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E2A EVIDENCE TO ACTION for Strengthened Reproductive Health

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

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.

E2A Project
1015 15th St. NW
11th Floor
Washington, DC 20002

www.e2aproject.org

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Researchers from CSK Research Solutions, Limited (Tanzania) conducted data collection and analysis under the direction of Dr. Catherine Kahabuka, Lead Consultant. The authors also acknowledge project team members for their contributions throughout the preparation and execution of this study, including Chaus Emmanuel, Clinical Services Mentor, Tuungane PHE; Phillipo Paul, Monitoring, Learning, and Evaluation Manager, PHE Officer, Pathfinder Tanzania; and Josaphat Mshighati, Regional Technical Advisor – Women-Led Resilience for Eastern & Southern Africa, Pathfinder International.

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. Technical, editing, and design support for this report were provided by Rita Badiani, E2A Project Director, Pathfinder International; Eric Ramírez-Ferrero, E2A Technical Director, Pathfinder International; Maren Vespia, Consulting Communications Director; Ilayda Orankoy, E2A Communications Coordinator, Pathfinder International; and Margo Young, Consulting Editor.

On behalf of the project team, E2A thanks the young first-time mothers and their partners who shared their experiences, helping to advance programming for young FTPs around the world.

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CONTENTS

ACRONYMS AND ABBREVIATIONS

CHW	Community health worker
E2A	Evidence to Action
FP	Family planning
FTM	First-time mother
FTP	First-time parent
HTSP	Healthy timing and spacing of pregnancy
IDI	In-depth interview
IUD	Intrauterine device
LARC	Long-acting reversible contraceptive
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
PHE	Population, Health, and Environment
USAID	US Agency for International Development

I. INTRODUCTION

In 2018, the Evidence to Action (E2A) Project and Pathfinder International Tanzania—through the Tuungane Project, an integrated population, health, and 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 short in 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 FTP program participants who adopted a contraceptive method during the course of 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 key for 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 FP experiences and identified the different factors that influenced their choice, communication, negotiation, decision making, and action. This report presents the findings and conclusions from the contraceptive use study, along with background information on the FTP program implemented under Tuungane. The insights emerging from this study contribute to the knowledge base on this vulnerable population and guide future programming efforts.

[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.

II. BACKGROUND ON TUUNGANE FTP COMPONENT

Becoming a parent for the first time marks an important milestone in the lives of women and men around the world. First-time parents (FTPs)—young, first-time mothers (FTMs) and their male partners—experience a time of evolving needs and challenges. During this pivotal lifestage, young FTPs need to acquire new skills, adopt healthy behaviors, and access FP, reproductive health, and maternal, newborn, and child health services that will safeguard the wellbeing of their new families and positively influence their future. Yet, historically, few programs have been designed to support these young people as they transition to parenthood, a global gap confirmed by E2A's 2014 review of available literature.[2] Over the past nine years, E2A has been working to address this gap, implementing FTP programs in multiple countries and gaining insights into the situations and experiences of FTPs, and how to program effectively for this vulnerable youth population.

A. Targeting FTPs through the Tuungane Population, Health, and Environment Project[3]

In 2018, the Evidence to Action (E2A) Project and Pathfinder International Tanzania launched an initiative focusing on young FTPs in the Greater Mahale Ecosystem of Tanzania as a new component of the Tuungane PHE project. Since 2011, Tuungane has been working in partnership with the Government of Tanzania in extremely remote, marginalized, and vulnerable communities to tackle some of their most complex development challenges, including access to voluntary FP services.

[2] Margaret E. Greene, Jill Gay, Gwendolyn Morgan, Regina Benevides, and Fariyal Fikree, Reaching Young First-Time Parents for the Healthy Spacing of Second and Subsequent Pregnancies (Washington, DC: Evidence to Action Project, July 2014).

[3] For more information about the Tuungane FTP component, see our report on the Phase 1 Tuungane FTP component: Anjala Kanesathasan. Improving Family Planning Outcomes for First-Time Parents in the Greater Mahale Ecosystem. Washington, DC: Evidence to Action Project, 2019.

The Tuungane project in Tanzania provided an opportune setting for FTP programming. 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. The Western Zone has the highest total fertility rate in the country—6.7 children—compared to the national rate of 5.2 children.[4] 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.[5] Importantly, these same two zones have the highest levels of teenage childbearing in Tanzania, with 38% (Western) and 34% (South West Highlands) of adolescents aged 15–19 years who have begun having children, compared with 21% nationally.[6] Katavi Region in South West Highlands leads the country, with a teenage pregnancy rate of 45.1%.[7]

According to the 2015–2016 Tanzania Demographic and Health Survey, 32% of married women in Tanzania use a modern contraceptive. However, modern contraceptive use in both Kigoma and Katavi regions is just 18%—among the lowest levels in the country.[8] Only 8.6% of women aged 15–19 years and 29% aged 20–24 years use a modern method of contraception.[9] Unmet need for FP among married women 15–24 years is approximately 23% across Tanzania and reaches 27–28% in both Kigoma and Katavi.[10] As a result, 57% of women in Tanzania have given birth or are pregnant with their first child by age 19.[11] Furthermore, in Tanzania, short birth intervals were more frequent among youth, with 14.2% of adolescent girls between ages 15-19 and 9.7% of young women between the ages of 20–24 reporting

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

[5] Ibid.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] Ibid.

[10] Ibid.

[11] Ibid.

short birth intervals—between 7–17 months.[12] This is compared to 6.0% among women ages 25–29, 4.2% among women ages 30–34, and 3.6% among women ages 35–39.[13]

These statistics suggest that young FTMs face unique challenges that limit their reproductive health choices and actions—challenges that are different from other adolescents and different from older married women. Young mothers often become isolated because household responsibilities and limited mobility keep them at home and away from health services and supportive social networks. This situation can be compounded for unmarried FTMs, who fear stigmatization by their families and communities for having a child outside a socially sanctioned union. For many FTMs, the choice of using contraception to plan when and if they want to have children is rarely their own. Their husbands, parents, in-laws, community and family elders, and religious leaders have significant influence over decisions that involve reproductive health and use of household resources.[14] Unequal power and gender dynamics, along with other contextual factors such as sociocultural preferences around fertility, can result in early, rapid, and repeat pregnancies, compromising the health of young women and their newborns.[15] The risks associated with early childbearing and closely spaced pregnancies are high for the woman and her new baby, including increased risk of both maternal and infant mortality.[16] Significant evidence posits that both mother and baby are healthier if at least 24 months passes between pregnancies.[17,18,19,20] Given the high levels of pregnancy among adolescents and young women in Kigoma and Katavi and the particular vulnerabilities of young FTMs, adding an FTP-focused component became a priority for Tuungane and E2A.

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[12] Ibid.

[13] Ibid.

[14] Anna Engebretsen and Gisele Kabore, *Addressing the needs of girls at risk of early marriage and married adolescent girls in Burkina Faso* (Population Council , May 2011), accessed June 25, 2013, http://www.popcouncil.org/pdfs/TABriefs/09_BurkinaFaso.pdf.

[15] 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.

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

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

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

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

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

Tuungane Population, Health, and Environment (PHE) Project

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

B. Tuungane FTP Interventions[21]

Launched in 2018, the FTP component of the Tuungane project focused on advancing healthy timing and spacing of pregnancy (HTSP), use of FP, and social support for young FTMs. As part of its broader PHE approach, Tuungane had already been working with the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) to strengthen FP service delivery at 23 health facilities and 44 surrounding villages in Uvinza and Tanganyika Districts. Building on this platform, Tuungane introduced the FTP component in 15 communities served by seven facilities (Buhingu, Ikola, Kalya, Karema, Kashagulu, Mwese, and Sibwesa) in the two districts. Community-based resource persons implemented all activities in partnership with the MoHCDGEC and the Local Government Authority, with supervision by Tuungane staff and technical support from E2A Washington, DC. Preparations for FTP activities began in early 2018, with the main period of implementation from May through September.

[21] For more information about the Tuungane Project, please see https://www.nature.org/en-us/about-us/where-we-work/africa/stories-in-africa/tuungane-project/

E2A applied a life-course and socio-ecological lens to determine the appropriate content and structure of the FTP component.[22] Given the FP mandate for both E2A and Tuungane, interventions primarily focused on the postpartum phase among FTPs to improve HTSP/FP outcomes and facilitate informed, voluntary use of modern contraceptive methods. In addition, the intervention aimed to strengthen the support of multiple influencers and systems for voluntary contraceptive use among young FTMs/FTPs, including addressing the underlying gender and social norms that influence FTP relationships, choices, and actions.

The FTP package of interventions straddled multiple levels of the FTP socioecological model to improve FP-related knowledge, attitudes, communication, decision making, and use by young FTMs/FTPs. Key activities included:

- ***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, each comprising 12–15 FTMs, met for nine sessions held every two weeks.
- ***Outreach with Husbands/Partners and Influential Women Relatives:*** Community health workers (CHWs) led informational sessions with key influencers, including partners/husbands, mothers, and mothers-in-law to build awareness about different methods and build support for contraceptive use by FTPs.
- ***Household Visits:*** CHWs visited FTM households to provide tailored services. With the aid of a mobile application, CHWs provided information to women and their partners, delivered condoms and oral contraceptives, made referrals for other FP methods and services, and gave follow-up support.
- ***Facility- and Community-Based FP services:*** The Tuungane program provided support and supervision to health facilities and trained health care providers and CHWs to provide youth-friendly FP counseling and services.

[22] For more information on E2A's FTP framework, see our FTP framework: Anjala Kanesathasan. Introducing E2A's First-Time Parent Lifestage (Washington, DC: Evidence to Action Project, March 2019).

C. Key Results from Tuungane FTP Phase 1

The results emerging from the first phase of FTP programming under Tuungane were striking, and the FP uptake by young FTMs/FTPs prompted this study to better understand why these young people decided to use FP at this particular moment in their lives. Select program results are highlighted here to provide background context for this study on FTP contraceptive use.[23]

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

Table 1: Voluntary contraceptive use by registered peer group members at intake vs. exit by background characteristics

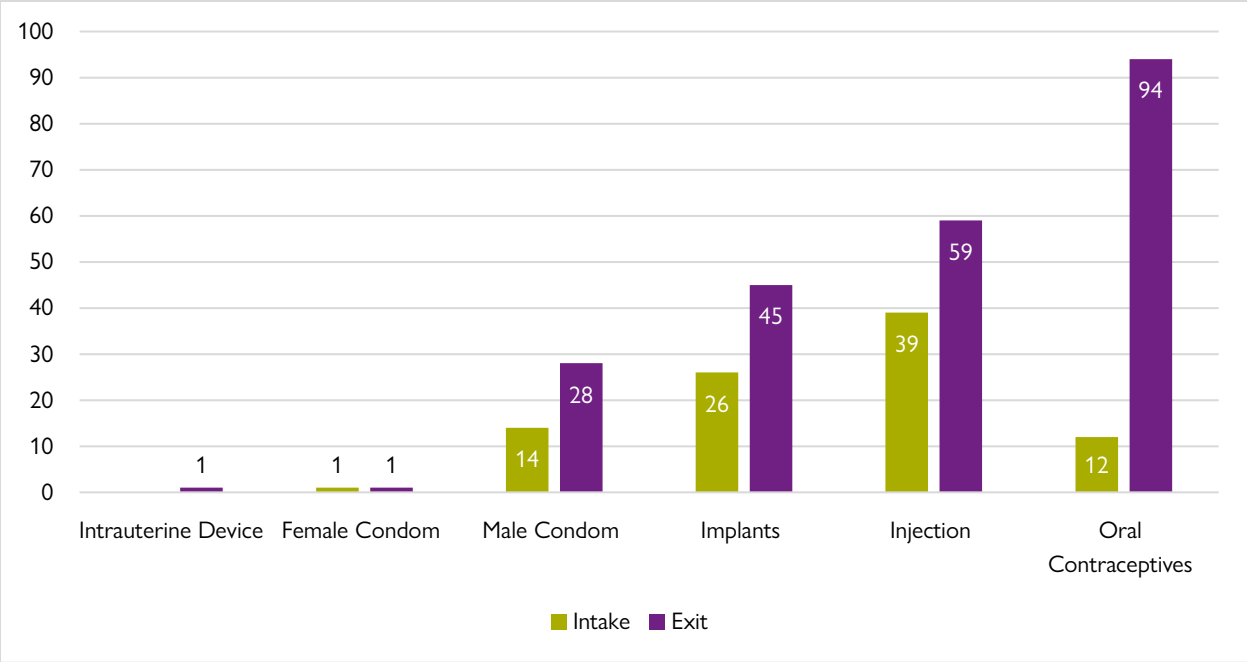
	Contraceptive Use at Intake (May 2018)		Contraceptive Use at Exit (Nov. 2018)		Percent Change
Total FTMs (N=347)	119	34%	228	66%	92%
15–19 year old	40	24%	98	60%	145%
20–24 year old	79	44%	130	72%	65%
Never Married	72	36%	141	70%	96%
Married or Cohabitating	42	32%	79	60%	88%
Separated or Widowed	5	45%	8	73%	60%

RESULT 2: Voluntary FP use by FTM peer group members increased across the full range of modern contraceptive methods, including long-acting reversible contraceptives (LARCs), available through community- and facility-based providers.

