Expanding Method Choice, and Access to Contraceptive Information and Services for First-Time Mothers in Shinyanga District, Tanzania

August 2017
About E2A

The Evidence to Action Project (E2A) 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 September 2019. E2A is led by Pathfinder International in partnership with ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.

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This publication was made possible through support provided by the Office of Population and Reproductive Health, Bureau for Global Health, U.S. Agency for International Development, under the terms of Award No. AID-OAA-A-11-00024. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the U.S. Agency for International Development.
Acknowledgments

The Evidence to Action (E2A) Project gratefully acknowledges the generous support of the US Agency for International Development (USAID) for the creation of this report and the work it describes.

We acknowledge the following individuals for their valuable inputs into drafts of this report: Katie Chau, E2A/Pathfinder International; Anjala Kanesathasan, E2A/Intrahealth International; Laurel Lundstrom E2A/Pathfinder International; and Anna Bryant and Elizabeth Williams, E2A/Pathfinder International, for editing and formatting.

Suggested Citation:

Regina Benevides, Catherine Kahabuka and Dolorosa Duncan, Expanding Method Choice, and Access to Contraceptive Information and Services for First-Time Mothers in Shinyanga District, Tanzania, (Washington, DC: Evidence to Action Project, August 2017).
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## Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AYSRH</td>
<td>Adolescent and youth sexual and reproductive health</td>
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<tr>
<td>BWEIM</td>
<td>Beginning with the end in mind</td>
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<tr>
<td>CCHP</td>
<td>Comprehensive council health plan</td>
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<td>CHMT</td>
<td>Council health management team</td>
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<td>CHW</td>
<td>Community health worker</td>
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<td>DMO</td>
<td>District medical officer</td>
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<td>DRCHC</td>
<td>District reproductive and child health coordinator</td>
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<td>E2A</td>
<td>Evidence to Action Project</td>
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<tr>
<td>FGDs</td>
<td>Focus group discussions</td>
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<tr>
<td>FP</td>
<td>Family planning</td>
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<td>FTM</td>
<td>First-time mother</td>
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<td>FTP</td>
<td>First-time parent</td>
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<tr>
<td>HMIS</td>
<td>Health management information system</td>
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<tr>
<td>HTSP</td>
<td>Healthy timing and spacing of pregnancy</td>
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<tr>
<td>IUD</td>
<td>Intrauterine device</td>
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<td>KIIs</td>
<td>Key informant interviews</td>
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<tr>
<td>LARC</td>
<td>Long-acting and reversible contraceptive</td>
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<td>mCPR</td>
<td>Modern contraceptive prevalence rate</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
</tr>
<tr>
<td>RBF</td>
<td>Results-based financing</td>
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<tr>
<td>RCH</td>
<td>Reproductive and child health</td>
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<tr>
<td>RHMT</td>
<td>Regional health management team</td>
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<tr>
<td>RMO</td>
<td>Regional medical officer</td>
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<tr>
<td>SDM</td>
<td>Standard days method</td>
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<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
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<tr>
<td>TFR</td>
<td>Total fertility rate</td>
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<td>VDC</td>
<td>Village Development Committee</td>
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Executive Summary

Pathfinder International, through its USAID-funded Evidence to Action (E2A) Project, implemented interventions for young women, including first-time mothers (FTMs), from July 2015 to September 2016, in Shinyanga District, Tanzania. E2A tested and documented a three-pronged approach to increase uptake of family planning (FP) information and services by young women, including FTMs. The approach strengthened FP programming for young women, including FTMs, by:

1. **Structural level:** Building the capacity of health providers on youth-friendly approaches and expanding the contraceptive method mix to include long-acting and reversible contraceptives (LARCs);
2. **Community level:** Strengthening community health workers’ (CHWs’) capacity to conduct balanced FP counseling with FTMs and their male partners; sensitize other household influencers; and provide the Standard Days Method®, condoms, and oral pills during home visits and FP community awareness events; and
3. **Individual level:** Engaging FTMs as peer facilitators to lead activities with groups of FTMs that explore their decision-making processes related to healthy timing and spacing of pregnancies (HTSP), contraceptive choice, and gender dynamics.

This report summarizes key lessons learned in implementing this three-pronged approach, captured through systematic process documentation. Findings in this report will be used to sustain and scale-up interventions for FTMs in Tanzania, and inform a framework for First-Time Parents programming, on which E2A and partners are developing, and that can be used to design effective FP/sexual and reproductive health (SRH) interventions for FTMs and young sexually active women around the world.

Implementation Context

Tanzania is faced with significant SRH challenges, including a high total fertility rate, low modern contraceptive prevalence rate, and high unmet need for FP. Young women face additional vulnerabilities and barriers to accessing FP/SRH services, including limited mobility, limited access to financial resources, service providers’ negative attitudes, lack of autonomy, limited access to FP/SRH information, and limited access to youth-friendly FP/SRH services. Only 13 percent of married adolescent girls, 15-19 years, and 40 percent of unmarried sexually active adolescent girls are using modern contraception. Among young married women, 20-24 years, only 30 percent are using modern contraception. Thus, 50 percent of young women in Tanzania are either mothers or pregnant with their first child by age 19.

