TANZANIA | STUDY BRIEF

Exploring the Contraceptive Use Histories and Decision-Making Processes of First-Time Parents in Western Tanzania

INTRODUCTION

In 2018, the Evidence to Action (E2A) project and Pathfinder International Tanzania—through the Tuungane Project, an integrated population-health-environment (PHE) project in Western Tanzania—launched a new program component focusing on first-time parents (FTPs).[1] The FTP component centered on advancing family planning and related gender outcomes for young first-time mothers (FTMs) through a package of community- and facility-based interventions over a five-month period (May–September 2018). Although of short duration, the FTP component generated strong results: FTM program participants' voluntary use of modern contraceptives increased from 35% to 66%, with increases across the range of available short- and long-acting methods. Importantly, the majority of FTM peer group members who adopted a contraceptive method during the intervention were first-time family planning (FP) users. Such dramatic results, especially in regions of high teenage pregnancy and low contraceptive use, suggested that there may be other factors unique to the FTP lifestage that prompted FP interest and action.

Understanding why and how FTPs use FP is fundamental to designing effective programs that can support young women and men at this time in their reproductive lives. Therefore, in March 2020, nearly two years after the start of the FTP intervention, E2A and Pathfinder Tanzania, in collaboration with a local research consultant, followed up with FTM program participants and their husbands/partners to better understand contraceptive use and method choice at the time of the intervention and in the time since activities concluded. This qualitative study on FTP contraceptive use explored FTM/FTP family planning experiences and identified the different factors that influenced their choice, communication, negotiation, decision making, and action.

The specific study objectives:

- Explore contraceptive histories of FTMs, both new and continuing users,[2] who adopted short-acting FP methods and long-acting reversible contraceptives (LARCs).
- Explore facilitating factors for FP uptake among FTMs/FTPs who participated in the program.
- Understand decision-making processes regarding FP use among FTMs/FTPs who participated in the program.
- Understand factors associated with FP method continuation/discontinuation/switching.
- Understand the role of partners/husbands in the FTMs' decision-making processes regarding FP use, including method choice and method continuation/discontinuation/switching.
- Explore FTMs' experiences accessing FP methods.
- Understand future contraceptive needs and intentions to use contraception.

1 E2A defines first-time parents as women under the age of 25 years who are pregnant with or have one child, and their partners.

2 For this study, a new user is defined as a first-time FP users who has never any method of contraception previously, and a continuing user is defined as any FP user that had used a method of contraception before adopting the method currently being used, which could have been before or after her pregnancy.

CONTRACEPTIVE USE STUDY METHODS

This contraceptive use study was conducted as a follow-up to the Tuungane FTP component implemented in Uvinza district of Kigoma region and Tanganyika district of Katavi region in 2018. The implementation of this study was led and managed by CSK Research Solutions and utilized qualitative data collection methods, specifically in-depth interviews (IDIs), to explore decision-making processes and actions related to contraceptive use among young FTM program participants and their partners/husbands.

The study research team successfully completed interviews with 43 participants, which included FTMs who were chosen based on predetermined recruitment criteria, including being a member of a Tuungane peer group and a contraceptive user—having adopted a short-acting contraceptive method during the 2018 intervention or a long-acting method either before or during the intervention—or being the husband/partner of an FTM peer group member at the time of the 2018 intervention.[3] To identify possible study participants, the project team first compiled a complete list of all FTM peer group members who participated in the 2018 FTP program, with details on contraceptive use, method type, and partnership status at the time of the intervention. The study team reviewed this information and selected four facilities with sufficient numbers of participants who met inclusion criteria. From these four health facilities, the study team randomly selected FTM program participants within each of the respondent categories. In case one or more of the randomly selected potential study participants did not meet the study inclusion criteria or declined to participate, the study team randomly selected additional respondents as replacements. The husbands/partners of the randomly selected FTMs were also recruited for participation. All of the men interviewed in the study were a husband/partner of an FTM program participant at the time of the 2018 intervention. While most of the husbands/partners that participated in the study were the partners of FTM study participants, this was not always the case in instances where the original FTM selected was not eligible or declined participation. The study research team also planned to recruit a larger number of short-acting method users than long-acting method users due to the high number of short-acting method adopters observed during the FTP program, though this was not strictly proportional to the method mix among program participants.[4]