As the graph on the next page illustrates, the greatest increase was with oral contraceptives use, perhaps due to increased access to CHWs who can initiate and resupply this method.

[23] For the full set of results emerging from Tuungane FTP Phase 1, see our report on the Phase 1 Tuungane FTP component: Anjala Kanesathasan. Improving Family Planning Outcomes for First-Time Parents in the Greater Mahale Ecosystem. Washington, DC: Evidence to Action Project, 2019..

Uptake of FP Use at Intake and Exit by Method (intake n=102; exit n=228)



RESULT 3: Of those peer group members who adopted FP over the course of the intervention, the vast majority—97%—were first-time FP users.

RESULT 4: FTMs and their key influencers seem to have deepened their understanding of HTSP and its benefits over the course of the intervention.

RESULT 5: While participation in FTP activities has improved knowledge and attitudes about FP, concerns about safety of some modern contraceptive methods persist among some FTMs and their key influencers.

RESULT 6: Peer group FTMs noted improved communications about FP with partners, although decision making about FP use remains a complex process for many.

RESULT 7: Despite improved FP outcomes for peer group members, they noted that many FTMs face several barriers to FP access and use, including partner/family opposition and social stigma or restrictions.

III. CONTRACEPTIVE USE STUDY PURPOSE AND OBJECTIVES

The FP results emerging from the Tuungane FTP component were notable, particularly increased contraceptive use across the method spectrum (including LARCs) and uptake by new FP users. These results were especially striking given the high teenage pregnancy rates and low contraceptive use rates in Tuungane communities. Understanding the experiences of FTMs who successfully adopted FP will shed light on the different factors that influenced their decision to use contraception at this particular stage in their reproductive lives and provide important insights to guide future FTP programming.

To this end, E2A and Pathfinder Tanzania supported a study to explore the FTM peer group members' contraceptive use and method choice, including both the new and continuing FP users of short-term and LARC methods. For this study, a new user is defined as a first-time FP user who has never used 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. The study focused on FTMs who participated in the FTP program, as well as the husbands/partners of FTM participants, to examine their contraceptive use experiences and identify the different factors that influence FTM/FTP contraceptive choices, including decision-making processes, communications/negotiations, and dynamics with husbands/partners. The study was conducted in March 2020.

The specific study objectives were:

1. To explore contraceptive histories of FTMs, both new and continuing users, who adopted short-acting FP methods and LARCs.
2. To explore facilitating factors for FP uptake among FTMs/FTPs who participated in the program.
3. To understand decision-making processes regarding FP use among FTMs/FTPs who participated in the program.
4. To understand factors associated with FP method continuation/discontinuation/switching.
5. To understand the role of partners/husbands in the FTMs' decision-making processes regarding FP use, including method choice and method continuation/discontinuation/switching.
6. To explore FTMs' experiences accessing FP methods.
7. To understand future contraceptive needs and intentions to use contraception.

IV. CONTRACEPTIVE USE STUDY METHODS

Study Design

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 study 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 aimed to include 30 FTMs who were new or continuing contraceptive users—including those that adopted a short-acting contraceptive method during the 2018 intervention or a long-acting method before or during the intervention—and 10 husbands/partners from four project locations (Buhingu and Kalya in Uvinza district, and Karema and Ikola in Tanganyika district).[24] Long-acting method users that adopted the method before the intervention were included in the study to ensure a large enough recruitment pool to gain sufficient information from a variety of voices. Even though these users may have initiated the long-acting method prior to their participation in the peer groups, they were still able to provide valuable insight into the contraceptive use and method choice of first-time mothers.

Study Participants

Study participants included FTMs who were both members of Tuungane peer groups and contraceptive users—having adopted a short-acting contraceptive method during the 2018 intervention or a long-acting method either before or during the intervention. The study also included the husbands/partners of FTM peer group members at the time of the 2018 intervention.[25] Participants for this study were drawn from the pool of FTMs/FTPs who participated in the program in Uvinza and Tanganyika Districts based on the criteria specified in Table 2.

[24] For purposes of this study, ***new users*** were defined as FTMs who adopted a contraceptive method during the intervention period, and ***continuing users*** were defined as FTMs who had already adopted a contraceptive method prior to the intervention period.

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

Table 2: Inclusion criteria for study participants

FTMs	Husbands/Partners
• Must be a participant of the Tuungane FTPs program (2018) • Must be residing in the selected study location • Must have adopted a short-acting contraceptive method during the intervention or a LARC method before or during the intervention (either new or continuing contraceptive users) • Must be willing to provide informed consent for participating in this study	• Must be a husband/partner of an FTM program participant (at the time of contraceptive use) • Must be willing to provide informed consent for participating in this study

A total of 40 IDIs were planned in the two districts and included: 16 IDIs with FTMs who had adopted a short-acting contraceptive method, including new users that adopted for the first time during the intervention and continuing users that used prior to the intervention; 12 IDIs with FTMs who adopted a long-acting method (both new and continuing users); and 12 interviews with partners/husbands of FTMs who participated in the program. The study successfully completed interviews with 43 participants, although there were some differences between planned and actual participants, as shown in Table 3. Additional information about these differences is provided below and in the limitations section.

Table 3. Planned and actual respondents and number of IDIs among each respondent category

Population	Number of Participants per Study Site	Total Number of Participants (4 sites)	Total Number Included in the Study
FTM program participants who adopted a short-acting contraceptive method (new and continuing users)	2 married (at time of intervention)	8	5
	2 unmarried (at time of intervention)	8	6
FTM program participants who adopted a LARC method (new and continuing users)	3 married or unmarried (at time of intervention)	12	17
Husbands/partners of FTM program participants (at time of contraceptive use)	3	12	15
TOTAL	10 participants per study site	40 participants	43 participants

C. Participant Identification and Recruitment

Study participants were selected from a pool of peer group members and their husbands/partners from the 15 program communities served by six facilities (Buhingu, Ikola, Kalya, Karema, Kashagulu, and Mwese) in Uvinza and Tanganyika districts. To identify possible study participants, the project team first compiled a list of 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. Potential FTMs and their husbands/partners from these four locations were then selected as follows:

- ***FTM Method Acceptors:*** Using the list of all FTMs who adopted a short-acting contraceptive method at each facility, the team randomly selected four FTMs (two married and two unmarried) per facility for participation in this study. The study team also randomly selected three FTMs (married or unmarried) per facility from a list of FTMs who adopted a LARC method.
- ***Husbands/Partners of FTMs:*** In each of the four study locations**,** the study team also identified the husbands/partners of the FTMs at the time of contraceptive use. 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 FTM initially selected was not eligible or declined participation.

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. This was repeated as needed until the study team reached the planned number of targeted study participants under each respondent category.

The study team engaged the Tuungane program's peer leaders/CHWs to assist with recruitment and interview preparation. The study team shared names of the randomly selected FTMs and their husbands/partners for participation in this study, as well as a study information sheet to read to all potential participants. The sheet contained key information about the study, including: study aims and objectives, why those being invited were chosen to participate in the study, what would happen if potential respondents choose to participate in the study (procedures for the study), and how the information would be used. The peer leaders and CHWs used these tools to contact potential participants about the study, and verbal consent was obtained from interested FTMs and husbands/partners. The peer leaders/CHWs were also provided with a recruitment form where they filled in the names and contact information of all the recruited participants for this study. The lists of FTMs and husbands/partners who had consented to be in the study was submitted to the study team and used to prepare for data collection.

D. Training and Piloting

The lead consultant from CSK Research Solutions served as the study manager and was responsible for providing the overall leadership in the implementation of this study. She was assisted by four research assistants—two women and two men. The two female research assistants are full-time staff at CSK Research Solutions, while the two male interviewers were recruited from a pool of strong qualitative interviewers that had previously worked with the CSK consultant.

The research assistants underwent training specific for this study, covering fundamental topics: study objectives and methodology (to ensure efficient screening of potential participants); 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. The training also aimed to ensure that the data collection team had thorough and in-depth knowledge of the E2A-led study and its goals, including roles and responsibilities of the data collection team. The lead consultant conducted the training in Dar-es-Salaam, Tanzania from March 6–9, 2020. Two transcribers also participated in the first day of training to familiarize themselves with the study and tools.

Interview guides for FTMs contained questions to assess their previous experiences with contraceptive use, including details on the decision-making process to use FP and to select a method. Questions also explored the involvement of their husband/partner (if relevant at that time) in these decisions and any subsequent FP action. Additionally, the guides contained questions to explore facilitators and barriers for FP uptake, as well as their experiences accessing chosen FP methods. The interview tool for husbands/partners explored similar topics, particularly their role/involvement in decisions to use FP and select a specific method.

The lead researcher and the research assistants piloted the data collection tools in two non-study communities, first in Dar-es-Salaam and then in Kigoma. This two-step pilot enabled the team members to check suitability, reliability, coherence, and clarity of the tools and to test the recruitment procedures. Feedback sessions were then conducted as a team. The team made corrections as needed to ensure that all interview questions were understandable and relevant to the study, that interview tools were clear and easy to follow, and that data capture systems were complete.

E. Data Collection

Two teams of interviewers (one male and one female research assistant per team), working concurrently in the two districts, collected data from March 9–14. They conducted all interviews in Kiswahili in quiet locations at the respective health facilities. On average, interviews took 30 minutes to complete, ranging from 17–45 minutes for FTM IDIs and 22–50 minutes for husband/partner IDIs. All interviews were audio-

recorded with the consent of the participant. Participants were generally cooperative and forthcoming throughout the interview. No participant seemed embarrassed or reluctant to respond to any of the questions. However, a few FTMs responded briefly to questions, despite multiple probes by the interviewer, which led to some shorter interviews.

F. Data Analysis

All interviews were digitally recorded and then transcribed and translated from Kiswahili to English. Trained research team members verified all the transcripts against the original audios to ensure that the transcriptions and translations were accurate. After transcript validation, transcripts were imported into a qualitative software, ATLAS.ti (Version 7.0), which was utilized for data analysis.

Data analysis began by developing a preliminary codebook that comprised pre-set codes derived from questions in the interview guides for the various respondent categories for this study. The preliminary codebook was then piloted on a few transcripts under each respondent category prior to being used for the actual coding. For each respondent category, coders compared the assigned codes under similar text segments, resolved any disagreements, refined or merged the pre-set codes, and/or proposed new codes. Coders repeated this process with different transcripts under the same respondent category until there was minimal or no disagreement in the application of codes.

The coding process was immediately followed by analysis of the coded transcripts. The key study objectives/research questions guided analysis of the responses, which involved exploration of the information emerging under the various codes. Data analysis also involved exploration for 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). Results were then merged under related codes to form the larger themes and sub-themes presented in this study report.

G. Ethical Considerations

The protocol for this assessment received Institutional Review Board (IRB) approval from the National Institute for Medical Research (NIMR), Dar es Salaam, Tanzania on February 5, 2020 to conduct the study (ref: NIMR/HQ/R.8a/Vol. IX/3044). The study was exempted from IRB review by PATH's Research Determination Committee on November 4, 2019 because it was determined not to be human subjects research. As per Tanzania's practice, documentation of IRB approval from NIMR was shared with the President's Office—Regional Administration and Local Government (PO-RALG), who granted researchers written permission to work in the specified regions and districts. This document was presented to the

regional administrative secretary of both Kigoma and Katavi, and additional government authorization letters were obtained to introduce the study at district, ward, and health care facility levels.

