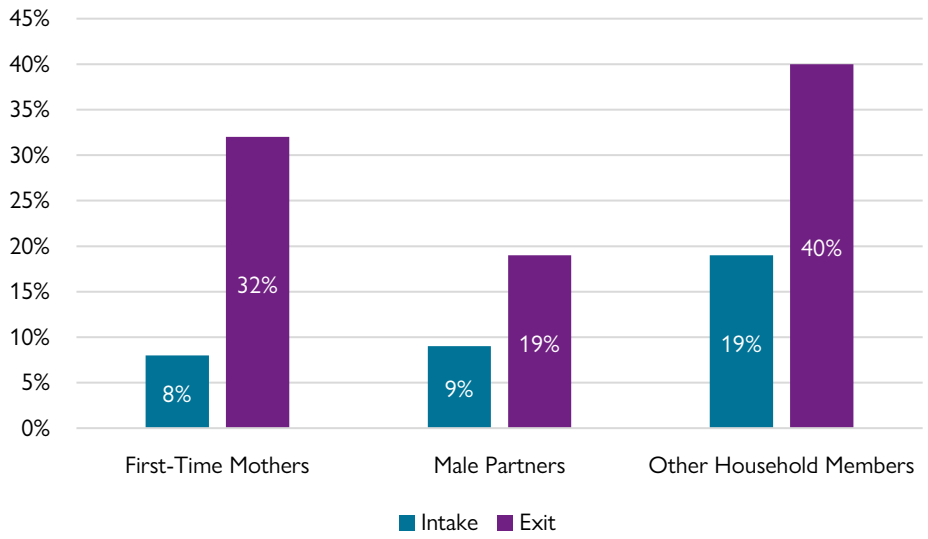
> *"The fatherhood and relationship small group sessions interested the men, especially hearing that as a father they need to communicate in a respectful manner with their partner and do household activities. They learned that every activity men do, women can do the same. Men learned that doing housework is good, and they felt that they can support their wives at home. But they also felt that women should stop talking about how they help with household activities and stop telling everyone, "my husband is doing everything for me at home." I also noticed that sometimes they do not understand their wives' workload and assume they have little work at home. Sometimes they hit them and say they are lazy."*
>
> **—CHW ISENGULE**

Overall, men and their wives and partners were interested in continuing and expanding the husband/partner group discussion sessions.

Finding 6: The FTP program exposed FTMs and their households to new PHE ideas. Participation in Tuungane PHE activities increased among FTMs, their husbands/partners, and other members of their households.

Phase 2 of the FTP program provided increased linkages for FTPs to Tuungane PHE activities through PHE-related peer group sessions, interactions with PHE champions, and a planned visit to a model household. After the implementation of these PHE-focused efforts, the percentage of FTMs that reported participating in at least one Tuungane PHE activity increased from 8% at intake to 32% at exit. FTMs most commonly reported participating in establishing a model household and joining a community conservation bank (COCOBA). The percentage of husbands/partners and other household members that reported participating in at least one PHE activity also increased during the intervention, as is shown in Figure 3 below. Becoming a model household was also commonly mentioned among these groups, followed by participation in beach management units (BMU) for husbands/partners and COCOBAs for other household members.

FIGURE 3: PERCENTAGE OF FTMS PEER GROUP PARTICIPANTS, MALE PARTNERS, AND OTHER HOUSEHOLD MEMBERS THAT PARTICIPATED IN AT LEAST ONE TUUNGANE PHE ACTIVITY, AT INTAKE AND EXIT



While more men and older women were aware of the Tuungane PHE activities than FTMs, and in some cases were more likely to have already participated, the PHE sessions for these key influencers were still beneficial in familiarizing them with all the PHE components. This is especially true for younger partners of FTMs.