Two teams of interviewers (one male and one female research assistant per team) were trained on the study objectives and methodology, qualitative research techniques in conducting IDIs, the content and meaning of questions included in all interview guides to be used in the study, and ethical research practices. Working concurrently in the two districts, the two teams collected data using interview guides for FTMs and their male partners, which were designed and pre-tested for this study. All interviews were conducted in Kiswahili, audio-recorded with the consent of the participants, and later transcribed and translated from Kiswahili to English.

The study objectives and research questions were used to develop codes to guide the qualitative data analysis process. These codes were revised during a pilot analysis process to ensure that the application of the codes was clear and consistent. Data analysis also involved exploration for the identification of any potential differences in responses among participants of different characteristics, particularly in terms of marital status at the time of contraceptive use (married vs. unmarried) and method choice (short- vs. long-acting method).

ETHICAL CONSIDERATIONS

The protocol for this assessment received Institutional Review Board (IRB) approval from the National Institute for Medical Research (NIMR) in Tanzania and was exempted from IRB review by PATH's Research Determination Committee because it was determined not to be human subjects research. This study was carefully designed to address ethical principles, including respect for persons, beneficence, and justice. Efforts were made to protect individual autonomy, minimize harm, maximize benefits, and equitably distribute risks and benefits. All study team members were given ethics and data confidentiality training so that they fully understood the concepts of informed consent and confidentiality, and a consent process was administered with each participant at the time of recruitment and before the interview.

STUDY LIMITATIONS

In order to understand the contraceptive experiences of FTMs who went through the 2018 FTM program, the study specifically included young FTM program participants who were contraceptive users. Therefore, this research is not a comprehensive study on the contraceptive experiences of all FTMs, but rather a follow-up study with peer group FTMs who were using a modern contraceptive method at the time of the Tuungane FTP project—including those who adopted a short-acting method during the course of the intervention and those who adopted a long-acting method either before or during the intervention. There were also some variations in achieving the planned mix of respondents. The study originally planned to include more short-acting method users, as the majority of FTM peer group members at the end of the intervention were using short-acting methods; however, the final study instead included more FTMs who had adopted LARCs. This occurred largely at the time of recruitment, when using the participant selection protocol to identify possible FTMs to replace those originally selected to participate in the study (due to the FTMs' refusal to participate or being unable to find them in the community). Due to the limited pool of potential study participants, the selected replacement FTMs inadvertently included more long-acting method users than originally planned. However, as all FTMs otherwise met the eligibility criteria and were able to share relevant insights on their contraceptive use experience, they were retained in the study. Finally, this study involved the recall of experiences and actions that happened almost two years earlier. As such, there is a potential for recall bias or incorrect/incomplete memories. The study team sought to compensate for this by asking participants to recall other events in their lives at that time and to use project activities as a time marker.

3 Male participants were all husbands/partners of FTM peer group members, but not necessarily those FTMs included in the study.

4 Please refer to the study limitations section for an explanation of the variation between the planned and actual study participants in regard to contraceptive method used.

Study Results

TABLE 1: BACKGROUND CHARACTERISTICS OF FTM AND MALE PARTNERS STUDY PARTICIPANTS

BACKGROUND INFORMATION	FIRST-TIME MOTHERS (n=28)	MALE PARTNERS (n=15)
AGE (Current)		
18–19 years	8 (28.6%)	
20–24 years	18 (64.3%)	9 (60.0%)
25+ years	2 (7.1%)	6 (40.0%)
MARITAL STATUS (During the program—2018)		
Single	18 (64.3%)	
Married	10 (35.7%)	
MARITAL STATUS (Current—2020)		
Single	6 (21.4%)	3 (20%)
Married	17 (60.7%)	7 (46.7%)
Cohabitating	4 (14.3%)	5 (33.3%)
Divorced	1 (3.6%)	
DURATION OF RELATIONSHIP WITH FTM (Years)		
2–3 years		4 (26.7%)
4 or more years		11 (73.3%)
NUMBER OF CHILDREN		
One child	20 (71.4%)	
Two children	8 (28.6%)	
FP METHOD (Of FTM)		
Implant	17 (60.7%)	11(73.3%)
Injection	7 (25%)	3 (20%)
Pills	3 (10.7%)	1 (6.7%)
Condom	1 (3.6%)	