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. A consent process was administered with each participant at the time of recruitment and before the interview. The interviewers also sought permission to both interview and record. Participation in the research was voluntary and participants had the right to withdraw from the study at any time, without any sanction. As all participants were aged 18 and above, there was no need to consider parental/guardian consent.

H. Limitations

This qualitative study on contraceptive use had a few limitations. It specifically included young FTMs who had participated in the 2018 FTP program and were contraceptive users, and therefore, were exposed to the ideas, information, and services provided through project activities. As the purpose of the study was to understand the contraceptive experiences of FTMs who went through the program, it did not include the perspectives of peer group members who did not adopt FP or non-participating FTMs in the community. Thus, it should be noted that this is not a comprehensive research 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 that adopted a short-acting method during the course of the intervention and those that adopted a long-acting method either before or during the intervention.

There were some variations in achieving the planned mix of respondents. The study originally planned to include more short-acting method users because the majority of FTM peer group members at the end of the intervention were using oral contraceptives, injectables, or condoms. However, the final study instead included more FTMs who had adopted LARCs. This occurred largely at the time of recruitment, when identifying possible FTMs to replace those originally selected to participate in the study (due 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—by its very purpose and objectives—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—such as their living arrangements and developmental milestones of their child—and to use project activities as a time marker. Throughout piloting, these approaches were refined and participants were able to recall past events with relative ease. However, the potential for recall bias remains and is noted here.

V. STUDY RESULTS

A. Background Characteristics

Tables 4 and 5 below summarize the background characteristics of the 28 FTMs and 15 husbands/partners who participated in the study. The majority of FTMs 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.

Table 4. Background characteristics of FTM study participants

BACKGROUND INFORMATION		Uvinza District		Tanganyika District		TOTAL (n=28)
		Buhingu (n=4)	Kalya (n= 10)	Karema (n= 7)	Ikola (n= 7)	
AGE (Current)						
1	18-19 years	0 (0.0%)	3 (30%)	1 (14.3%)	4 (57.1%)	8 (28.6%)
2	20-24 years	4 (100%)	6 (60%)	5 (71.4%)	3 (42.9%)	18 (64.3%)
3	25+ years	0 (0.0%)	1 (10%)	1 (14.3%)	0 (0.0%)	2 (7.1%)
MARITAL STATUS (During the program—2018)						
1	Single	3 (75%)	9 (90%)	3 (42.9%)	3 (42.9%)	18 (64.3%)
2	Married	1 (25%)	1 (10%)	4 (57.1%)	4 (57.1%)	10 (35.7%)
MARITAL STATUS (Current—2020)						
1	Single	2 (50%)	3 (30%)	0 (0.0%)	1 (14.3%)	6 (21.4%)
2	Married	1 (25%)	7 (70%)	5 (71.4%)	4 (57.1%)	17 (60.7%)
3	Cohabiting	0 (0.0%)	0 (0.0%)	2 (28.6%)	2 (28.6%)	4 (14.3%)
4	Divorced	1 (25%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (3.6%)
FP METHOD						
1	Implant	3 (75%)	6 (60%)	5 (71.4%)	3 (42.9%)	17 (60.7%)
2	Injection	0 (0.0%)	3 (30%)	2 (28.6%)	2 (28.6%)	7 (25%)
3	Pills	0 (0.0%)	1 (10%)	0 (0.0%)	2 (28.6%)	3 (10.7%)
4	Condom	1 (25%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (3.6%)
NUMBER OF CHILDREN						
1	One child	4 (100%)	6 (60%)	3 (42.9%)	7 (100%)	20 (71.4%)
2	Two children	0 (0.0%)	4 (40%)	4 (57.1%)	0 (0.0%)	8 (28.6%)

Fifteen husbands/partners (eight in Uvinza and seven in Tanganyika), all partners of FTMs who were peer group members, were interviewed for the study. 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 (reported by 11 of the 15 men).

Table 5. Background characteristics of male partners Study Participants

BACKGROUND INFORMATION		Uvinza District		Tanganyika District		TOTAL (%) n=15
		Buhingu (n=4)	Kalya (n= 4)	Karema (n= 4)	Ikola (n= 3)	
CURRENT AGE						
1	20–24 years	1 (25%)	4 (100%)	3 (75%)	1 (33.3%)	9 (60%)
2	25+ years	3 (75%)	0 (0.0%)	1 (25%)	2 (66.7%)	6 (40%)
CURRENT MARITAL STATUS						
1	Single	1 (25%)	1 (25%)	1 (25%)	0 (0.0%)	3 (20%)
2	Married	1 (25%)	2 (50%)	3 (75%)	1 (33.3%)	7 (46.7%)
3	Cohabiting	2 (50%)	1 (25%)	0 (0.0%)	2 (66.7%)	5 (33.3%)
FP METHOD OF FTM						
1	Implant	4 (100%)	2 (50%)	3 (75%)	2 (66.7%)	11(73.3%)
2	Injection	0 (0.0%)	2 (50%)	1 (25%)	0 (0.0%)	3 (20%)
3	Pills	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (33.3%)	1 (6.7%)
DURATION OF RELATIONSHIP WITH FTM (years)						
1	2–3 years	1 (25%)	3 (75%)	0 (0.0%)	0 (0.0%)	4 (26.7%)
2	4 or more years	3 (75%)	1 (25%)	4 (100%)	3 (100%)	11 (73.3%)

B. 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 during or after joining a peer group (referred to in this report as "new users"), while 10 (3 married, 7 unmarried) said they used FP at some point prior to joining the peer groups (referred to in this report as "continuing users"). Interviews with all FTMs explored the factors that facilitated their decisions to use FP. Results are presented below for new and continuing users, with distinctions by marital status also noted.

New FP Users (FTMs who adopted FP after joining peer groups)

For the 18 new users (both married and unmarried) 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 this exposure—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 FP was not necessarily relevant or appropriate for young women such as themselves. FTMs said they were "too young" to consider FP, which was perceived to be appropriate only 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.

> **FTM (Married,[26] 23 years old, long-acting method user, Uvinza):** *I just used to hear people talking about FP, and that someone is using an implant and another one is using condoms and some injection. I used to hear groups of people talking about it.*
> **Interviewer:** *Why didn't you consider using it prior to joining the peer groups as you used to hear about it and you were already staying with a man?*
> **FTM:** *During that time, I didn't know the meaning of FP. I [had] yet to understand it.*

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. As one married FTP noted:

> *They said, if you use FP 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 FP. Therefore, we had not thought of using FP 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. While accurate information about the safety of FP plays a role, many unmarried FTMs reported that the primary motivating factor for using FP was not wanting another unplanned pregnancy.

[26] Throughout the report, the marital status indicated with the study participant quotes refers to their marital status at the time of the FTP intervention.

FTM (Unmarried, 19 years old, short-acting method user, Tanganyika): *I saw I don't have a husband, I don't have a job to do, and I may get impregnated again while still at home. Before, I made my parents angry when I got pregnant while at home, so I thought it was better to use FP this time…*

Interviewer: *That act of getting pregnant without planning or expecting, did it contribute any how to push you to use FP?*

FTM: *Yes… Because, I saw at that time it was a mistake. Therefore, I had to use FP not to do another mistake.*

As one unmarried FTM said, the end of a relationship could also trigger the decision to use FP:

Interviewer: *You told me that you didn't make the choice to use FP at the beginning of the peer group intervention, but you made your decision during a later group session. What made you change your mind?*

FTM (Unmarried, 18 years old, long-acting method user, Uvinza): *After I saw how things were changing between my partner and I. The things that we were doing before were good, but the things at the end were bad.*

More unmarried than married FTM new users cited life hardship as another factor that contributed to their decision to begin using FP. Several unmarried FTMs noted struggling with childcare costs, often due to limited or no support from their male partners.

Interviewer: *What motivated you to use FP?*

FTM (Unmarried, 20 years old, short-acting method user, Uvinza): *Life was hard [silence]. I didn't understand my partner by then, he wasn't settled. I gave birth while at home. The challenges I went through when I was at home, life was hard. The father of my child was not sending any money. I started working early. These challenges made me decide to use FP.*

When it comes to his income, he just does fishing and bodaboda *[motorcycle used for public transport], and the* bodaboda *is not even his... I am pregnant and I need things. He only has [an income of] 10,000 per day, while we haven't eaten, and we have a small child who might fall sick. As a mother, if you don't change your mind [about using FP], the child will die or the child will be in hard environment.*

—Unmarried FTM, 23 years old, long-acting method user, Uvinza

Married FTMs were less likely to report that unplanned pregnancies or life hardships were driving factors for using FP. Instead, for this group, the benefits of child spacing (for their next and subsequent pregnancies) seems to have been a key motivating factor. As highlighted in the quotes below, the most commonly cited reason for using contraception 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**

> **FTM (Married, 25 years old long-acting method user, Tanganyika):** *I thought of using FP after getting education…I was interested because I wanted to space my children…*
>
> **Interviewer:** *During that education, what convinced you and made you think of planning your family?*
>
> **FTM:** *There are many advantages when you plan your family. One of them is working at appropriate time[s], because when you have many children you can't wake up in the morning and work. But when you have one, two or three children, you can just manage these children. In the morning, they go to school while you continue doing house chores. You get time to work, and you can even do business. When you have five, six children, it becomes difficult.*

> **FTM (Married, 20 years old, short-acting method user, Tanganyika):** *The way they were teaching us about FP inspired me to use FP. I understood it well—that FP has benefits, and that's why I decided to join.*
>
> **Interviewer:** *Can you tell me the thing that you learned that motivated you, or the thing that you did not know that led you to join FP?*
>
> **FTM:** *They taught us the benefits of FP. They include FP gives the mother and father time to work, and to plan when to have the next child. I saw that this is good, and this made me decide to use FP.*

Unmarried new users also mentioned child spacing as a motivating factor for FP use, although less frequently than their married counterparts, and also for slightly different reasons. As seen above, married FTMs largely noted the benefits of having what they consider to be a reasonable number of children, with adequate time between births to allow time for income-generating activities. Unmarried FTMs seemed more likely to stress health benefits, specifically protecting the health of their newborn child by not having a second child too soon.

First of all, timing, I got [pregnant] without expecting it. Secondly, what made me join the method is that it will help my child to have good health, and I will have good health and it'll get me time to work.

—Unmarried FTM, 20 years old, long-acting method user, Tanganyika

I was afraid of getting pregnant while my baby was still young. I found it was better way to protect myself and if I have another child, [my first baby] can be healthy.

—Unmarried FTM, 21 years old, short-acting method user, Tanganyika

As noted throughout the above results, all new users highlighted the value of the FTP program's FP information and understanding the benefits of FP in helping guide an informed decision about FP use. Prior to the intervention, both married and unmarried FTMs reported having limited understanding of FP or knowledge of modern contraceptive methods. For example, one unmarried FTM said that prior joining the peer groups, she was not aware of any FP methods, while another unmarried FTM said she only knew of injectables.

Even when they had heard or received some information about contraceptive methods, FTMs noted that the information was often insufficient. As an example, one FTM reported having received FP education from care providers at the facility where she went for post-natal care services; however, she felt that the information provided was not enough to make her decide to use FP, as she explained in this exchange:

FTM (Married, 20 years old, long-acting method user, Tanganyika): *The nurses [at the clinic] were also telling us to use FP because people were having unplanned children.*
Interviewer: *Why didn't you then start using when the nurses were telling you?*
FTM: *I didn't have enough education. The nurse's education was not deep. They didn't give us the positive and negative sides of FP.*

I made this decision [to use FP] on my own, because my first child was not planned. I became pregnant when I was very young and my mind was not yet very matured. After that, I became more interested after I received education from the peer groups. I thought that I will not have unplanned pregnancies again, because I am using FP. That is why I used FP methods.