Documentation Methods

The process documentation of the interventions for FTMs was guided by learning questions to assess how the approach was implemented, specifically how aspects of design and implementation would hinder or facilitate sustainability and scalability of the interventions to other areas of Tanzania. The learning questions

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\(^a\) E2A and Pathfinder International define first-time mothers as young women under age 25 who are pregnant for the first time or with one child.

\(^b\) Peer facilitators were FTMs who were selected based on certain criteria to organize and lead group discussions among their peers.
were developed based on E2A’s FTP approach and the 12 recommendations of ExpandNet’s Beginning with the end in mind Framework. Through focus groups discussions (FGDs) and key information interviews (KII) with key project implementers, the documentation team assessed, at three points in time, the extent by which the learning questions were considered during the design and implementation of the FTMs interventions. The documentation team conducted 15 FGDs with frontline implementers including service providers, CHWs, and peer facilitators. Additionally, eight KII were conducted with Pathfinder International staff, and regional and district Ministry of Health representatives. Quantitative data on FTMs use of FP services were captured through the health management information system (HMIS), regular project monitoring indicators, and a community-based FP service delivery system developed by Pathfinder International.

**Summary of Key Findings**

All respondents concluded that the FTM interventions added great value to the pre-existing service delivery system. Both CHWs and facility-based providers reported that, previously, it was difficult for them to reach young women and FTMs, but peer facilitators enabled linkages between them and young women and girls. They said they observed an increase in the number of young clients seeking FP services, and reported having attended to young clients referred by peer facilitators.

Substantiating the qualitative findings, monitoring data shows that 2,559 women, 10-24 years, received counseling for FP services from CHWs during the one-year implementation period. Of these, 970 (38 percent) were FTMs. Of the 494 new or lapsed users who accepted a community-based method of FP, 202 (41 percent) were FTMs, and of the 363 young women referred for a facility-based method, 145 (39.9 percent) were FTMs. New or lapsed users refers to clients who did not report using a Family Planning method at the time of registration with a CHW. The number of new or lapsed FTMs who accepted a FP method increased throughout the period, increasing from 41 FTMs accepting a method during the first quarter to 77 FTMs accepting during the fifth quarter. Also, in line with the qualitative findings, FTMs referred for a facility-based method expressed a preference for injections. The number of FTMs accepting LARCs remained low and stable, with few FTMs accepting intrauterine devices (IUDs) as compared to implants.

Both service providers and CHWs said they greatly appreciated the training they received on how to effectively offer FP/SRH services to young women and FTMs, specifically in fulfilling the specific needs of the different subgroups of young women. The training for service providers on LARCs facilitated several facilities to start offering LARCs for the first time. Respondents all mentioned that enhanced collaboration among CHWs, service providers, and regional/district health managers strengthened supervision and coordination systems, leading to improved service quality, provision, and access. FTM peer facilitators, CHWs, and service providers described the following as the key learnings and recommendations for effective implementation and scale-up of the FTM interventions.

**Lessons Learned & Recommendations**

**Ensure peer facilitators have requisite knowledge, support, and tools to effectively lead peer groups:** To help them better respond questions from their peer group participants, peer facilitators said they wanted to receive comprehensive training to learn about all contraceptive methods as well as better facilitation skills so that they can confidently educate their peers. Peer facilitators mentioned that some
FTM households were too far to reach, especially without any means of transport. They also said FTM
were busy with cash-generating activities, sometimes leading to poor attendance at peer group meetings.
Peer facilitators recommended that the program provide them with means of transport and incorporate
income-generating activities for the young women, such as loan funds or other entrepreneurship activities,
which would reduce dependence on the fathers of children of FTM. Peer facilitators reported that the
activity cards which used stories to prompt questions were easy to use and understand, while the cards
that prompted group members to act out dramas were liked by younger FTM and students, but disliked
by older youth and pregnant women. They mentioned that they could have used additional tools, such as
books, fliers or flip charts with pictures, and teaching models for demonstration. They cited the need to
have all tools in local languages.

**Address barriers to FTM using FP/SRH services:** Peer facilitators said their group members
reported several barriers to use of FP/SRH services that need to be addressed for effective implementation
of interventions for FTM: judgement by community and family members, fear of side-effects, long
distances to healthcare facilities, lack of resources for transport and services, poor treatment by providers,
and beliefs in myths and misconceptions related to FP.