Background Characteristics

The majority of the 28 FTMs interviewed for the study were over 20 years old and still had only one child at the time of the interview. Most were not married in 2018 and were living with their parents at that time. By 2020, almost three-quarters reported being married or cohabiting, with the majority reporting that they were still with the same partner they had at the time of the intervention. As per the study design, all interviewed FTMs were contraceptive users during the intervention period, with the majority using a long-acting method, the contraceptive implant.

By March 2020, most men had been in a relationship with their FTM partners for four or more years, well before the start of the intervention period. This means that most men were in a relationship with their partners at the time of the contraceptive use explored during this study, with most couples using a long-acting method.

Factors Facilitating the Decision to Use FP (FTMs)

All interviews with FTMs explored their contraceptive use histories, including when and why they first adopted FP. Of the 28 FTMs included in the study, 18 (7 married, 11 unmarried) reported adopting FP for the first time after joining a peer group (referred to in this report as "new users"), while 10 (3 married, 7 unmarried) said they used FP prior to joining the peer groups (referred to in this report as "continuing users").

For the 18 new users who adopted FP for the first time after joining peer groups, the most commonly mentioned facilitating factor was the exposure to FP information and counseling through FTP interventions. The timing of the exposure to FP information through the FTP intervention—after they had given birth to their first child—seems to have been important. Many new users reported that prior to the intervention, they felt they were "too young" to consider FP, which was perceived to be an issue for older married women with children. Given this sentiment, many new users said that they did not previously seek or listen to information about FP when it was discussed around them.

New FP users interviewed during the study also indicated several other factors that impacted their decisions to use FP. Married FTM new users said that they did not consider using FP before being pregnant or having at least one child. Two reasons were reported for this: (1) it was expected for them to have a child after being married, and (2) many were concerned about the safety of FP, especially with regards to possible impact on future fertility.

"They said, if you use family planning before having a child, you might not be able to have a baby again. It is better to have a child first and then decide to use family planning. Therefore, we had not thought of using family planning before having a baby."

—MARRIED FTM, 20 YEARS OLD, SHORT-ACTING METHOD USER, UVINZA

Importantly, the first pregnancy of many FTMs was unplanned and seemed to be a factor in facilitating new openness for using FP, particularly for unmarried new users. Furthermore, more unmarried than married FTM new users cited life hardship, such as struggling with childcare costs, as another factor that contributed to their decision to begin using FP. Married FTMs were less likely to report that unplanned pregnancies or life hardships were driving factors for using FP. Even so, the most commonly cited reason for using contraception for this group was that child spacing would allow them (and their husbands) to participate in income-generating activities such as farming and small-scale business.

"What helped me to decide to use FP for the first time was that I wanted to continue doing other things such as a business. Because when you are pregnant, you cannot do business well…So, I wanted to develop myself by doing other things such as farming."

—MARRIED FTM, 19 YEARS OLD, LONG-ACTING METHOD USER, TANGANYIKA

Of the 28 FTMs included in the study, only 10 (three married, seven unmarried) said they used FP prior to joining the peer groups. Importantly, all but one of these FTMs adopted FP only after the birth of their first child. Perhaps unsurprisingly, therefore, continuing users noted many of the same facilitating factors that new users mentioned, including the advantages of child spacing and dealing with life hardships. Almost all continuing users said they decided to use FP for the first time after having heard about advantages of using FP either from someone they knew in their community (most commonly, a friend or relative) or from a nurse at a health facility where they went for other (non-FP) healthcare services.

"I had a friend in school who motivated me to use family planning. She used to tell me, 'If you use family planning, you and the baby will also be healthy. You will give your baby the best care until when you decide to have another baby.'"