—Unmarried FTM, 20 years old, short-acting method user, Uvinza

Other unmarried new users noted that complex issues with their partners and uncertainties about their relationships also influenced decisions to have a child and/or use FP:

> *I had decided that I cannot use FP before I get married. We had planned to get married, but I don't know whether he was lying to me or not. [Regardless], my plan was to give birth to a child first and then use the method.*
>
> **—Unmarried FTM, 20 years old, long-acting method user, Tanganyika**

> *I decided to use FP because I become pregnant when I was at home. I didn't think it was good to become pregnant again at home, because I was seeing my current man. Men are very deceitful. I could get another pregnancy while I was still at home. That is why I decided to use FP.*
>
> **—Unmarried FTM, 20 years old, short-acting method user, Uvinza**

> *I wasn't sure about our relationship between my partner and me. I wasn't sure if he would marry me.... I started using FP after I got the education about FP at the peer groups. The education was good. It then convinced me to use FP, considering how my life was. Prior to the peer group education, I had no thoughts about FP.*
>
> **—Unmarried FTM, 20 years old, long-acting method user, Uvinza**

Through their participation in peer groups, all FTM new users, both married and unmarried, noted having gained knowledge on different contraceptive methods, as well as the advantages of using FP. Both also noted the importance of having their concerns about the safety of FP and modern contraceptive use addressed.

Although FTMs generally reported finding all information as being useful, there were some differences in the most compelling knowledge-related facilitating factors for married and unmarried new users. As noted above, married FTMs more frequently cited the value of information about child spacing, especially in terms of allowing time for economic activity and addressing financial needs. Married FTMs also noted other advantages of child spacing as having contributed to their decision to use FP, including allowing time for the newborn child to grow in good health, and facilitating planning for parents to have their desired number of children, especially given financial constraints. While child spacing was the most frequently mentioned motivating factor, several married FTMs also flagged the importance of addressing concerns about safety, saying that they would never have considered using FP if they had not been convinced it was safe to use.

Safety was also a concern for unmarried FTM new users. In fact, they most commonly cited the intervention's addressment of their concerns about FP safety and side effects—particularly with respect to

affecting future fertility—as the main knowledge-related factor behind their decision to start using FP. More unmarried than married FTMs cited concerns related to safety as the main reason behind their hesitation to use FP prior to their participation in peer groups. Unmarried FTMs believed FP methods could cause them not to conceive in the future, and like their married counterparts, many also reported wanting to have at least one child before considering FP.

> *I heard many things about FP. I was told that people don't get pregnant when they use FP, and that others face problems when they use it…like, they aren't able to give birth, or the methods affect them… They said it's not good to use FP if you don't have a child yet. You should at least have a child then you can start using. But even then, I got scared.*
>
> **—Unmarried FTM, 20 years old, long-acting method user, Uvinza**

> *I heard in the streets that FP has side effects. You may use FP, but you'll delay having a child when you want to have one. There are people who had used one injection only, but they have not had babies since then. I got scared when I heard this.*
>
> **—Unmarried FTM, 24 years old, long-acting method user, Tanganyika**

> *I heard people saying that the injectables are bad. They used to say that they can make you unable to conceive when you wish to, and they kill the eggs.*
>
> **—Unmarried FTM, 21 years old, short-acting method user, Tanganyika**

For many unmarried FTMs, these concerns about safety and side effects persisted, even after having had an unplanned pregnancy and delivering a child. For these young women, having the opportunity to hear and understand correct information about FP and different contraceptive methods helped to catalyze their decision to start using FP.

> *We were having false beliefs that when you use FP, you will never give birth again and that made us worried. So, when they came, they counselled us about how FP is [and]we were convinced, and we started using it."*
>
> **—Unmarried FTM, 23 years old, long-acting method user, Uvinza**

> *"Before that time [the peer groups], I heard when you put loop [IUD], it can get lost, or an implant can get lost in the body. After being educated, we understood that when you put an [IUD or] implant, it does not get lost. And injections, the [side-]effects happen depending on one's body. The education encouraged me to use FP."*
>
> **—Unmarried FTM, 22 years old, short-acting method user, Uvinza**

Interviewer: *Had you already thought of FP?*

FTM (Unmarried, 20 years old, short-acting method user, Uvinza): *I thought about it, but people said they have side effects, so I decided to wait first."*

Continuing FP Users (FTMs who adopted FP prior to joining peer groups)

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. One FTM whose first pregnancy was unplanned and who had not thought of using FP before having her child provided additional details about her decision to start using FP. In her case, financial concerns overrode any other fears she and her partner may have had about the safety of using FP:

FTM (Married, 20 years old, short-acting method user, Uvinza): *I decided to use FP because I was not doing well economically. I thought adding another child might bring problems on my side, because economically, I am not doing well. I said to myself, if I use FP, it will give me time to prepare for another child. Then I was convinced to use FP.*

Interviewer: *Had you ever thought of using FP prior to that?*

FTM: *They said, if you use FP 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 FP. Therefore, we had not thought of using FP before having a baby.*

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 FP. She used to tell me, "If you use FP, 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

FTM (Unmarried, 21 years old, short-acting method user, Tanganyika): *As we come to hospital [for ANC and delivery] the nurses advised us to use FP methods. They say that you can opt for the method or decide not to use them. I felt a need to use FP and I did so.*

Interviewer: *Was this before or after delivery?*

FTM: *I decided to use FP after first delivery.*

The one FTM who reported using FP prior to the birth of her first child said she used contraceptives when she was 15 years old and still in school:

> *I will tell you, and I will not hide anything from you. I was involved in it [FP] because I was still a student and I had friends who involved me in using FP... They just told me about it [FP], so that we can protect ourselves from getting pregnant.*
>
> **—Married FTM, 23 years old, long-acting method user, Tanganyika**

The above FTM reported having used an implant at that time, which she accessed through a public health facility in Tabora region. However, after using it for only two months, people at her home found out and told her to remove it. Ultimately, she had an unplanned pregnancy. She continued:

> *I had it [the implant] for two months, then people at home figured out that I was using implant. I was asked to go and remove it. I was in Form 3 by then. That is when my parents refused to take me to school. Then we moved after a while when things settled down. This is the time I also became pregnant. I gave birth and I breastfed the baby. Then I got this man whom we moved in with.*
>
> **—Married FTM, 23 years old, long-acting method user, Tanganyika**

C. Decisions Regarding FP Method Choice (FTM)

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. Although the study included more long-acting method users (17 out of 28), 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. Responses about method choice are presented below by contraceptive category (long- and short-acting methods) for both new and continuing users, with marital status highlighted where it is relevant.

As FTMs shared their contraceptive use histories, many explained how they considered their options, weighed the benefits of short- or long-acting methods, and determined which option would best fit their needs at the time. The following quotes—both from unmarried implant users—give a detailed sense of how FTMs arrived at their decisions to use FP and select a specific contraceptive method. The second quote also shows how contraceptive use needs and choices have continued to evolve for this FTM, now almost two years after the initial intervention period.

FTM (Unmarried, 22 years old, long-acting method user, Tanganyika): *I delivered the baby with difficulty. It was through caesarean section. Then I thought that if I don't use FP, I will get another pregnancy while the baby is still young and the caesarean wound is not yet healed. This is why I decided to use FP.*

Interviewer: *Did you plan to have your first pregnancy?*

FTM: *No, I did not plan it. I was like, "I got this first pregnancy without planning it, so I can't get the second pregnancy that way. I should use FP. I should first wait and think. When I want the second child, that is when I will give birth."*

Interviewer: *You said you never used FP before, but you had some thoughts of FP before getting pregnant. Did you know about FP?*

FTM: *I did not know. When I got pregnant and gave birth to my first-born child, that was when I thought of using FP.*

Interviewer: *When did you decide to use FP?*

FTM: *A few months after delivery. I learned [from the peer group] that there are short-acting and long-acting methods. There are pills and injections, and then implants, loop. I decided to put the implant for three years.*

I adopted the [implant] because I heard people say that it is one of the FP methods, and it could help me to prevent pregnancy while I still lived at my parent's home. I went to a dispensary and first requested for an injectable. They advised me to use an implant, because I didn't have a lot of children and they wanted me to enjoy my life more. They told me that it was a long-acting method, and it can last for five, four or three years. So, I was interested in using an implant lasting for three years before I gave birth to this last [second] child. When I got my new partner, I removed the implant, got pregnant and gave birth to this child. Then, I reinserted an implant that I use till now.

—Unmarried FTM, 19 years old, long-acting method user, Uvinza

Long-Acting Contraceptive Method Users (New and Continuing)

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 the 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

I chose long-acting (implant) because it lasts for a long time until you want to get another child.

—Married FTM, 20 years old, long-acting method user, Tanganyika

I chose [the implant] because I found that if I used an injectable, I could forget to go for it when it is time for the next injection, which could lead to unwanted pregnancy. So, the long-acting one could prevent pregnancy throughout the period I wished not to have a child.

—Unmarried FTM, 22 years old, long-acting method user, Uvinza

Taking the pills every day and going for injection every three months—that's where I saw the disturbance [inconvenience].

—Unmarried FTM, 18 years old, long-acting method user, Uvinza

Less frequently mentioned reasons for choosing long-acting FP methods included being advised by a care provider that a long-acting FP method was a better option for them (as seen in a previous example) and concerns about being able to access services when the next injection is due.

Because you might want to get injections, and it is done every after three months. Then you find the nurses are not around. Or the date to return might be on a Saturday when the injection is not there, because they don't provide the services over the weekends.

—Married FTM, 20 years old, short-acting method user, Uvinza

Short-Acting Contraceptive Method Users (new and continuing)

Of the 28 FTMs included in the study, 11 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. Importantly, short-acting method users cited concerns about safety and side effect with long-acting methods as a reason for choosing the former, while long-acting method users preferred this method's convenience and ability to meet reproductive intentions (regardless of whether or how concerned they were about safety and/or side effects).

Several married and unmarried FTMs believed that long-acting methods were less safe (particularly the intrauterine device, or IUD), as compared to short-acting FP methods, noting various myths and misconceptions that made them less desirable.

> **Interviewer:** *Why did you use short-acting and not long-acting methods?*
> **FTM (Unmarried, 20 years old, short-acting method user, Uvinza):** *I thought long-acting methods would be bad. I just thought they were bad, because other people say that they get lost in the body.*

Several new FP users said they wanted to first try a short-acting method, most commonly pills, to see how their bodies responded before switching to long-acting FP methods.

> *I decided to first use the short-acting to see how [my body] will react—if it is good or bad. I wanted to see if it will act negative towards me. Since it's a short-acting method, I can stop using it, because it lasts for a short period of time.*
> **—Married FTM, 22 years old, short-acting method user, Tanganyika**

Reasons for Choosing a Specific Contraceptive Method (new and continuing users)

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, especially for new FP users and unmarried FTMs. Several FTMs reported having opted for certain short-acting or long-acting FP methods because they knew someone who used them without any problems, were advised by peers/friends who believed such FP methods were better than others, or the method was popular in their community.

> **FTM (Unmarried, 19 years old, long-acting method user, Tanganyika):** *Many people said that implant is better, so I used that.*
> **Interviewer:** *Who said so?*
> **FTM:** *I heard people saying that.*
> **Interviewer:** *Who are those people?*
> **FTM:** *My friend who was giving me advice. I think she had used implant before.*

For many new users, the influence of project peer groups and peer leaders came out strongly. However, the patterns seem to vary. Findings suggest that the majority of FTMs who chose short-acting FP methods (injections and pills) were influenced by the project's peer groups, while those who chose LARCs (commonly the implant) were influenced by individuals in their communities. This pattern may reflect the fact that many new users in the peer groups may have preferred to start their FP experience with a short-acting method (as discussed above).

We discussed this in the peer group—like, "Which method is better so that we can use it?" And we opted to use injection.

—Married FTM, 23 years old, long-acting method user, Tanganyika

Young women [peer leaders] said, "Use implants, they are good. Any FP method is good, but the implant is the best." They said injections have side effects.

—Unmarried FTM, 25 years old, long-acting method user, Uvinza

Findings also suggest that peers and community members influenced decisions of unmarried FTM new users, as compared to their married counterparts. For married FTMs, partners could be influential and even decide which method to use (more results on the role of partners in decisions to use FP and select a method are presented in section D below):

Interviewer: *What were the reasons that made you use a long-term method over a short-term method?*

FTM (Married, 23 years old, long-acting method user, Uvinza): *It's because it was my [partner] who told me to use such a method.*

Importantly, for a few unmarried FTMs, uncertainties about their relationships, including the timing and frequency of sexual activity, also seemed to influence method choice. Some noted the pros and cons of different short-acting methods, highlighting the convenience of methods that require less user action:

Like with pills you have to swallow every day, when you forget and sleep with a man, you get pregnant. Again, condom is worn when you sleep with a man. But when you have injection, you stay until your three months end then you inject again, therefore there is no disturbance like swallowing pills every day.