**Tailor messages and services to meet the needs of different groups of young women/FTMs:**
CHWs reported two messages as effective in advising *young unmarried girls* to consider a contraceptive:
1) the method would help avoid unplanned pregnancies and increase chances of successfully completing
education; and 2) descriptions of complications associated with teenage pregnancies, including risk of
death. Three key messages were reported as effective in advising *young married women* to consider a
contraceptive: 1) having time to work and contribute to family income, including helping the mother-in-
law and/or mother in household and farm activities; 2) giving the couple enough time for their children
and themselves; and 3) advising about the consequences and costs related to teenage pregnancies among
spouses and in-laws. In terms of service provision, many young women told peer facilitators they preferred
to receive FP/SRH services from younger and female providers rather than their older, male counterparts.
They expressed a strong need for confidentiality, both from the service provider and from the point of
service provision, which they preferred not be accessed by adult clients simultaneously.

**Improve collaborative mechanisms between CHWs and service providers:** CHWs expressed
need for collaboration with facility-based providers in two ways: giving priority to FP clients as other
clients, and filling referral notes of clients so they could be returned to the CHWs and examined for
feedback on their experiences receiving services.

**Ensure well-equipped health facilities, including adequate commodities, training, and client
confidentiality:** Some service providers reported lack of IUD kits and insufficient sterilization equipment.
Additionally, some facilities did not have service providers trained in LARCs provision. Many FTM did
not want to spend much time at the facilities because they feared being seen, resulting in some leaving
without being attended. Some service providers reported tackling this challenge by identifying young girls
seeking FP services and attending them as soon as they could. Other service providers reported allowing
young girls to come during late afternoon hours and on weekends.
Engage family members and male partners to reach FTMs with FP/SRH services: Peer facilitators, CHWs, and service providers mentioned resistance from family members, including parents, spouses, and in-laws, as a main barrier to young women’s utilization of FP/SRH services. Among the established reasons for such opposition were myths and misconceptions about contraception, and the idea that their wives, daughters, and daughters-in-law would become prostitutes if they used contraception. Therefore, it was necessary for community-based interventions to focus on FP/SRH education and discussion of outdated social norms. Recommended approaches proposed for reaching various family and community members with FP/SRH education include: providing FP/SRH education through community and religious leaders, distributing brochures and posters with FP/SRH messages, educating women who bring their children for vaccination, and engaging respected elderly men to teach older men about FP/SRH. Among family and community members, the most opposition to FP came from men, particularly spouses of FTMs. This report details multiple approaches for reaching men with FP/SRH information and services.
I. Introduction

Pathfinder International’s community-based family planning (FP) programs began in Shinyanga District of Tanzania in 2004. Since then, Pathfinder has worked closely with the national Ministry of Health (MOH) and local government authorities to recruit and support community health workers (CHWs) in five districts to: counsel clients on a full range of FP methods; offer short-term methods (e.g., combined oral pills, progesterone-only pills, and male and female condoms); and refer clients who opt for clinical methods (implants, IUDs, injectables, permanent methods) to a health facility.

The FTMs program build on the Standard Days Method (SDM)/CycleBeads Project implemented by Pathfinder International/E2A in the Shinyanga Region from 2013-2016. Through the E2A Project, Pathfinder International trained and supported 230 existing CHWs and their 32 facility-based supervisors to use the Balanced Counseling Strategy to counsel women on all methods, provide non-prescriptive methods (including SDM using CycleBeads), and offer referrals to facilities for clinical methods. A mobile phone app was used by the CHWs to counsel and refer, and for monitoring, supervision, data collection, and reporting.

The SDM project sought to increase contraceptive prevalence in Shinyanga District Council through introduction of a new method—SDM using CycleBeads. From 2015-2016, Pathfinder Tanzania, also through E2A, implemented approaches to reaching young women, including first-time mothers (FTMs), with contraceptive information and services through engagement of the existing 230 CHWs and 32 facility-based provider supervisors, as well as FTMs, themselves, as peer facilitators.

This technical report describes the approaches used to reach FTMs and young women with FP/SRH services. The report was developed through a documentation process that included focus group discussions (FGDs) and key informant interviews (KIIs) with frontline implementers, including CHWs, FTM peer group leaders, and facility-based providers, as well as program staff and government counterparts. Findings in this report will inform sustainability of the interventions for FTMs in Shinyanga District and scale-up of the interventions throughout the Shinyanga Region and nationally.
II. Background and Implementation Context

**National**

**Adolescent SRH in Tanzania**

- Almost 2 out of 5 girls are married before reaching 18 years. ¹
- 9% of young women, 15-24, have had sex by age 15, and 50% have had sex by age 18. ²
- Only 13% of married adolescent girls, 15-19 years, and 30 percent of young married women, 20-24 years, use a modern contraceptive. ²
- Unmet need for FP among adolescent girls, 15-19 years, increased from 16% in 2010 to 23% in 2015/2016. ² ⁴
- 50% of girls were pregnant or already had a child by age 19 in 2014/16, a slight increase from 44% in 2010. ² ⁴
- 27% of females who gave birth before age 20 said they would have preferred to have waited. ⁴

Tanzania faces significant sexual and reproductive health (SRH) challenges, including a high total fertility rate (TFR), low modern contraceptive prevalence rate (mCPR), and high unmet need for family planning (FP). According to the 2015/2016 Tanzania Demographic and Health Survey, the TFR in Tanzania is 5.2 live births per woman, 32 percent of married women use a modern method of FP, and 22 percent have an unmet need for either spacing or limiting births.