—MARRIED FTM, 23 YEARS OLD, LONG-ACTING METHOD USER, TANGANYIKA

Decisions Regarding FP Method Choice (FTMs)

Interviews with FTMs also explored how they chose their specific contraceptive method once they had decided to use FP. The study deliberately included short- and long-acting method users to examine factors in the selection of both categories of contraceptives. Married and unmarried FTMs gave similar reasons for choosing their method (whether short- or long-acting), and in general, FTMs had a good understanding of short- and long-acting options and were able to articulate clear reasons for their method choice.

The majority of FTMs participating in the study (17 out of 28) were using a long-acting contraceptive method (all implant contraceptive users). Half of married women (5 out of 10) chose a long-acting method, as compared to one-third of unmarried FTMs (6 out of 18). In discussing their reasons for selecting the implant, these FTMs (both married and unmarried) cited three main points: (1) they wanted to wait for a longer time period before becoming pregnant again, (2) they were worried about forgetting to take pills or go for injectables, and (3) they felt a long-acting method was more convenient (or caused less disturbance) than short-acting methods, which require more frequent user action.

"I chose the implant because of its time [duration]. Even if I [eventually] have another pregnancy, my child would have grown already and become aware of himself or herself, and she or he will know that 'my mother is having another child and I am no longer a child.'"

—UNMARRIED FTM, 20 YEARS OLD, LONG-ACTING METHOD USER, TANGANYIKA

Eleven of the twenty-eight FTMs included in the study were using short-acting contraceptive methods, mostly the injectable contraceptive and oral contraceptive pills. These FTMs primarily cited two reasons for choosing a short-acting method: (1) a sense that short-acting contraceptive methods were safer than long-acting methods, and (2) the preference to start with a short-acting option and then move to a long-acting method if desired.

When it came to FTMs selecting a specific short-acting or long-acting FP method, the study revealed that influence from peers/friends and the community played a significant role. However, this influence varied based on marital status and whether a woman had used contraception previously. For many new users, the influence of the project's peer groups, and peer leaders came out strongly, particularly for unmarried FTMs. For married FTMs, however, findings suggest that peer groups and the community may not influence their choice of FP method as strongly, and that partners could be influential and even determine which method to use.

The input of peers and community members was also important in influencing which methods were not chosen. The study highlighted several negative perceptions about specific contraceptive methods (especially the injectable and the IUD), often based on the experiences or input of friends or peers.

"We heard of stories from users. They said, 'The injection has delayed my pregnancy because I never gave birth again.' She just received four injections. But whenever she comes to the hospital, she is told that the drug is still in the body. Therefore, only when the drug is flushed from the body can she get pregnant."

—MARRIED FTM, 25 YEARS OLD, LONG-ACTING METHOD USER, TANGANYIKA

Findings from this study established that FTMs who adopted FP methods prior to participating in the peer groups (continuing users) had limited information to guide their choices at that time. Several reported that the information/education they received through the peer groups prompted them to switch to other methods.

Partner Roles in FP-Related Communication and Decision Making (FTMs)

Of the 28 FTMs in the study, 23 reported being in a relationship at the time they were attending project peer groups. Of these, 10 were married. One of the objectives of this study centers on understanding the role of the women's partners in communication about FP, the decision to use FP, and the selection of a specific contraceptive method.

Sixteen FTMs (six married, ten unmarried), out of the twenty-three who were in relationships at the time, reported never having discussed FP issues with their partners prior to joining peer groups. The two most commonly given reasons for this were: (1) having no knowledge of FP issues and (2) not seeing the need to discuss FP before they even had one child.

"It is very hard to tell a man whom you have not had a child with to use family planning. It wouldn't be easy to accept because he would want a baby."

—UNMARRIED FTM, 20 YEARS OLD, LONG-ACTING METHOD USER, UVINZA

Other FTMs said they were afraid that their partner would not be receptive to the idea of FP and therefore did not even try to initiate conversations about FP use. At the same time, simply discussing the possibility of program participation opened the door to communication about FP. A few FTMs, however, reported having discussed FP with their partners prior to joining peer groups, with either the FTM or the male partner taking the lead in introducing the topic.