—Unmarried FTM, 19 years old, short-acting method user, Tanganyika

Other unmarried FTMs said they were afraid that if they opted for long-acting FP methods, they may not be able to afford removal costs in case they needed it removed. It should be noted that, by policy, all public health facilities in Tanzania are required to provide contraceptive services, including both the insertion and removal of LARCs, free of charge. This is confirmed to be true for all facilities supported by the Tuungane project. However, while private facilities receive free FP commodities through the government supply chain, they can charge a cost recovery free to cover the cost of other consumables (such as gloves, syringes, and infection prevention materials). The FTM quoted below could have been referring to experiences she heard about from others who went to a private facility for FP services.

I used a short-acting method, because I may get a fiancé and get married [and want to have a child]. [An] implant may be [expensive] to remove. You may come here to remove… and you may not have that 10,000Tshs at that time. With the injection, you just inject every three months and you can stop without any obstacle.

—Unmarried FTM, 19 years old, short-acting method user, Tanganyika

Finally, just as peers and community members were influential in method choice, their input 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. Other negative rumors or misconceptions were also mentioned, which persisted despite information provided through the project.

There was one friend of mine who used injection. It brought problems for her to the extent of causing low blood (anemia), as she was experiencing flow every month. Even in peer groups, most of them prefer pills, so I also decided to take pills.

—Married FTM, 18 years old, short-acting method user, Tanganyika

We heard of story from users. They said, "The injection has delayed my pregnancy because I never gave birth again." She just injected 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

I decided to choose an implant. There are some who chose the injection, but it didn't go well with them. Some see a lot of blood during menstruation and for some it drains their bodies. That's why I decided to use an implant.

—Married FTM, 19 years old, long-acting method user, Tanganyika

I used implant because I imagined it as something that was safe and best for me. I heard that loops [IUDs] have a tendency of disappearing. So, I was scared to use it.

—Unmarried FTM, 20 years old, long-acting method user, Uvinza

Some say the loop [IUD] may twist and bend; this is why I decided to put implant.

—Unmarried FTM, 22 years old, long-acting method user, Tanganyika

Use of implants was high among IDI informants and with all project FTMs; FTMs noted that the project largely addressed their earlier concerns about implants and they felt it was safe to use this particular

LARC. On the other hand, negative perceptions about the IUD were common, not only due to misconceptions (as noted above), but also due to how and where the method is located.

> *With the IUD, I was told was that it is placed in the secret parts (female genital area). I wasn't given any education on that one, I just used to hear people saying that. And so I was afraid it might go to the womb.*
> **—Unmarried FTM, 20 years old, long-acting method user, Tanganyika**

> **Interviewer:** *Why didn't you opt for IUCD?*
> **FTM (Unmarried, 25 years old, long-acting method user, Uvinza):** *Because they put it down there, I was just scared.*

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 switching to other methods after receiving information/education through the peer groups. For example, one FTM said she first used the injectable contraceptive, as that was the only method she knew at that time. She added that she was not given enough information on other FP methods at the facility where she went to get services.

> **FTM (Married, 20 years old, long-acting method user, Uvinza):** *When I went to the facility, I asked them to give me injections. The nurse told me there was implants, injections, IUCD and condoms…but she didn't give me any further information. So, I told her that I wanted injections. She just agreed and gave me the service.*
> **Interviewer:** *So, she [the nurse] did not explain about other methods?*
> **FTM:** *Yes.*

Following her participation in the project, this same FTM switched to implant (LARC).

D. 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 these women's partners in communication about FP, the decision to use FP, and the selection of a specific contraceptive method. Each of these topics are explored in the sections below, as well as a brief look at other people (largely the mothers and mothers-in-law of FTMs) who were involved in FP decision making. Input from the partners is also presented in section G.

FP Discussions Among Couples Prior Joining Peer Groups

Of the 23 FTMs who were in relationships at the time, 16 FTMs (6 married, 10 unmarried) reported never having discussed FP issues with their partners prior to joining peer groups. When asked why, they gave varied responses, with the two most common being: (1) having no knowledge of FP issues, and (2) not seeing the need to discuss FP before they even had one child. These responses echo comments noted earlier in this report, with FTMs saying that they felt FP was not appropriate or relevant for young women like themselves.

> **Interviewer:** *Why do you think you had not discussed with him?*
> **FTM (Married, 20 years old, short-acting method user, Uvinza):** *Because we didn't know anything about FP.*
>
> *It is very hard to tell a man whom you have not had a child with to use FP. 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 (like the one below) 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.

> *I thought he would refuse. But when I asked him to join the peer group, he agreed. This is when I started involving him about FP.*
> **—Married FTM, 23 years old, long-acting method user, Tanganyika**

A few FTMs, both married and unmarried, 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. In a few scenarios, male partners initiated the FP discussions by indicating that they wanted their wives to go for FP services. In other scenarios, it was the FTMs who asked their male partners for advice/permission regarding FP use.

> *He said, "You should go to the health center to find out about FP so that you can use it, so that we don't become pregnant when our other baby is still young.*
> **—Married FTM, 20 years old, short-acting method user, Tanganyika**
>
> *It is like that. I told him I want to join FP, but he told me the methods have side effects. We both discussed, but I was worried so I didn't go.*
> **—Unmarried FTM, 22 years old, short-acting method user, Uvinza**

Partner Role in Decision to Use FP

All FTMs (except one unmarried FTM) said that their male partners were involved in decisions related to FP use. Further inquiry established that many FTMs (both married and unmarried) shared what they learned in the peer groups with their partners on a regular basis, especially information about the advantages of HTSP and FP. This paved the way to later seeking their partners' approval/permission to use FP. Both married and unmarried FTMs reported that this early and continuous engagement with their partners in discussions about FP helped to facilitate partner support when they eventually raised the issues of whether to use FP.

Several FTMs reported this conversation to have gone quite smoothly, with most partners approving their use of FP almost immediately. As one FTM noted:

> *I asked him whether I should join the FP method, and he said: "You've given good advice. We can plan to have another child after this one is 5 or 6 years old." So, he allowed me to [use FP]. He also said "even after removing this [implant], you can add another one for three years."*
>
> **—Married FTM, 19 years old, long-acting method user, Tanganyika**

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. This FTM provides a detailed explanation of the exchange with her partner before he agreed to use contraception, largely focusing on the benefits of having the number of children that they can manage well.

> **FTM (Married, 25 years old, long-acting method user, Tanganyika):** *I told him, "We need to plan our family. We should space our children so that we can get time to work." But the partner says, he wants a child now that the first child has grown up. It was like a song that I had to keep repeating: "Let us plan our family. When we plan, we will get advantages. When you go to work and I also go to work, we can build (our house)." It took me time until he agreed.*
>
> **Interviewer:** *Do you remember what convinced him to agree?*
>
> **FTM:** *What convinced him is telling him that we need to plan our family. Because when we do, we can work freely. So, when we go to the farm with only one child, we just carry him/her, and we go there and work properly. Not like having four or five children and going with them to the farm—you won't do the work properly. You need to hurry home for the children. I convinced him, "Even when you travel for work, I won't have to tell you to send money. That we have no food." So, when you have two children, he can travel and leave some food for us. You call him after a month, when he would have got some money after working there and send it to you.*

He didn't agree on the same day. I told him [that I wanted to use FP], and he refused. I did not force him, I left him alone. After two days I told him again, and then he agreed.

—Unmarried FTM, 22 years old, short-acting method user, Uvinza

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. One FTM reported that her husband advised her to use traditional methods as an alternative to modern FP methods. She explained:

When I started planning to use FP, I told my partner about it, he kind of hesitated a bit in the beginning. He said, "Don't those things have side effects as other people say?" I said, "We see many people using and we don't hear them complain about the side effects. Maybe it happens to 1 out of 10 people." He advised that we use traditional methods, but I refused. I said, "I see people using them, but they conceive." Then we started kind of agreeing and disagreeing. In the end, he said I could use FP so that we don't affect the baby."

—Married FTM, 22 years old, short-acting method user, Tanganyika

Another FTM recounted the negotiation with her partner about using modern FP:

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

Four FTMs reported that it was their partners who introduced the idea of using FP. Further analysis of their narratives established that for three out the four couples involved, their first pregnancies had been unplanned and that "life hardship" was the primary reason raised by their partners for using FP. In one of the scenarios, the FTM reported that her partner was the one who selected the FP method for her to use.

He is actually the one who would mostly tell me that I should go to the health center to find out about FP, so that we don't conceive when the baby is still young. I am the one who was lazy in coming to the health center.

—Married FTM, 20 years old, short-acting method user, Tanganyika

FTM (Married, 23 years old, long-acting method user, Uvinza): *He told me, "You are supposed to start using FP, because life has started becoming tough." Then I told him, "How can I start using FP while we have only one child?" He was the one who started telling me to use FP, because life at their home had started becoming difficult.*

Interviewer: *What did you tell him when he told you that?*

FTM: *I didn't answer him that day, and then on the next day he told me again and he kept on telling me until I decided to come and put it in during the clinic day. He was the one who told me to come and use an implant."*

FTM (Unmarried, 18 years old, long-acting method user, Uvinza): *He is the one who brought in that idea. I came to consider his advice because he was talking about it almost every day. Then I came and got the method.*

Interviewer: *What did he tell you about FP when you discussed about it?*

FTM: *He said that he knew that as I go to dispensary, I get advised about using FP and my friends are making use of FP methods like implants for protection. He told me to do the same to avoid getting pregnant while the baby is still young.*

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 support 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.

I started seeing my periods, and then I told him that I wanted to use FP because the child was still young. He said it is not good, and he refused. I went to take the pills without him knowing, he didn't even know about it.

—Unmarried FTM, 20 years old, short-acting method user, Uvinza

I involved him [in discussions about FP], but he completely refused to accept this idea. He said that he had no interest in that conversation and said that I had to make my own decision without involving him. He walked out after dinner and came back late in the night. I started telling him that given his way of behaving, I was determined to use FP method even if he wouldn't support my idea. He threatened to beat me, but I didn't change my mind. We went on having some quarrels. I just waited for a while to see his further reaction. When the child was four months old, I reminded him about it. He said that I should not get him involved in what I decided. And that if there were side effect as a result of the method, I was the one to suffer the consequences. I told him that I was determined to go for the method, and I believed that it had no side effect.

—Unmarried FTM, 22 years old, long-acting method user, Uvinza

Partner Role in Contraceptive Method Selection

The majority of FTMs (both married and unmarried) reported that their partners largely supported their choice of contraceptive method. In these cases, the FTMs said that they were able to inform their partners about which method they wanted to use, and their partners accepted that decision. Four married FTMs reported their husband being the ones who selected FP methods for them (none of the unmarried FTM reported this). For these FTMs, all reported that they were happy with the choices made by their male partners, and some said it was the same method they would also have chosen. Very few FTMs (only one married and one unmarried FTM) reported selecting the FP method together with their husbands, having multiple exchanges before agreeing on which FP method to use.

The following quotes illustrate different scenarios reported by FTMs about their partners' roles in selecting a method:

> *I told him the different methods, but I told him I want to use the pills. He then asked me, "Will you manage to take pills every day?" I said I could. He allowed me.*
>
> **—Married FTM, 20 years old, short-acting method user, Tanganyika**

> *I told him about all methods of FP. I mentioned to him about injections, implants, pills, loop, but he suggested that I use injection... I also preferred to use injection.*
>
> **—Unmarried FTM, 22 years old, short-acting method user, Uvinza**

> *He asked me, "What kind of method do you want to use?" I told him I want an implant. When I came from the sessions, I used to educate him about what we were taught. He said, "I also advise you to use implants, because the implants do not delay pregnancy." Because in the beginning I wanted to use injections, but he told me don't use injections, use implants. Then we agreed with each other to use implants.*
>
> **—Married FTM, 25 years old, long-acting method user, Tanganyika**

Other People Involved in FTMs' Decisions to Use FP

While the study primarily focused on partner/husband roles in FP-related decision making, the interviews also explored the involvement of other key individuals. A few FTMs reported that their mothers-in-law were involved and were supportive of FP use by the couple.