> *"Families joined model households, COCOBA, community agricultural workers, and beach management unit, but for male partners of first-time mothers, this was a new thing to them, especially young boys, and others were not aware that all are PHE activities. People know Tuungane not PHE. Ten men joined model household, as we are living near the lake. PHE champion taught them well about BMU, and five joined becoming beach management unit members. Like first-time parents, they also preferred COCOBA because it will give them income-generation opportunities."*
>
> **—CHW ISENGULE**

This increased participation in Tuungane PHE activities by FTMs was also noted by CHWs and PHE champions. These program implementers described the benefits of these new PHE program components, expressing that they exposed FTMs to new ideas. The visits to model households and the PHE-focused discussion sessions introduced FTMs to small steps they can take, even if they do not yet have their own household.

"Participation increased far beyond our expectation. Half of the first-time mothers registered as new model household. The same with men who participated in the meeting. And not only for these who participated in the groups but there are other young women that joined model household by being inspired by their fellow young women and men."

—PHE CHAMPION ISENGULE

Conducting these informational sessions in the peer group format helped young FTMs understand how PHE activities are as relevant to them as they are to older, more established people.

"Through this meeting I learned that many young women are not reached with PHE information even if they see some PHE things like tip tap, energy-serving stoves, etc. They think all things are for adults. Also, adults do not teach their kids [about] PHE or its importance. These are some things I learnt during this period. You visit an FTM household living with her parents and you find their tip tap and energy-serving stoves, but only parents understand its significance and why they are there."

—PHE ISENGULE

However, some PHE champions also noted that FTPs/youth are not necessarily positioned to participate in many of these activities, since they do not own their own household or have financial assets, which can cause problems.

"I think when the project started, they didn't think there would be such a large increase of young people as there is today. In particular, there was no clear thinking about these first-time parents. PHE activities did not take these groups into consideration though they could benefit from PHE aspects, such as climate-smart agriculture and visits by community agriculture workers. FTPs can benefit from CHW home visits and family-planning education, and participation in a BMU and further aquatic environmental education. But there are still challenges for young people, particularly those who live with their parents, have no farm or no job, and cannot make their own decisions."

—PHE CHAMPION BUHINGU

This has caused some PHE champions to begin thinking about how these PHE activities can better engage youth and be made more relevant to their needs.

"Tuungane should think now about how it will engage youth in their work and interventions, because today there are many more young people than before, and they are the fathers and mothers of tomorrow. First, education should be provided to first-time parents and other youth like what we did. Family planning education should continue, because these FTP program participants are only a small part of the youth in our community. There are young people with two or more children, others that are not yet parents, but these groups were for first-time parents only. We see how the program helped to convey messages and change the community, so what if we have interventions for all youth in the community? I think the whole community will learn. This is how PHE should be modified."

—PHE CHAMPION ISENGULE

Finding 7: Peer-to-peer outreaches reached a wider range of young women missed by the FTP-specific programs and built the capacity of previously trained peer leaders.

The outreaches and home visits by former peer leaders and deputy peer leaders reached a wide range of young women in the community. Fifteen peer leaders and 16 deputy peer leaders were trained to conduct these outreaches and home visits. Each peer leader and deputy peer leader pair conducted one outreach session per month for four months with young women of all parity levels in their community, averaging 18 participants per outreach. Each peer leader also conducted home visits to eight young women per month. These activities reached many additional young women who would have otherwise been missed by the FTP program with information about HTSP, FP, PHE, and gender.

In general, the peer leaders and deputy peer leaders valued the chance to share information related to HTSP, FP, PHE, and gender roles with young women in the community. Peer leaders noted that this approach is an effective way to reach many young women and their household members with the information they really want and need.

"This approach should continue because we see how it is important. We reached people out of the FTP groups, helped them to understand family planning education, and provided referrals to a health facility for family planning contraceptive methods. Because we are so few, we have not been able to reach far places. If these new peer leaders are allowed to make home visits, many young people will be reached, because the beneficiaries of this education are not just young people, They are even older women, because when you get to the house, you are talking to many people. You don't discriminate as long as they want to listen. Today we see many mothers motivating their daughters to use family planning. They tell them life has changed since what we did in the past, taking care of a family has become so expensive that you must plan otherwise you will fail to serve your own family."

—PEER LEADER KAREMA

This approach strengthened the capacity of the peer leaders, gave them greater influence within their communities, and opened up the potential for new opportunities, such as becoming a CHW. Peer leaders are uniquely positioned to reach young women, as they are able to reach and speak with peers in a way that others cannot.