Young people, representing slightly over 30 percent of the total population, are especially affected by these challenges. Only 13 percent of married adolescent girls, 15-19 years, and 30 percent of young married women, 20-24 years, use a modern contraceptive. Moreover, 23 percent of married adolescent girls, 15-19 years, and young women, 20-24 years, express an unmet need for FP. Among all unmarried sexually active adolescent girls 15-19 years, 40 percent are using a contraceptive method, and among all unmarried sexually active adolescent girls in union, 15 percent are using a method of contraception. Thus, 50 percent of young women in Tanzania are either mothers or are pregnant with their first child by age 19.² In Tanzania, several policies are in place that continue to inhibit uptake of FP services, especially among FTM and other young women.

- CHWs are not allowed to offer injectables in Tanzania
- The government does not allow provision of FP information and services in schools
- The current HIV testing policy does not allow HIV testing among minors (under 18 years) without parent/guardian consent
- Current law requires adolescents below the age of 16 need parental consent to receive FP services or an HIV test, unless they are married or have children
- All service providers are directed, under a new health law, to prioritize older people for health services, including FP
- The expulsion and denial of education rights to child mothers in Tanzania ³

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³ This law has garnered increasing visibility in local and international media. In 2010 the Ministry of Education and Vocational Training clarified that there was no official policy preventing girls from returning to school after giving birth, and produced guidelines to help schools understand their responsibilities to girls who become mothers (5).
In addition to these policy challenges, the reasons for the poor SRH indices in Tanzania are similar to those in other developing countries: human resource shortages, which pose a critical barrier to health service accessibility, especially in rural areas; low quality and high cost of care, further inhibiting service utilization; under-prioritization of FP in the government’s sector-wide approach for health sector financing; and chronic stock-outs of commodities, especially in rural settings. Young women face additional barriers, including limited mobility, limited access to financial resources, lack of autonomy, limited information about SRH and FP, and limited access to youth-friendly FP/SRH services.

Based on these challenges and experience working in the underserved communities of Shinyanga Region, Pathfinder International implemented the program, “Expanding method choice within a community-based family planning program to first-time mothers (FTMs) in Shinyanga District Council of Tanzania.” The program, implemented through Pathfinder’s USAID-funded Evidence to Action (E2A) Project, sought to expand access to and utilization of FP/SRH services among young women of Shinyanga, with a focus on FTMs—young women under 25 who are pregnant or have had one child. Pathfinder and E2A originally aimed to reach first-time parents (FTPs), but due to limited time of the project, the intervention focused on FTMs, rather than the FTMs and their male partners. Their partners were reached only through counseling during community health workers’ (CHWs) house visits.

**Shinyanga Region**

The Shinyanga Region of Tanzania is primarily rural. Sociocultural issues and weak health infrastructure impede women’s access to FP services. The TFR in the Lake Zone, of which the Shinyanga region is located, at 6.4 children per woman, exceeds the national average of 5.2. The region was ranked second (after Mbeya) for the number of girls who dropped out from secondary school due to pregnancy (4, 5). The region has a very youthful population, with more than 19 percent of people between 15-24 years and about 48 percent under the age of 15 years. Furthermore, Shinyanga is a drought-prone region with high food insecurity.

Shinyanga District Council, where FTM interventions were implemented, is one of the six councils in Shinyanga Region, situated at the center of the region. Administratively, it is divided into 4 divisions, 26 wards, 117 villages and 685 hamlets, and it has a total population of 362,884. The council has 39 health facilities, 4 of which are health centers and 35 are dispensaries. All 39 health facilities provide reproductive and child health (RCH) services including prevention of mother-to-child transmission (PMTCT) option B+. In addition, regular outreach clinics provide immunization services. At the time of program inception, there were 102 health providers (64 skilled providers) in the 39 health facilities of Shinyanga District Council. Of the skilled providers, 36 had been trained to counsel on and provide short-term methods and

Per the guidelines, schools must re-admit girls after they have given birth; however, girls may still be expelled as soon as their pregnant status is revealed because their presence in the classroom is often regarded as disruptive and setting a bad example. Pregnant girls are permitted to take examinations, although they are clearly at a disadvantage because they are deprived of classroom teaching.

d FTPs are defined as young women under 25 who are pregnant or have had one child, along with their male partners.

e Health providers with certificates and above who can be trained for LARC and PM.
only 12 had been trained to counsel on and provide long-acting reversible contraceptives (LARCs). Shinyanga District Council has 126 villages and the FTMs program covered 64 villages (52 percent).