> *I told her [mother-in-law], "Mama, the father of the child told me to use FP." Then she said "Has he agreed for you to use it?" And I said "He has agreed for me to use it and he is the one who actually told me to go and put it in." Then she said "Then that's good, just go."*
>
> **—Married FTM, 23 years old, long-acting method user, Uvinza**

FTMs, especially those who were unmarried, also noted that their own mothers were sometimes involved. For the most part, their mothers supported FP use.

> *My mother had seen the situation—that I had given birth at home. She was okay with me using FP. She told me to use the methods, but that I should be careful with the methods I am using.*
>
> **—Unmarried FTM, 20 years old, short-acting method user, Uvinza**

However, a few did not:

> *She told me "Why do you want to use FP? I didn't use it and gave birth to all of you. Why do you want to make it that it becomes difficult for you to become pregnant?"*
>
> **—Unmarried FTM, 19 years old, long-acting method user, Tanganyika**

Other people that both married and unmarried FTMs reported consulting about FP were friends, sisters, and CHWs. One FTM served as a confidante and source of support regarding FP use for a friend who was in a similar situation—highlighting again the important role that friends/peers play in influencing contraceptive use for this population.

> *[My friend and I] were in the same case. She had also gotten an unexpected pregnancy like me, but I had the baby first and then her. So I advised her to use FP because if she had another child, she won't have time to work. And we are not sure if the men we have will marry us. She also decided to use FP, as she didn't know who would give her money to spend, even an amount as little as 500 or 2,000 shillings.*
>
> **—Unmarried FTM, 20 years old, short-acting method user, Uvinza**

Other FTMs, like the one below, had a different view regarding involving people other than their male partner in decisions on FP use.

> *Those things just involve the husband and wife in the house, and when the husband agrees then you put it in. Even if you tell your relatives, they cannot stop you while your husband has already decided.*
>
> **—Married FTM, 19 years old, long-acting method user, Uvinza**

A few unmarried FTMs also reported making the decision solely on their own.

E. Access to Contraceptive Methods (FTMs)

After learning about FTMs' decision-making processes with respect to using FP and selecting a method—often with their partner's involvement in some way—the interviewers then explored FTMs' experiences with accessing and using a contraceptive method. Overall, the majority of FTMs were able to access and obtain their method of choice without any problem, including 14 implant users and 8 short-acting method users. 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). Detailed input is

presented below for those who were able to access their method (both short-acting and long-acting method users) and for those who faced challenges.

Access to Contraceptive Methods

Almost all FTMs reported accessing the chosen FP methods at nearby public health facilities that are supported by the Tuungane project. For many FTMs, the public health facility was the only nearby source where they could access methods without charge. Interestingly, despite having increased access to CHWs through the program, only one FTM reported receiving her method (the pill) from her CHW. All implant users had to obtain their method from a facility, and even short-acting method users reported traveling to a facility to receive their pills and condoms. When asked why they did not obtain their method directly from the CHW, one pill user reported that FP was only available at a facility, while another indicated that the health care facility was the source she trusted most.

Importantly, all FTMs reported that they felt that facility FP providers treated them well, including those who faced some challenges in accessing a specific method (presented in next section). Further inquiry regarding their interactions with FP providers established different scenarios when obtaining their methods: A few FTMs were first given information on various available FP methods, but many said that they were simply asked which method they wanted and then provided with that method. A few FTMs reported being advised by providers to change their initial method choice:

> *They first asked me why I am was not putting an implant. I told them I wanted condoms. They told me implant is also good, because it has two years, or three years of protection against pregnancy. I still insisted that I wanted condom. They said there is no problem. She then gave me [condoms].*
>
> **—Unmarried FTM, 20 years old, short-acting method user, Uvinza**

> *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**

As can be seen from all the three quotes above, some of the guidance given to FTMs at health facilities raises questions about 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. However, all three FTMs in the above examples went into the facility with a method already identified and sufficient knowledge—from the information received during peer groups or during interactions and counseling from the CHWs—to make an informed decision regardless of provider input. Two of the three FTMs were ultimately able to get their initially requested method. However, in the case of the 18-year-old woman from Uvinza, she received the three-year implant that was recommended by the provider. These stories reflect that, with some providers, there is still need for additional refresher training and capacity building to ensure full voluntary informed choice for young women.

Challenges and Delays in Accessing Contraceptive Methods

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 counseling skills, or misunderstanding about the timing of postpartum contraceptive initiation), or the facility had too few staff to provide care to everyone coming to the clinic on any given day. For example, one FTM said she wanted to initiate FP when her child was four months old but was told by a provider at the facility that she had to wait until the child is eight months old before she could get an injection (her method of choice). They gave her the option of getting an implant on that day, but she refused and decided to wait for four months to get the method she wanted.

> *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**

A few FTMs reported being told to wait for their menses to return after giving birth before they could be allowed to access FP.

> *They say that you must wait until you've seen your period. So, I stayed for like a year until I saw my first period, then I started using FP.*
>
> **—Married FTM, 20 years old, short-acting method user, Tanganyika**

Others reported long wait times before they could see a provider, including one who had to return to the facility on another day to receive her method.

I waited for a long while before getting the service at this facility… from 8 a.m. to 1 in the afternoon.

—Unmarried FTM, 18 years old, long-acting method user, Uvinza

There were many women wanting FP services, 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 last two FTMs quoted above received their chosen method: the first had the implant inserted on the day she went, while the second returned to the facility as per the new appointment and received the injectable contraceptive. However, their stories 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)

The study also explored FTM contraceptive behaviors since the intervention period and their future FP intentions to better understand how their contraceptive needs evolve over time. 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 FP, 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. More details are provided below on reasons for continuing with, switching, or stopping FP, and for future intentions.

Facilitating Factors for Continued FP Use

For FTMs who were continuing with their original method choice, they reported that the contraceptive continued to meet their FP needs, a decision facilitated by the fact that they experienced no or minor side effects.

The first thing that helped me is that I don't see any side effects. I still have desire for my husband. Others will tell you, "If you put an implant, you won't have desire for men." I tell them, "I still have desire for my husband." I don't feel like vomiting. I don't feel dizzy. I am just as I used to be, and so I have every reason for continuing to use it.

—Married FTM, 23 years old, long-acting method user, Uvinza

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.

> *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**

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.

A few FTMs (particularly new FP users) reported switching methods due to side effects with their original method choice—usually going from a short-acting to a long-acting method. Others also noted the switch from short- to long-acting methods but did not always provide clear reasons for doing so.

> *I had one injection, and then I experienced side effects like seeing my periods twice a month. I stopped using it because I felt it was a disturbance. Then I used the implant.*
>
> **—Married FTM, 20 years old, short-acting method user, Tanganyika**

> **FTM (Married, 18 years old, short-acting method user, Tanganyika):** *Honestly, I didn't get any side effects. I just decided to stop and to use an implant. I used pills for three months only, then I shifted to implant.*
>
> **Interviewer:** *And what was the main reason to shift to implant?*
>
> **FTM:** *No reason. It was just a decision. I can't say I got any side effects, like bleeding or what, no.*

Further probing of this respondent revealed that convenience was a factor in switching to the implant, which did not require her to take daily action (as with the pill).

Reasons for Stopping FP Use

Three FTMs had stopped FP use altogether by the time of the study, although one switched methods first, 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.

> **FTM (Married, 22 years old, short-acting method user, Tanganyika):** *One year after I put the implant—in 2019—I started feeling waist pain and thereafter stomach pain. Whoever I told, told me to watch out (and said) it might be the implant as it has side effects. I didn't agree with them straight away. I took some time and later went for tests. I was given medication, but I could still feel on and off waist pain. The pain persisted and in February, I had fever and waist pains. I had gas in the stomach every time I ate ugali. People still insisted it was the implant. I then went to remove it to see if it is true.*
>
> **Interviewer:** *Did your husband and in-laws influence you to remove?*
>
> **FTM:** *Yes, especially when my in-laws talked about the implant with my husband. Then he started also complaining, I then decided to remove."*

Another FTM said:

> *I used it [implant] in the beginning but later it gave me problems, then I removed it. For me I removed because I started to be sick, my stomach was not good. Therefore, when I went to get treatment, they told me to remove it."*
>
> **—Married FTM, 25 years old, long-acting method user, Tanganyika**

In addition to experiencing weight gain that she felt was a side-effect of the method, the third also indicated that pressure from her husband and family to have another child, and her readiness to take that step, contributed to her discontinuation of FP use.

> **FTM (Married FTM, 20 years old, long-acting method user, Tanganyika):** *I just removed it, because people are telling me that I have gained a lot of weight. I said to myself that maybe it is the implant that is making me fat. So I thought of removing it so that I can lose weight. My husband also told me, "Our child had grown up so you should go and remove the implant."*
>
> **Interviewer:** *Would you have removed the implant if you were not ready to have another child?*
>
> **FTM:** *I would have left it if I were not gaining weight. I remember the day I came to remove it, the nurses struggled a lot. It had gone inside my skin/fats. They told me I have gained a lot, so the implant had gone deep inside.*
>
> **Interviewer:** *Are you ready to have another child personally?*
>
> **FTM:** *Yes, I am ready. At times the in-laws also talk a lot about it, they scold you, saying "The child has already grown up, you must get another child."*

When the above FTM was asked whether she would use FP after having her next child, she confirmed she would use again soon after birth. When asked what method she would use, she said she would use an implant but was still concerned about the weight gain.

Future FP Intentions

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. Benefits of child spacing were particularly important, as noted by this FTM:

> *As I told you, I want to use FP methods to allow my child to grow healthy. By using FP, you can be able to space your children even at six-year interval.*
>
> **—Unmarried FTM, 21 years old, short-acting method user, Tanganyika**

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

The study included interviews with the husbands/partners of FTM participating in the FTP program (who may or may not have also participated in the study) to understand their perspectives on FP-related decisions and contraceptive use with their partners. Although the study was not designed to match couple accounts of their contraceptive histories, husband/partner input provides another perspective on the decision-making process involved as FTPs begin using contraceptive methods. In total, 15 men participated in the study, and the sections below present their reflections on FP communication, decision making, and contraceptive method selection.

Facilitating Factors for Husband/Partner Involvement in FP Discussions and Decision Making

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. Of the three men who reported not being involved, two said the FTMs just informed them after they had adopted the FP method. For those men who said they were involved in discussions and decisions about FP use, many noted that their FTM wives/partners had regularly informed them about them about 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.

Whenever she came back [from the peer group session], she used to tell me what she had been taught. She would say, "This is what we have been taught today." She continued with this until they finished their meetings. When she came and told me about joining FP, I told her FP methods have got side effects. But she educated me and said they just have small side effects. So, she explained to me and I agreed with her.

—Male Partner, 25 years old, long-acting method user, Tanganyika

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

As reflected in these quotes, improved understanding about FP, 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.

I understood the advantages and disadvantages. I also loved the idea because it gives me time to work and it also gives time both to my child and my wife as well.

—Male Partner, 26 years old, long-acting method user, Tanganyika

Knowing that we were young also made me to think that it is good to use FP. If we are this young, and we decide to give birth without plans, how many children shall we have in the future? Taking into account our families are struggling financially. Therefore, that was also a very strong reason.

—Male Partner, 23 years old, long-acting method user, Tanganyika

I looked at the life I was living and still building for myself. If I have many children, I will be responsible to take care of those children including their mother and me in general. If I have a big family, it could have been so difficult to deal with other things that were surrounding me at that time. Another big thing is about providing education to the children. I thought it will cost me, and I will fail.

—Male Partner, 26 years old, long-acting method user, Tanganyika

Additionally, several husband/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 other men, young children, and families.

> *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**

> *My younger brother was not using FP. We were living as a family there at home. So, my younger brother reproduced consecutively—that is, he was having a baby after every few months. The pregnancies were not planned. And so when [my wife] came to tell me about FP, I found that I have every reason to do it, that it is possible for me to not be like my younger brother. People had started to laugh at him. Even at the village they would make fun of him, like "What is up with you? Why do you have a pregnancy after every two minutes? You do not even rest." So, that thing made me say, "No, I must use FP."*
> **—Male Partner, 34 years old, long-acting method user, Uvinza**

A few male partners said the fact that the first pregnancy was unplanned also contributed significantly to them deciding to support FTM's FP use.