All FTMs (except one unmarried FTM) said that their male partners were involved in decisions related to FP use. Both married and unmarried FTMs reported that early and continuous engagement with their partners in discussions about FP, catalyzed by discussing what they learned from peer group sessions, helped to facilitate partner support when they eventually raised the issues of whether to use FP. Several FTMs reported this conversation having gone quite smoothly, with most partners approving their use of FP almost immediately. However, a few FTMs reported that the process of reaching agreements with their partners about FP use was not automatic and required time and effort.

Both married and unmarried FTMs also reported that their male partners had several concerns regarding the safety of FP methods, especially the fear that their wives would not be able to conceive easily, or at all, if they used modern contraceptives.

"I told him about injection, but he said, 'Injections are very bad, and they cause tumors in the stomach.' Then I said I will use pills, but he refused. Then I said I am going to use an implant, but he said, 'if you put an implant you won't do hard work.' But I said 'other people are putting them—it just depends on what you do.' He then said, 'I heard that when you put an implant, you will be bleeding the whole month.' But I said it depends on how my body is. So, he said 'Just go and have it. It's all up to you, just go.' Then I came and put it in. And I am thankful to God, things are moving on well."

—UNMARRIED FTM, 23 YEARS OLD, LONG-ACTING METHOD USER, UVINZA

More unmarried FTMs, as compared to married FTMs, reported resistance to FP use from their partners. Further, while all married FTMs said their partners eventually supported them in using FP, two unmarried FTMs reported that their partners completely refused to consent to their use of FP or to be involved in the discussion. Both women went ahead and used FP without their partners' knowledge/support. Regarding the partner's role in contraceptive method selection, the majority of FTMs (both married and unmarried) reported that their partners largely supported their choice of contraceptive method.

Access to Contraceptive Methods (FTMs)

Overall, the majority of FTMs were able to access and obtain their method of choice without any problem. However, a few FTMs noted some challenges and delays in obtaining a contraceptive method, sometimes resulting in a different method being used (compared to the initial choice).

Almost all FTMs reported accessing the chosen FP methods at nearby public health facilities that are supported by the Tuungane project. All FTMs reported that they felt that facility FP providers treated them well, including those who faced some challenges in accessing a specific method. However, insights from some of the interviews revealed that, for a few FTMs, some of the guidance given at health facilities indicated gaps in provider knowledge or possible bias, while at the same time, trying to help their clients choose a method that fits with their reproductive life stage.

"I requested for injectable. They advised me to take implants, because they said it was a suitable method for me at that time."

—UNMARRIED FTM, 19 YEARS OLD, LONG-ACTING METHOD USER, UVINZA

"I went to her [facility provider] requesting to use an implant. She asked me about the number of children I have. I told her that I had one child and requested to use an implant lasting for five years. She then advised me to take a three-year-implant."

—UNMARRIED FTM, 18 YEARS OLD, LONG-ACTING METHOD USER, UVINZA

Only a few FTMs reported delays or challenges in accessing their selected FP method at the point of service delivery—either because the providers felt that they did not meet the criteria to initiate FP (indicating possible gaps in provider knowledge and/or counseling skills), or the facility had too few staff to provide care to everyone coming to the clinic on any given day.

"They said, 'The baby is still young, how many injections will you use? So, you need to use implant of three years to avoid pregnancy.' Then I didn't answer them. Then they said, 'Or [if] you can tolerate [waiting] until the child is eight months, then you will start injection.' Therefore, I tolerated until my child reached eight months of age, and then I came to start injection."

—UNMARRIED FTM, 19 YEARS OLD, SHORT-ACTING METHOD USER, TANGANYIKA

"There were many women wanting family planning, and nurses are few, as we know. The nurse was attending sick people and pregnant women who had come for antenatal clinic services. Because she was alone, she told me she won't be able to serve me on that day. She gave me another appointment."