Rationale for reaching FTMs

Evidence shows that both mothers and babies are healthier if at least 24 months elapse between last birth and next pregnancy. Young mothers have special needs in this regard. Norms around fertility, inequitable gender norms, and associated provider assumptions and practices lead young mothers to have closely spaced pregnancies, compromising their health and that of their newborns, and diminishing their opportunities.

E2A’s literature review\(^f\) showed that very little programming has been dedicated to spacing second and subsequent pregnancies by at least 24 months among young mothers, despite the enormous need. The literature reviews points to several cultural, economic, and programmatic issues that need to be addressed to encourage the healthy timing and spacing of pregnancies (HTSP) among FTMs. A technical consultation\(^h\) held by E2A on the topic proposed a broader definition for FTMs/FTPs\(^i\), and pointed to the need to develop an integrated, comprehensive framework to address the specific needs of this FTMs/FTPs and encourage HTSP. Evidence from the FTM interventions in Shinyanga District Council will inform the final iteration of that framework.

III. Programmatic Approach: FTMs Program

In Shinyanga District, E2A tested and documented a three-pronged approach. The approach strengthened FP programming for young women, including FTMs, by:

1. **Structural level:** Building the capacity of health providers on youth-friendly approaches and expanding the contraceptive method mix to include long-acting and reversible contraceptives (LARCs);
2. **Community level:** Strengthening community health workers’ (CHWs’) capacity to conduct balanced FP counseling with FTMs and their male partners; sensitize other household influencers; and provide the Standard Days Method®, condoms, and oral pills during home visits and FP community awareness events; and
3. **Individual level:** Engaging FTMs as peer facilitators to lead activities with groups of FTMs that explore their decision-making processes related to healthy timing and spacing of pregnancies (HTSP), contraceptive choice, and gender dynamics.

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\(^i\) Young women under 25 years who are pregnant or already have one child and their partners
The approach was based on Pathfinder’s FTP strategies in other countries (PRACHAR, GREAT, FTP in West Africa), but was adapted and tested for the Shinyanga context.

**Figure 1. Socioecological model: project design**

![Socioecological model: project design](image)

**IV. Programmatic Aims and Objectives**

The programmatic strategy sought to reduce unintended/unwanted pregnancies by increasing access to broader FP method choice for young women who are currently pregnant or already with one child. The project’s main objectives are described below.

**Objective I: Improve counseling and skills for LARC insertion and removal, including infection prevention, and capacity to provide FTM s counseling on HTSP among facility-based providers at dispensaries and health centers.**

Activities under this objective aimed to increase the capacity of service providers to provide LARCs in facilities and to support outreaches to underserved facilities, leveraging ongoing support from other partners. E2A/Pathfinder selected and trained 40 providers from 39 facilities in the provision of a broad mix of contraceptive methods, focusing on LARCs. The training emphasized the importance of dual protection, HTSP, and full compliance with relevant USAID and Government of Tanzania guidelines. In selecting the providers for training, priority was given to facilities: with a large catchment population of women of reproductive age/potential FP users, including a substantial proportion of young women; at which E2A support was already being received and CHWs had already been trained in basic FP methods and were referring clients; with less than two providers trained in LARCs provision; in areas of the Catholic health centers where no modern FP methods were provided, except for SDM).

The 40 providers received a supplemental two-day training on SRH counseling and services for young women (10-24 years), and were oriented on the mobile phone-based Balanced Counseling Strategy used by Pathfinder’s ongoing community-based SDM project in Shinyanga Region. As supervisors of the CHWs and mobile outreach teams, facility-based providers needed to be familiar with the phone-based
application. Additionally, the phone-based application has robust data collection and reporting capabilities that monitor, track, and report the activities of the CHWs through collection of data on service utilization, method switchers, and referrals made by CHWs for various services, among others.

E2A supported facility-based supervisors to provide continuous, on-the-job reinforcement and updates for service providers on FP counseling and service provision during joint supportive supervision visits, and monthly meetings with facility-based providers and CHWs.

**Objective II: Improve the capacity of CHWs to create demand for and increase access to a comprehensive package of quality services, information, and counseling on HTSP for FTM s.**

Activities under this objective aimed to build the capacity of the existing CHWs in Shinyanga District Council to conduct outreach, home visits, and counseling with FTM s and key influencers. E2A/Pathfinder selected 64 CHWs for these interventions. CHWs in each village were selected from a pool of CHWs already working with Pathfinder. A majority of CHWs were selected through applications and interviews conducted by the Pathfinder/E2A FTM s Program Coordinator, in collaboration with the village leaders and the health facility in-charge. The CHWs were selected using pre-identified criteria: applicant’s ability to read and write, ability to respond to questions (intelligence/cleverness), and applicant’s perception of the FTM s program. This led to selection of one CHW from each village where the FTM s program was implemented. This process was preferable to selection by village leaders, as some of the village leaders would favor their close family members and relatives who did not necessarily meet the right criteria. A minority of the CHWs were selected by the MOH.