> *It was something that happened without us expecting it. Because, alas though we were in a relationship, we had no intention for having a child at that time. But we got a child when we had not planned to. So, we decided to use FP so that we don't get another child.*
> **—Male Partner, 21 years old, long-acting method user, Uvinza**

As reflected in several of the experiences above, most men noted that it was their FTM wives/partners who largely initiated the discussion about FP, often through sharing what she was learning in the peer groups. However, a few men reported having discussed FP with their partners before the intervention period, citing previous exposure to FP information from school or relatives as motivating factors to initiate the discussion or decision to use FP.

> *I studied FP issues as I went to school. I remember when I was in Form Three, our biology teacher insisted on FP issues saying, "You should be careful in this generation. You should talk to your partners if you have a partner so that you can use FP methods." Therefore, I related that education I got in school.*
> **—Male Partner, 23 years old, long-acting method user, Tanganyika**

Male Partner (23 years old, long-acting method user, Uvinza): *After delivery [of our first] child, I saw that my wife could get exhausted easily. Then, I thought that if we get the next child after a year or year and half, it could be difficult for us to care for these children. They would be like twin children and my wife would not be comfortable. So, I advised her to insert the implant until when we decide having another child.*

Interviewer: *Who came up with the decision?*

Male Partner: *It was me.*

One other male partner summarized the process that he and his wife went through when arriving at the decision to use FP:

> *We talked about what FP means. We also discussed on what we can do to care for our family. We decided to use FP to prepare the future for our family. It was not a good idea for us to have unplanned children.*
>
> **—Male Partner, 23 years old, short-acting method user, Uvinza**

Husband/Partner Concerns About FP Use

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. Men specifically cited fears that FP use causes infertility, cancer, and/or miscarriages. Some comments reflected common myths/misconceptions about specific methods (e.g., concerns that IUDs may get lost in a woman's body), but they also noted concerns with possible side effects (e.g., weight gain).

> *They [community members] used to say that [contraceptive methods] have some side effects to a woman, and she can lose her ability to conceive completely. You can also find that a woman gets prolonged and heavy menstrual bleeding. So, when I thought about all this, I used to get discouraged on using FP and used to hold up a notion that Africans are meant to reproduce. However, my partner kept on insisting on using FP. So, I decided to support my partner on FP use.*
>
> **—Male Partner, 25 years old, long-acting method user, Uvinza**

> *People are saying that it is better to use an implant rather than using a loop, because the loop is likely to disappear into the body. This interferes with someone's reproductive potential. This is why she decided to use an implant.*
>
> **—Male Partner, 25 years old, long-acting method user, Uvinza**

We were told a person who uses pills tend to have large abdomen, as if she is pregnant. We tried to ask, they reduced our fear that having large abdomen is due to body build up. After that, we chose this method as our first FP method.

—Male Partner, 21 years old, short-acting method user, Tanganyika

Most husbands/partners said their concerns were addressed, either through the education received from CHWs (during outreach sessions), information shared by FTMs (based on what they learned in peer groups), or education received from care providers at facilities (for those who escorted their partners for FP). 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 husband shared the process that he and his wife went through, noting his initial opposition to FP use and highlighting some of their back-and-forth exchanges before he agreed. This again echoes remarks made by FTMs about the decision-making process they experienced.

It's true that we had conflicts, because I believed that a FP method is not very right. So, we had conflicts here and there. But fortunately, she still continued to insist it upon me and gave me education.

—Male Partner, 34 years old, long-acting method user, Uvinza

One final issue raised by married men was that they were not ready to support FP use until their wives had had at least one child. This, in part, was due to concerns about future fertility (as noted above), but men also stressed social expectation for couples to have children soon after marriage:

You know, when you are married, people watch you and say, "How is it that you are married for a whole year and still no baby?" So, we could not use FP.

—Male Partner, 34 years old, long-acting method user, Uvinza

Husband/Partner Involvement in Selecting a Specific Contraceptive Method

Interviews with the husbands/partners of FTM peer group members also explored their involvement in selecting a specific contraceptive method. Their responses were largely in agreement with FTM accounts presented earlier, with the majority of men (11 out of 15) reporting that they accepted whatever method their wives/partners had selected. Of the remaining four, two said they selected the method jointly with their wives and two said they were the ones to select the method.

As noted in the above sections, 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. Again, as noted above, for most men, this knowledge came through their partners (who shared what they were learning in peer

groups) or through interactions with CHWs or providers. In a few cases, men reported information they had received from a facility provider, which did not necessarily provide full information or address their concerns.

Men highlighted specific reasons for choosing/supporting the use of a short- or long-acting contraceptive (and often, for a specific contraceptive method). As 11 of the 15 men in the study had wives who were using the implant contraceptive, most mentioned the advantages of a long-acting method that: 1. matched their desire to wait a few years before having another child; and 2. were more convenient to use, as they did not require daily or periodic user action or resupply. For men whose wives were using short-acting methods, they reported that they supported this choice, because they were unsure when they might want to have another child and liked the flexibility of this method. A few men also noted that short-acting methods were popular and easily available in their communities.

> *Another reason that made us use a long-acting method is that we were not planning on having another child in the near future.*
>
> **—Male Partner, 21 years old, long-acting method user, Uvinza**

> *As a couple, we discussed on the best method for us and which method will be easily accessible according to our environment. Therefore, we both opted for pills because it is the service which is easily accessible to our environment, and at that time it was popular in our environment. Therefore, we had to use that method [pills], although other methods were available but very difficult to get them. Implants, loops, injection—you need to come here at ward hospital whenever you need them. Pills and condoms were easily accessible there. These were available through the CHW.*
>
> **—Male Partner, 21 years old, short-acting method user, Tanganyika**

Accessing these methods at the facility or via the CHW was generally not perceived to be a problem, although as noted in the above quote, some men appreciated methods that could be accessed locally. Only two male partners (of married FTMs) reported escorting their wives for FP services. Like the FTMs, several male partners indicated that they support continuing FP use in future.

> *My thoughts are that it is a good method, especially when you have already had a child. Right now, it is not the time to just give birth randomly, one year after another. That's why we are advised by experts to use FP.*
>
> **—Male Partner, 21 years old, long-acting method user, Uvinza**

> *We will continue using it until we decide to change it.*
>
> **—Male Partner, 29 years old, long-acting method user, Tanganyika**

VI. DISCUSSION

This study explored the contraceptive use histories of young FTMs and the husbands/partners of FTMs to better understand their use of FP at this particular stage in their lives. Although the study focused on a very specific subset 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 FP understanding, attitudes, communication, decision making and action. The findings of this study are expected to contribute to the global knowledge base on this vulnerable population and guide future programming efforts.

In sharing their contraceptive use histories, most of the young FTMs said they had no experience using a contraceptive method until after the birth of their first child. Of the 28 FTMs included in the study, 27 initiated FP only after they had a child. Prior to reaching this lifestage, they did not think that FP was relevant or appropriate for them. As such, many FTMs said they had little interest in or exposure to information about FP or different contraceptive methods. FTMs, especially those who were unmarried, said they were "too young" to consider FP, which they felt to be an issue for older married women with children. FTMs also believed that women should have at least one child before using FP, due in part to concerns that FP use can cause infertility, but also due to social expectations that couples should have a child soon after marriage. With the transition to motherhood, FP became more relevant for their lives.

Along with this shift in FP attitudes, FTMs reported several other factors that catalyzed interest in using FP, with some important distinctions emerging between married and unmarried women. For young unmarried FTMs, having had an unplanned pregnancy with their first child proved to be an important trigger for using FP after the child's birth. They did not want to repeat the experience of having an unplanned pregnancy, which had strained relationships with their parents and partners and created financial and other life hardships. FP allowed them (and their partners) to have time for income-generating activities and avert the added burden of caring for another child. Finally, unmarried FTMs also noted that uncertainties about their relationship with their partner influenced FP use. While most unmarried FTMs reported having a partner during the intervention period, many expressed concerns that their relationships were unstable and without a clear sense of long-term commitment (at the time). This prompted many unmarried FTMs to use FP, both to focus resources on the health and wellbeing of their current child, and to prevent having another child while their situation was so uncertain.

Married women highlighted slightly different reasons for adopting FP. Unlike the unmarried FTMs, they were less likely to report that unplanned pregnancies or life hardships were reasons for their use of contraception. Instead, married FTMs focused more on the broader, long-term benefits of HTSP and FP for themselves, their partner, and their family. Using a contraceptive method not only allowed the FTM

and her husband to plan the number and timing of their children, but also helped them achieve other life goals, notably developing economic and livelihood pursuits. While both unmarried and married FTMs spoke of the need to pursue income generation, unmarried women seemed to focus on meeting immediate needs, while married FTMs saw "time to work" as being part of a longer-term process to build their families. These differences in perspectives between married and unmarried FTMs—reflecting the relative security of married FTMs of being in a stable relationship and, perhaps, the status of being a socially accepted wife and mother—are important findings emerging from the study.

Regardless of other motivating factors, all FTMs reported that having accurate, trusted information about FP and different modern contraceptive methods was critical to their adopting a method. Even if they were generally more open to the idea of FP now that they had a child, FTMs still held many concerns about the safety of FP use, as well as multiple myths and misconceptions about specific contraceptive methods. All FTMs highlighted the importance of being exposed to information and services through the program (via peer groups and home visits), which helped build their FP knowledge and address their specific concerns. Although FTMs valued all FP-related information, married and unmarried FTMs noted slightly different topics that proved most useful to them, perhaps again reflecting their general life situation: married FTMs emphasized information about HTSP and spacing benefits, while unmarried FTMs stressed the importance of having their myths and misconceptions about FP/methods corrected.

For all of these FTMs (both married and unmarried), it is difficult to pinpoint the interactions or sequencing of different facilitating factors. It may be that having good information about FP made the issue more relevant to them, or it could be that their new status/role as mothers made them more receptive to the information, activities, and services provided by the program. In either case, having access to accurate, trusted information at this particular moment in their life appears to be a key factor in their decision to start using FP, including general information about HTSP; method-specific information, including the advantages of different methods; and information to clarify and correct the many myths and misconceptions about different contraceptive method.

The study also yielded some interesting findings about FTM method choice. In general, FTMs had clear reasons for choosing one method over another. For long-acting method users, especially married FTMs, this type of method aligned with their reproductive intentions to wait several years before having another child. Both married and unmarried FTMs, including those who switched from a short- to long-acting method, also mentioned convenience, specifically noting the ease of use with methods that did not require daily or periodic action or frequent resupply. Method selection for some unmarried FTMs again reflected their overall life situation in different ways: a few FTMs noted that their uncertainties about their relationships or a previous unplanned pregnancy led them to select a long-acting method; others noted the importance of having a method (either short- or long-acting) that allowed flexibility to stop using FP

should they decide to have another child with their partner, or possibly, a new partner. A few new FP users (mostly unmarried FTMs) said that they started with a short-acting method first, giving them time to adjust and see how their body reacted, before possibly switching to a long-acting method. This suggests continuing concerns about FP, even as they initiate use. Importantly, FTMs noted the influence of peers and community members in their method choice—largely in determining which method to use (based on positive experiences) or which methods not to use (based on negative experiences or rumors). Peer influence was also noted in overall decisions to use FP but was particularly important when selecting a specific method.

This study showed that FTMs reported little difficulty in accessing their method of choice. Most obtained their method from a nearby public health facility, including short-acting method users; very few accessed pills or condoms through their local CHW. Most had already decided on their method before visiting the facility and received that method without problem. Importantly, the few FTMs who reported being challenged by providers about their method choice were able to insist on their preference (there were no medical contraindications) or understand the provider's suggestion for an alternate method. For all FTMs, having prior knowledge about FP and their preferred method was an advantage when obtaining the method. Generally, FTMs felt that they were treated well by facility providers. However, despite provider training and mentorship—including on LARCs, PPFP, and the needs of adolescents and youth—several comments suggest possible continued issues with provider knowledge, preferences, and social concerns related to postpartum initiation of FP for young women and service delivery capacity (e.g., time for counseling, managing workloads) that warrant further exploration and correction as needed. For the Tuungane project, the findings from this report were communicated to program implementors to ensure that these issues were addressed during routine mentorship and supervision at the project-supported health facilities.