> *"A peer leader is more familiar with young women sometimes more than CHW. We observed that young women feel secure to talk to other young women more than older people."*
> **—PEER LEADER KAREMA**

CHWs were generally very supportive of activities conducted by the peer leaders, which helped ease the workload of the CHWs. Since CHWs are unable to cover all households in their communities, peer leaders help bridge the gap in reaching young women with FP and PHE information. When possible, CHWs attended outreach sessions, helped with home visits when issues arose, and provided referrals to health services.

> *"Awareness raising, education, and continuous sensitization is something that should be done all the time. What peer leaders are doing—providing health education and referrals—is something good and should be sustainable because one understands best when you visit her at home and can be inspired with what you're saying rather than at a health facility, because we have a shortage of health care providers, and they are occupied. So, conducting home visits and outreaches is the best way of talking with youth in general."*
> **—CHW KASHAGULU.**

> *"I strongly recommend that this approach should continue since peer leaders have reached people that we didn't expect that we could reach. This is a growing opportunity for peer leaders too and, really, they help us, since the population has increased compared to where we started five years ago. I observed young women are more comfortable talking to their fellow women."*
> **—CHW MCHANGANI**

Coordination among peer leaders and other program implementers—including CHWs, CHW supervisors, and PHE champions—was generally effective.

> *"Coordination with CHWs, CHW supervisors, and PHE champions was good, since what connected us was responsibilities. As peer leader, I will invite young women to join the group, but wherever I face challenges, CHW will help. Also, CHW and PHE champion have to come to the meetings as per schedule. The CHW played great roles ensuring everything went smoothly. He was there any time we need support. I have never worked with PHE champion before, but through outreach, we cooperated both together: I provided referral to him, he received and send back to me."*
> **—PEER LEADER BUHINGU**

Despite the success of this intervention strategy, there were some challenges. For example, it took time for the community to understand the intervention. At first, some community members were reluctant to engage with peer leaders for home visits.

> *"Some [community members] raised doubts about the peer leaders and asked me, "We see peer leader are now doing your roles, are they also CHW?" Sometimes peer leaders have been visiting homes and not finding any one there, despite the fact that they arranged the visit. Or they find them, and they say they are engaged in other activities. Another challenge is young women asking peer leaders questions that they already know just to test their understanding. This has been a challenge sometimes, but wherever they fail to answer a question, they told us and we scheduled another visit to go together so that the peer leader can gain expertise for such question."*
>
> **—CHW MCHANGANI**

To ensure the continued success of this strategy, and to continue to strengthen the capacity of these young peer leaders, refresher trainings will be needed. Through capacity building, these peer leaders can also become influential adults in the community, and new peer leaders will need to be trained as they enter into the first-time parent lifestage.

> *"For carrying out our responsibilities smoothly, I think we need a refresher training each year or perhaps to be trained as a CHW will be great. Training other young women to become CHWs will help to reach many young mothers in the community. More importantly, whatever circumstances, this program should continue."*
>
> **—PEER LEADER BUHINGU**

Emerging Recommendations

The second phase of FTP programming under the Tuungane project generated additional evidence and learnings about how to implement effective programming for FTPs and the potential FP and gender impacts that can be achieved by investing in this population. The Phase 2 FTP program was particularly important in highlighting the possibilities for and importance of systematic engagement with key influencers, greater linkages and integration with PHE programming, and additional outreaches to young women of all parity levels. The results and lessons learned presented above helped inform the following emerging recommendations for working with first-time parents in Tanzania and globally.

Recommendation 1: Include peer-to-peer outreach to reach young women in rural, remote settings with HTSP/FP, gender, and PHE messages and links to community resource persons.