CHWs were trained on rights-based, youth-friendly, and gender-sensitive approaches to FP/SRH/HTSP. CHWs also received a supplemental training in conducting home visits and providing counseling to FTM s and their key influencers, including husbands and in-laws. The trainings were designed based on adapted versions of Pathfinder International’s training module on conducting home visits and counseling for young married women and FTP, and key influencers.¹

Following the trainings, the CHWs were supported to conduct community-based outreaches and home visits with young mothers, particularly FTM s, to share information about HTSP, and encourage communication between couples about fertility choices and household decision making about FP, thereby contributing to demand generation for FP/SRH services. CHWs participated in integrated immunization outreaches to create opportunities to offer and increase access to FP/SRH services.

In terms of collaboration with health facilities, CHWs collected FP methods from service providers and referred clients to service providers for LARCs. MOH service managers supervised the service providers, while the service providers in turn supervised all the activities implemented by the CHWs, and the CHWs supervised the activities that were implemented by the peer facilitators. Service providers were supposed to send feedback to the CHWs about the services they offered to referred clients. CHWs met monthly with their supervisors at health facilities to discuss reporting and challenges.

¹ Trainings for CHWs were designed and adapted using Pathfinder’s guide: *Providing Reproductive Health Services to Young Married Women and First-Time Parents in West Africa: Training for Community Health Workers.*
Objective III: Create an enabling environment and sustainable conditions to provide wider access to FP services, with a focus on young mothers and FTPs, through the VDC, community engagement of key leaders, and strengthening referral linkages between facilities and CHWs.

Activities under this objective sought to leverage ongoing demand- and supply-side investments of the SDM project and other partners to expand demand and access to a wider contraceptive method mix. Existing investments included those in outreach immunization; antenatal care; HIV prevention, care and support; and other SRH and child care services conducted by regional and district health facilities.

CHWs conducted community mobilization activities to engage with community and opinion leaders (ward leaders, religious leaders, etc.) to contribute to shifting social norms in favor of young women’s access to FP/SRH services. The CHWs, in collaboration with village leaders, helped to recruit 114 FTPs to serve as peer facilitators and facilitate FTM peer groups. Criteria used to select peer facilitators were: being a FTM, the ability to speak in front of others, ability to read and write, residence in the same village, and known to be respected in the community. Other low-priority criteria were: younger than 25 years, and having only one child or being pregnant for the first time.

E2A/Pathfinder trained the peer facilitators to develop their knowledge and skills, including a focus on HTSP, human-rights based approaches to SRH, gender and positive parenting skills, and skills to facilitate small group discussions. The most common approach used by peer facilitators to invite other FTPs to the peer groups was walking from house to house and inviting FTPs to be involved in peer group discussions. They reported that it was not difficult to identify households with FTPs in their neighborhoods. Other methods used for recruitment were inviting FTPs: during church sessions and Friday prayers in mosques, at health facilities using the RCH clinic and other services, and on their way to the farm and market. Some peer facilitators, during their house-to-house visits, asked FTPs to invite other FTPs.

The peer facilitators formed 155 peer groups, and 3,867 young women/mothers participated in the peer groups; of these, 738 were aged 10-14, 1,067 were aged 15-19, and 2,062 were aged 20-24 years. The average number of participants per group was 12. E2A/Pathfinder established referral networks to which young mothers’ groups could connect:

- Nutrition counseling and services for pregnant women, infants and children
- PMTCT services
- HIV counseling, testing, treatment and care
- Gender-based violence services

To support the peer facilitators, CHWs participated in peer group meetings when they had time and responded to the difficult questions that peer facilitators could not answer, check on peer group meeting attendance, give feedback on topics discussed, and address any issues raised by their group participants.

Objective IV: Strengthen the coordination of systematic mobile outreach services by district and regional health authorities to enhance coverage and optimize utilization of resources, including integrating SRH and FP services with immunization days.
To avoid duplication and ensure wider coverage, Pathfinder/E2A leveraged opportunities to offer an integrated health package, particularly for young women and FTMs, through quarterly coordination meetings that brought together district/regional health authorities and relevant partners involved in mobile outreach activities.

**Objective V: Support the documentation of and disseminate the FTMs strategy and contribute to scale-up within the district, region and beyond.**

E2A supported process documentation, detailed in this report, which seeks to facilitate learning for potential scale-up of the intervention. From the design of the project, E2A sought to ensure interventions were tailored to the diverse needs of the communities the project serves, and include best and promising practices that can be scaled up to meet the needs of larger populations.

E2A also sought to involve district, regional, and national health authorities from the outset. E2A worked with Shinyanga regional and district governments and other partners to identify the most pressing youth health needs and evidence gaps. The data analysis and initial qualitative information pointed toward evidence gaps in how to address teen pregnancy and reach FTMs with HTSP needs.