—MARRIED FTM, 20 YEARS OLD, SHORT-ACTING METHOD USER, UVINZA

Ultimately, the second FTM quoted above received her chosen method when she returned to the facility for the scheduled appointment. However, her story, and the stories of other FTMs highlight some of the challenges FTMs face at the point of service delivery that delayed their access to contraceptive methods—not only inconveniencing them, but also placing them at risk for unintended pregnancies.

Current FP Use and Future Intentions (FTMs)

At the time of the study—which occurred almost two years after the start of the intervention period—all but three FTMs (25 of 28) reported that they were still using family planning, including 13 implant users and 12 short-acting method users. About two-thirds (17 out of 25) said that they were using the same contraceptive method they used at the time of the intervention.

For FTMs who were continuing with their original method choice, they reported that the contraceptive continued to meet their family planning needs, a decision facilitated by the fact that they experienced no, or minor, side effects. FTM input further suggests that being informed about what to expect in terms of side effects from the outset of method use helped FTMs manage side-effects. A few FTMs also cited male partner support as another factor that contributed to their continued FP use, with some adding that if their partners had wanted them to stop using, they would have had to comply.

"I got some side effects at the beginning, but I had already been informed about it earlier. I was told there will be some small side effects such as dizziness, vomiting. Those are the side effects that I got. I used to have frequent high temperatures and sometimes I used to feel feverish and feel cold. Because I was informed early, I stayed [with the method] for about five months and then it became normal and I decided to continue until this time."

—UNMARRIED FTM, 20 YEARS OLD, LONG-ACTING METHOD USER, TANGANYIKA

Three FTMs had stopped FP use altogether by the time of the study, although one had already switched methods from pills to an implant. All three FTMs indicated side effects from the implant as a reason for stopping their most recent method, including stomach pain and weight gain, while one also indicated pressure from her husband and family to have another child.

Almost all of the FTMs who participated in this study, including those who were not currently using FP, said they intended to continue using or use FP again in the future. For the most part, FTMs reiterated the same reasons given for adopting FP initially as their reasons for continuing to use FP in the future, with the benefits of child spacing being particularly important.

"As I told you, I want to use FP methods to allow my child to grow healthy. By using family planning, you can be able to space your children even at six-year interval."

—UNMARRIED FTM, 21 YEARS OLD, SHORT-ACTING METHOD USER, TANGANYIKA

Husband/Partner Perspectives on FP Use and Decision-Making (Men)

The majority of husband/partners (12 out of 15) reported being involved in the FP use decisions, usually at the prompting of their FTM wives/partners. Many of these men noted that their FTM wives/partners had regularly informed them about what they were learning in the peer groups. Men credited this continuous sharing of information (as did the FTMs) as reinforcing their support for FP use, as they were already aware of the benefits.

"She always educated me about these topics after she came back from peer group sessions, although I am busy most of the times. I don't get much time for these issues, but she was able to share with me some information about FP."

—MALE PARTNER, 23 YEARS OLD, SHORT-ACTING METHOD USER, UVINZA

Improved understanding about family planning, especially on the advantages of child spacing, was an important factor in building support for contraceptive use. In addition to the information shared by their FTM wives/partners, some men noted CHWs were also

important providers of FP information. Men highlighted the health and economic benefits of spacing as being particularly influential, along with FP allowing the couple to have the number of children that they could support. Several also noted that they were just at the start of their family lives, so being able to plan for a future that they could manage and succeed was important. Additionally, several husbands/partners said they supported FP use because they had witnessed the negative effects of women getting pregnant too early after giving birth or too frequently (having too many children) on women, other men, young children, and families. A few male partners said the fact that the first pregnancy was unplanned also contributed significantly to them deciding to support FTMs' FP use.

"I was convinced just because of the situation I was observing from my friends. Just before the baby has stopped breastfeeding, the mother gets pregnant again. The child had to stop breastfeeding because of the pregnancy the mother has. I didn't like that situation."

—MALE PARTNER, 21 YEARS OLD, SHORT-ACTING METHOD USER, UVINZA

The majority of husbands/partners reported being hesitant about their wives/female partners using FP due to concerns about FP safety. This echoes the remarks of FTMs, who also reported partner concerns with the safety of FP use. Most husbands/partners said their concerns were addressed, either through the education received from CHWs, information shared by FTMs, or education received from care providers at facilities. A few male partners said their concerns were allayed after the FTMs had stayed with the adopted FP methods for more than a year without any problems. One final issue raised by married men was that they were not ready to support FP use until their wives had at least one child. This, in part, was due to concerns about future fertility, but men also stressed social expectation for couples to have children soon after marriage.