Notably, almost two years after the intervention period, the majority of study participants were continuing to use FP, with many still using the same method they had originally selected. This suggests that their initial method selection was well-reasoned, and that the method continued to meet their health and life needs. FTMs flagged the importance of being informed about possible side effects in advance as being critical to managing these if/as they arose. Experiencing few side effects (or being able to anticipate and manage these), along with partner support, were key reasons for continuing with their method. Even with the few FTMs who did stop FP, their stories showed that this was a thoughtful, deliberate process (e.g., switching methods to address side effects before discontinuing, or wanting to get pregnant again). 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 resume FP use in the future.

One of the core objectives of this study was to understand husband/partner roles in FP-related communication and decision making through the FTMs, as well as directly from husbands/partners of peer group members who used FP during the intervention period. Although this study was not designed to analyze data for matched couples, it gathered information from both partners to provide different perspectives on the same types of FP issues, behaviors, and experiences, and identify some of the couple dynamics that shaped contraceptive use for these FTPs. Interestingly, input from FTMs and husbands/partners were generally in alignment, sharing similar insights into how and why they arrived at a decision to use a modern contraceptive method. It should also be noted that FTMs mentioned a few other individuals who influenced FP-related decisions, including their mothers, mothers-in-law and friends/peers (as noted above).

For the most part, FTMs indicated that they had not discussed FP with their partners prior to the intervention period, largely because they did not know much about the issue and did not necessarily see its relevance, but in some cases, because they were concerned that their partner would not be receptive. Participation in the program proved instrumental in opening the door to communication about FP, and many FTMs routinely shared the information/skills they were learning with their partners. Both married and unmarried FTMs reported that this early and continuous engagement about FP helped to facilitate partner support when they eventually raised the question of whether to use FP.

Husbands/partners largely echoed the FTMs with regards to communication about FP and specifically appreciated having access to information about FP and different contraceptive methods through their wives/partners (who in turn had learned about these from peer groups) and through local CHWs via home visits. The men reported that their own improved knowledge of FP, especially regarding the benefits of child spacing, was an important factor in building support for contraceptive use. Men highlighted the health and economic benefits of spacing, along with being able to plan for the timing and number children that they could support. They had seen others in their community deal with the stress of having too many children too quickly, which also made them more receptive to the idea of using FP. Several men specifically mentioned that they were just beginning their families, so having the capacity to plan for a future that they could manage and ultimately succeed in was valued—an important finding for this young FTP population.

For the young FTMs, the majority of whom were in a relationship during the intervention period, their partners played an important role in decisions to use FP—especially since so many were new users. Most FTMs reported that they (the FTM) initiated discussions about FP use, although a few noted that their husbands were the ones to introduce the topic. FTMs shared many different scenarios for how they eventually arrived at the decision to use FP. While some indicated that their partners agreed relatively quickly, others had several exchanges to address partner concerns about FP/method safety and side effects before gaining his acceptance. In general, married FTMs were able to secure partner support for FP use,

but some unmarried FTMs reported greater resistance from partners who did not want to use FP or be involved in the decision.

Again, husbands/partners largely shared the same perspectives as the FTMs on how they arrived at the decision to use FP. Most men agreed that it was their wives/partners who initiated the discussion about using FP, although a few said they were the first to raise the issue. In general, they were open to the idea of using FP, given the multiple benefits of child spacing. However, many also had significant concerns about the safety of some FP methods that made them hesitant to use contraception. This included fears that FP use causes infertility, myths/misconceptions about specific methods, concerns about potential side effects, and user inconvenience. For the most part, these concerns were addressed through exchanges with their wives/partners or in consultation with a CHW or facility provider.

When it came to selecting a contraceptive method, FTMs reported that their partners largely accepted whatever method they had chosen without much further discussion. In a few cases, FTMs said their husbands/partners took the lead in discussing FP use and selecting a method. It is clear from their contraceptive use histories that discussions about method type—particularly short- vs. long-acting contraceptives—were embedded within their larger decision to use FP. Reasons for method selection largely aligned with reproductive intentions, with FTMs (especially those who were married) who wanted to wait for a few years before having another child using a long-acting methods, and those who wanted more flexibility with the timing of their next child (especially unmarried FTMs) choosing a short-acting method. In general, husbands/partners shared the same rationale for method selection and agreed that they generally went along with whatever specific contraceptive their wife/partner had selected. It is important to note, however, that peers and community members played an important role in influencing which specific short- or long-acting method was chosen. This was particularly true for the FTMs, where peer influence drove uptake of certain methods, like implants and pills, but negated interest in others, especially the IUCD. Men, too, were influenced by methods that were perceived as being popular in their communities. That said, the continued use of FP by almost all study participants—many still staying with their initial contraceptive choice—suggests a decision-making process that worked well for the individuals and couples involved.

VII. PROGRAM CONSIDERATIONS

This study provides important insights into the contraceptive use histories of FTMs who participated in the 2018 Tuungane FTP program and the husbands/partners of FTM program participants. E2A and Pathfinder supported this study to understand the factors that facilitated FP uptake for this population, as well as their decision-making processes to use FP and select a specific contraceptive method. While the study has limitations, the findings emerging from interviews with FTMs and husbands/partner suggest several areas for programs to consider and incorporate when working with young FTPs.

A. *Reach FTMs with tailored information about HTSP and FP and address concerns and misconceptions about the safety and side effects of modern contraceptive methods.*

While FTMs in the study highlighted multiple factors that motivated them to use FP, having access to accurate, trusted information about the benefits of HTSP and FP and about different contraceptive methods was critical to facilitating uptake. Also important is addressing concerns about the safety of FP use—particularly fears that contraceptive use leads to infertility—and addressing method-specific myths and misconceptions. Having had a child made FP more relevant and appropriate for many FTMs, creating an important opportunity to support contraceptive action. Programs interested in reaching this population should prioritize providing access to quality information and services at both the community and facility level—ideally as early in the FTP lifestage as possible.

B. *Take the time to understand the varying situations, needs, and capacities of different subsets of FTMs (and FTPs), particularly with regards to marital status.*

While some aspects of their contraceptive histories were common across different FTMs, some important variations emerged between those who were married or in a stable relationship and those who were unmarried. For many unmarried FTMs, the uncertainties about their relationships and life situation influenced their contraceptive needs, motivations, and decision-making processes. While all FTMs needed access to basic HTSP/FP and contraceptive information, there were nuanced differences in terms of which benefits and methods were more relevant to married and unmarried FTMs. Understanding these and tailoring messages/activities accordingly will increase the effectiveness of FTP programs.

C. *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.*

The study showed that most FTMs who had a partner at the time of FP use included her partner in the decision to use FP, largely at her initiation. Findings also underscored that FTMs' early and

continuous partner engagement, along with interactions with CHWs and facility providers, facilitated FP use, especially when these exchanges helped to improve men's knowledge of the benefits of HTSP/FP and addressed concerns about FP safety and side effects. Reponses from husbands/partners indicate that they valued having multiple points of access to information, both directly (via home visits, outreach sessions, and facility visits) and indirectly (via FTMs sharing information/skills learned through peer groups). It may be that different access points are more effective within different types of relationships (e.g., married FTMs may be better positioned to share information with their husbands). While the onus of conveying FP information should not fall on the FTMs alone, this does appear to be a valuable channel for catalyzing discussion and conveying information. Programs should therefore consider building FTM communication skills and supporting information sharing between the couple. Having multiple types of engagement with the husbands/partners of FTMs is essential and should focus on building HTSP/FP knowledge and encouraging communication and shared decision making about FP.

D. 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.

The study highlighted the importance of FP as a means to help FTPs, especially those who were married, plan for their family—not just with regard to the number and timing of children, but also for other important areas of their lives, especially their economic wellbeing. For these young people at the start of their family lives, access to information and tools that help them plan for the long-term seems to be particularly useful and welcome. Projects interested in supporting FTPs should consider interventions that facilitate couple/joint planning for all aspects of their lives, including their reproductive intentions. Ideally, programs should also connect FTPs to other available programs and services, especially those that support income-generation and livelihoods for these young families.

E. Tap into the power of influential peers and community members to expand access to FP information, address concerns about safety and side-effects, and inspire voluntary FP use.

FTMs repeatedly noted the influence of friends and peers in shaping their ideas about FP and different contraceptive methods—both positively and negatively. For these young women, most of whom did not have access to FP information prior to the program, the experiences of others were important factors in their decisions to use FP and in their method choice. To a lesser extent, men also indicated that they were aware of FP use in their community and which methods were most popular. This suggests that FTP programs should consider tapping into peer networks to diffuse correct information about FP, work with satisfied contraceptive users to promote voluntary FP use, and address concerns (especially about future fertility and side effects).

F. Understand and engage other critical influencers of FP attitudes and behaviors, including healthcare providers, to ensure support for FTM/FTP contraceptive use.

Most of the FTMs in the study were in a relationship at the time of contraceptive use, and it was largely this partner who was involved in their decisions to use FP. However, FTMs did identify a few other individuals who influenced their FP actions, especially their mothers, mothers-in-law, and friends/peers. Programs should take the time to understand the other influential individuals for FTMs/FTPs, recognizing that these may vary for different subsets of young people (especially married vs. unmarried). Having activities that engage these different influencers is important to ensure that FTPs are supported in their decisions and actions to use contraception.

G. 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.

The contraceptive histories of FTMs and husbands/partners showed that they generally were able to access the specific methods of their choice. In sharing their experiences, they noted the value of having identified their method prior to seeking services, especially if service providers have limited time for counseling. Having a good understanding of their method choice also enabled them to handle any alternate method suggestions from providers and make their informed choice accordingly. Most importantly, FTMs indicated that having advanced knowledge of possible side effects helped them to manage these when/if they arose and continue with their method or make an informed decision to switch to another method. Especially in areas where FP service delivery may be constrained, programs should include flexible activities, like home visits, that can provide timely support to FTMs/FTPs in selecting a method that best meets her/their reproductive and life needs, and provide tailored information about this method before she/they begin use.

H. Ensure that community- and facility-based providers have the time and capacity to deliver accurate, quality FP counseling and services to young FTMs/FTPs and ensure informed, voluntary choice for contraceptive use.

Almost all of the FTMs/FTPs in this study reported obtaining their contraceptive method through a health facility, and they felt that the providers they encountered treated them well. At the same time, a few FTMs and husbands/partners shared experiences that suggest quality of care concerns, including possible gaps in provider knowledge, preferences towards certain contraceptive methods, and workloads that limited time for counseling and service provision. While the study could not validate these issues, they do raise the importance of ensuring that both community- and facility-based providers have accurate information about different contraceptive methods and are able to deliver

quality services. Especially for this population, which typically has little previous interaction with the health system and may have limited resources to travel to a facility, it is important to ensure that every encounter with health providers is of high quality, that they can access FP without difficulty or delay, and that contraceptive use is both fully informed and voluntary. Programs should also consider: (1) educating providers and CHWs about the special needs of FTMs/FTPs, (2) updating their knowledge of the contraceptive methods, the timing to initiate use in the postpartum period, counseling skills, and (3) including providers and CHWs as facilitators in the peer group sessions focused on FP methods.

I. ***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.*** Finally, perhaps the most striking finding emerging from the study is the need to provide young people with FP information and services before they become parents. Most FTMs reported that prior to having a child, they did not feel that FP was relevant or appropriate for them—to the extent that they generally did not listen to or seek out information about FP or contraception. Social norms that limit FP use by both married and unmarried young women were also a factor. However, in sharing their experiences, it is clear that such information would have been useful for many FTPs, especially those who had an unplanned pregnancy. While reaching young people at this stage in their lives—as they become parents—is vital, they should ideally have access to HTSP/FP concepts and information earlier, with activities that facilitate reflection on if/how voluntary contraceptive use can support their reproductive and life goals. Providing young people with age- and lifestage-appropriate information and services and helping them develop plans and goals for their future is key to ensuring their health and the health of their future families.

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PHOTO Sala Lewis

EVIDENCE TO ACTION PROJECT

1015 15th St NW, Suite 1100
Washington, DC 20005, USA
Phone: +1 (202) 775-1977
Fax: +1 (202) 775-1998/1988

e2aproject.org

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