Regional and district health managers were then involved in the program design phase, participating in a five-day planning workshop in Bagamoyo. Further involvement of MOH officials during implementation included: sharing the project plan through existing technical working group meetings which happen quarterly; planning and implementation of the various trainings related to the project; and project monitoring and supportive supervision to service providers.

E2A designed and tested the FTMs intervention with scale-up in mind. E2A developed learning questions to generate evidence and applied ExpandNet’s *Beginning with the End in Mind* (BWEIM). A systematic documentation process was undertaken during the testing phase, creating a foundation for the next phases: adapting implementation and continuing to document learning; and supporting the implementation and scaling-up planning process.

**V. Documentation Methods**

The process documentation was guided by learning questions to assess how the FTMs approach was implemented, including aspects of the program design and implementation that would hinder or facilitate its sustainability and scalability to other districts and regions of Tanzania. The learning questions were developed based on E2A’s FTP approach and the 12 recommendations of the ExpandNet’s BWEIM Framework and the design of the program. The BWEIM Framework provides a quick overview of the scalability of a project that is being planned, proposed, or in the process of implementation. Through focus groups discussions (FGDs) and key information interviews (KIIs) with various key implementers, the process documentation team assessed, at three points in time, the extent by which the learning questions and the 12 recommendations outlined in the BWEIM Framework were considered throughout the design and implementation of the FTMs project.

The FGD and KII guides included questions to assess general perceptions about the program among the implementers, and their experiences with challenges, opportunities, and lessons learned from
implementing the technical strategy. Both FGDs and KIIs sought to create a space for collective reflection, critical thinking, and joint problem-solving, including refining the implementation of the technical strategy where necessary. Routine project indicators were also tracked.

Overall, 15 FGDs were conducted with frontline implementers, including service providers, CHWs, and FTM peer facilitators, and eight KIIs were conducted with Pathfinder staff, and regional and district Ministry of Health (MOH) representatives. The MOH representatives included the Regional Medical Officer (RMO), the District Medical Officer (DMO) and the District Reproductive and Child Health Coordinator (DRCHC). The FGDs and KIIs were conducted during the three visits to the program site by the process documentation consultant; the site visits were scheduled approximately two months apart during the implementation period.

Table 1: Process Documentation

<table>
<thead>
<tr>
<th>Process Documentation Objective</th>
<th>Participants Category</th>
<th>Respondents</th>
<th>Activity</th>
<th>Sample Size(^5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explore experiences of,</td>
<td>Frontline Implementers</td>
<td>Peer facilitators</td>
<td>FGDs</td>
<td>6 FGDs = 35 unique participants</td>
</tr>
<tr>
<td>challenges, opportunities and</td>
<td>CHWs</td>
<td>FGD</td>
<td></td>
<td>6 FGDs = 36 unique participants</td>
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<tr>
<td>lessons learned from</td>
<td>Service providers</td>
<td>FGD</td>
<td></td>
<td>6 FGDs = 33 unique participants</td>
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<tr>
<td>implementing the technical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>strategy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gather perceptions of the</td>
<td>MOH officials</td>
<td>- RMO</td>
<td>KIIs</td>
<td>6 KIIs = 3 unique participants</td>
</tr>
<tr>
<td>technical strategy among</td>
<td></td>
<td>- DMO</td>
<td></td>
<td></td>
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<tr>
<td>MOH officials, as well as</td>
<td></td>
<td>- DRCHC</td>
<td></td>
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<tr>
<td>their recommendations</td>
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<tr>
<td>towards successful</td>
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<tr>
<td>implementation of the</td>
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<td>strategy, including</td>
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<td>considerations to increase</td>
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<td>project sustainability and</td>
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<td>scalability to other districts</td>
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<tr>
<td>and regions</td>
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<tr>
<td>Document Pathfinder’s</td>
<td>Pathfinder Staff</td>
<td>- Pathfinder’s FTM Project Coordinator</td>
<td>KIIs</td>
<td>2 KIIs = 1 unique participant</td>
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<tr>
<td>experience of implementing</td>
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<tr>
<td>the FTM strategy, including</td>
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<tr>
<td>barriers and facilitators</td>
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</table>

\(^5\)One FGD was composed of the same participants that were followed up and interviewed at all the three information-gathering activities. New groups of respondents were interviewed across all the respondent categories each time. For KIIs, similar individuals were interviewed during the first and last site visit.

- During the first site visit (April 29-May 1, 2016), three FGDs and four KIIs were conducted: one FGD was conducted with each of the three frontline implementers (service provider, CHW, and

\(^1\) Refer to appendices for the interview guides used for each participant category
peer facilitators), while the four KIIs were conducted with the Pathfinder Program Coordinator, RMO, DMO and the DRCHC.