In regard to husband/partner involvement in selecting a specific contraceptive method, the majority of men reported that they accepted whatever method their wives/partners had selected. Men's knowledge of FP and different methods was a factor in their involvement or agreement with method selection. Almost all men had a good understanding of short- vs. long-acting contraceptives, and most were familiar with a few specific methods.

Discussion and Recommendations

This study explored the contraceptive use histories of young FTMs and the husbands/partners of FTMs to better understand their use of family planning at this particular stage in their lives. Although the study focused on a very specific sub-set of FTPs—young FTMs who participated in an FP-focused program specifically designed for FTPs, and who used a modern contraceptive method during the intervention period—their experiences provide important insights into the different factors that shaped their family planning understanding, attitudes, communication, decision making and action. The full report, which can be found online at e2aproject.org, includes an extended discussion of the findings. In this document, we briefly highlight four of the most significant findings:

1. The importance of a woman's first pregnancy/birth in shifting her attitudes and intentions towards FP use. Prior to this pivotal lifestage, many FTPs felt they were "too young" to consider FP or felt they needed to have at least one child before initiating FP due to both concerns about FP safety as well as social expectations to have a child soon after marriage.
2. The FTP program played an important role in increasing knowledge of and promoting conversations about FP use during this pivotal lifestage, which then promoted FP uptake, continuation, or switching to a method that better suits the woman's/couple's needs.
3. Contrary to common stereotypes, men were generally interested in FP, and in almost all cases, involved in the decision to use a method. Once educated, men were generally supportive of FP use.
4. Some potential concerns about provider knowledge, perceptions, and service delivery capacity, even despite training and mentorship provided by the Tuungane project, highlighted the importance of continuous reinforcement of provider understanding and preparedness to provide voluntary, unbiased, informed-choice counseling, including a focus on FP counseling and service provision for youth and initiating FP during the first year after giving birth. For the Tuungane project, this study finding was communicated back to program implementors to ensure that these issues are addressed during the project's ongoing supervision and mentorship efforts.

The findings emerging from interviews with FTMs and husbands/partners are expected to contribute to the global knowledge base on this vulnerable population and suggest the following areas for programs to consider and incorporate when working with young FTPs:

- Reach FTMs with tailored information about HTSP and FP and address concerns and misconceptions about the safety and side effects of modern contraceptive methods.
- Take the time to understand the varying situations, needs, and capacities of different subsets of FTMs (and FTPs), particularly with regards to marital status.
- Ensure that programs engage the husbands/partners of FTMs both directly and indirectly to improve their understanding of HTSP/FP and different contraceptive methods in ways that build their support for contraceptive use.
- Consider working with FTPs as couples and facilitate joint life stage planning, not just for HTSP/FP, but also for their broader family and life goals.
- Tap into the power of influential peers, family, and community members to expand access to FP information, address concerns about safety and side-effects, and inspire voluntary FP use.
- Understand and engage other critical influencers of FP attitudes and behaviors, including healthcare providers, to ensure support for FTMs/FTP contraceptive use.
- Encourage FTMs/FTPs to select their preferred contraceptive method and have full information about that method—including potential side-effects—prior to obtaining and using the method.
- Ensure that community- and facility-based providers have the time and capacity to deliver accurate, quality FP counseling and services to young FTM/FTPs and ensure informed, voluntary choice for contraceptive use.
- Reach young women and men BEFORE they have a child, both to build their understanding of FP and different contraceptive methods, and to connect them to appropriate services.

To learn more about the study implementation and results as well as the recommendations for future programming, please read the full report at e2aproject.org.

Photos: Sala Lewis

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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. E2A addresses the reproductive health care 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. E2A is led by Pathfinder International, in partnership with ExpandNet, IntraHealth International, and PATH.

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