In rural areas like the Tuungane communities, young women face many barriers to accessing FP/RH information and care. This FTP intervention showed that using trained peer leaders to conduct outreaches and home visits with young women of all parity levels allowed the program to reach many more women and their households with information and services. While the initial investment in training and capacity strengthening for peer leaders is high, this phase of the program found a way to continue engaging peer leaders with previously built capacity, which proved to be a worthwhile approach. As young women themselves, these peer leaders are uniquely qualified to conduct outreaches and home visits, as young women may be more comfortable speaking about sensitive topics with their peers. When working in collaboration with CHWs and other community resource persons, this approach also connects young women to health services. Furthermore, this approach strengthens the peer leaders' capacity and their influence within their communities. Programs should consider additional opportunities for these peer leaders such as training them to become CHWs. Former peer leaders can also serve as mentors to new peer leaders, training and supporting them in their role.

Recommendation 2: Continue to build approaches that engage husbands/partners of FTMs and build their support for FTM health action.

Program implementers indicated that the men's small group discussions were a successful approach. The men appreciated being involved in the program, and the FTMs benefited from their involvement. The men were interested in participating in the groups and interested in the topics discussed. Future programs should continue to engage men by intervening with both partners separately, for the benefit of the couple. This approach provides young couples with the time and space to learn and think about difficult topics on their own before discussing as a couple. Programs could consider bringing the couple together at key points in order to facilitate communication and joint decision making.

Recommendation 3: Provide FTMs/FTPs and other youth with PHE information, exposure to PHE best practices being applied, and links to activities in order to encourage adoption of relevant PHE behaviors and incorporation of PHE principles when planning for their future.

FTM/FTP program participants were receptive to learning about PHE and eager to join Tuungane PHE activities. The Tuungane project should continue to engage FTPs and other youth with PHE information and introduce them to PHE practices and activities. Teaching youth about PHE allows them to integrate PHE practices into their lives, and to consider PHE practices when planning for their future. Furthermore, showing FTPs that PHE best practices are being applied by their peers made PHE tangible and attainable for these young people. It was also clear, however, that some PHE activities and groups were still designed in a way that did not enable meaningful FTP/youth participation, due to the fact that most do not have their own household, or the financial resources need for participation. In the long term, Tuungane and other PHE projects should consider how to redesign current activities to make them more welcoming and relevant to youth or potentially create youth-specific PHE groups/activities.

Recommendation 4: Link young women and couples—including FTMs/FTPs—to income-generating activities designed for young people to improve their livelihoods and economic potential.

Tuungane includes economic activities, such as COCOBAs and climate-smart agriculture groups, under its broader PHE mandate. However, as mentioned above, these activities are not always structured for young women, since they do not own their own household or have financial assets. The Tuungane project should continue to explore ways to make COCOBAs and other PHE groups more receptive to young women. In addition to teaching FTMs/FTPs and other youth about PHE and engaging them in PHE activities, programs should also connect FTPs to other programs and services that support income-generation and livelihoods. This could potentially include small business promotion (related to fishing, agriculture, soap making, or poultry, for instance), cooperative undertakings, job creation schemes, sewing circles, credit and savings groups tailored to FTPs, or skills training programs. Their needs are particularly acute during the FTP lifestage, when new parenthood brings additional costs and stresses to young people's lives. The need for income-generation and livelihood opportunities is particularly important in remote settings such as the Tuungane project communities where opportunities for young people are limited.

Recommendation 5: Build the capacity of Council Health Management Teams, Local Government Authorities, and facility-based providers to design and implement continued FTP programming

In order to ensure the sustainability of FTP programming in the Tuungane project areas after E2A and Tuungane have ended, the project should focus on building the capacity of Council Health Management Teams and Local Government Authorities to design and implement future FTP programs. This is a process that project has included from the beginning, with the involvement of the facility supervisors in the FTP

program monthly review meetings, and will be further emphasized during the next phase of the E2A-implemented FTP program under Tuungane. Facility-based providers can undergo a training of trainers so that they are qualified to train and mentor CHWs and peer leaders for future FTP initiatives. The project can also coordinate closely with CHMTs to orient them on all components of the FTP program, including the male partner and older women approaches, in order to ensure they are fully equipped to take full ownership and continue FTP programming for the benefit of FTPs, their families, and the Tuungane communities.

PHOTO: Sala Lewis (Tanzania)

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E2A EVIDENCE TO ACTION
for Strengthened Reproductive Health

PHOTO Sala Lewis

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