- During the second site visit (Jun 31–July 3, 2016), six FGDs were conducted; three FGDs with the same groups of frontline implementers who participated in the first round of FGDs, and three others with new groups of frontline implementers in the same categories above (service providers, CHWs and peer facilitators).
- During the third and final site visit (August 2–9, 2016), six FGDs and four KIIs were conducted; three FGDs were conducted with similar frontline implementers who participated in the first and second round FGDs, while three FGDs were conducted with completely new frontline implementers in the same three categories. The four KIIs for the third visit were also targeted to the same individuals that participated in the first round KIIs (Pathfinder Program Coordinator, RMO, DMO and DRCHC). However, while the Pathfinder Program Coordinator and RMO were available, the DMO and DRCHC were represented by their assistants because they were away in other regions.

Selection of respondents for FGDs and KIIs

Respondents for KIIs were selected purposefully based on positions/responsibilities for the program.

- **CHWs**: Selected from 64 trained CHWs through “CHW champions” engaged by the SDM Project; priority given to CHWs who had active FTM peer facilitators in their villages.
- **Peer facilitators**: Selected from 114 trained peer facilitators; priority given to those whose peer groups were active and peer facilitators who could be reached at the time of invitation.
- **Service providers**: Almost all the 40 service providers were invited to attend the FGD sessions. Participation in the FGDs mainly depended on when the service providers were trained and their availability at the time of invitation.

Limitation of the process documentation methodology

The main limitation from the process documentation was that the documentation team did not have the opportunity to speak to the FTM peer group participants themselves and solely relied on reports of FTM peer facilitators. It would have been interesting to hear from the FTMs themselves about their attitudes and experiences in being part of the peer groups.

Data management and data quality

All FGDs and KIIs were digitally recorded. The audio files were then transcribed and translated from Swahili to English before their content was analyzed. The analysis of the transcripts was conducted manually using thematic analysis.\(^k\) The analysis process began with the development of codes,\(^l\) which were primarily derived from the research questions in the interview guides. The various meaningful segments

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\(^k\) Examining and recording patterns (or “themes”) within data.
\(^l\) Meaningful segments of texts that are used for condensing and organizing extensive qualitative materials into smaller analyzable units.
of texts in the transcripts were assigned to their respective codes. Additional codes were generated as they appeared within the transcripts during the coding process. The coded data materials were then condensed into meaningful themes that are presented under the next section below on key lessons learned from implementation of the FTMs strategy.

To complement the qualitative findings generated through the process documentation, this report incorporates quantitative data on FP services utilization by FTMs. The quantitative data were captured through HMIS service statistics and regular monitoring indicators, and through a community-based FP service delivery system developed by Pathfinder International.

VI. Results: Quantitative

Contraceptive use amongst FTM group participants through peer groups

Data collected through the FGD with peer facilitators, showed a positive role of the small groups in increasing the acceptance of contraceptives. A good example is in Figure 2 which depicts the number of peer group participants who started using a contraceptive after participating in peer groups led by the 20 peer facilitators who reported it in the third round of FGD. In total, 293 participants comprised the 20 peer groups. Of these, 176 (60 percent) were using a contraceptive when joining the groups. Of the remaining 117 participants, 72 (62 percent) started using a contraceptive after 6 months of implementation. All peer facilitators reported having at least one member of their group (ranging from 1-8) start using a contraceptive after joining the group. Eleven peer facilitators led groups where 1-3 members started using a contraceptive; five, where 4-5 initiated; and three where 6-8 initiated. Consistent with the observations of service providers and CHWs, the injectable was the most commonly chosen method (adopted by 28 group participants), followed by pills (adopted by 19 group participants). The type of contraceptive adopted was not reported for six FTMs (all belonging to the same peer facilitator).

There was no difference in the number of new FP adopters in groups led by peer facilitators who reported having ever used contraceptives compared to those who had never used FP methods.

Figure 2. Number of FTMs newly adopting contraceptives through peer groups (n=72)
In total, data on contraceptive use was obtained for 1,881 out of the 3,867 (49 percent) FTMs who participated in peer groups. Of these, 289 (15 percent) reported using a contraceptive when joining the groups. By the end of the program, 614 (39 percent) of the 1,592 FTMs who were not using a contraceptive when joining the groups had adopted a contraceptive.

**Figure 3: Contraceptive use and uptake amongst FTM peer group participants (n=1,881)**

- FP use at start of peer group
- Adopted FP method during implementation
- No FP method used

**Preferences and trends in contraceptive use among FTMs in the program area**

**Contraceptive use amongst FTM at community level**

The following indicators include those derived from FTMs in the program area, including those not participating in the peer groups. During the one-year intervention, of the 2,559 women, 10-24 years, who received counseling for FP services through CHWs, 970 (38 percent) were FTMs. 857 new or lapsed users accepted or were referred for a contraceptive method; 494 were through community distribution and 363 were through facility referrals. Of the 494 new or lapsed users who accepted a community-based method, 202 (41 percent) were FTMs, and of the 363 new or lapsed users referred for a facility-based method, 145 (39.9 percent) were FTMs. The number of FTMs counseled for FP stayed consistently high: 92 FTMs were counseled during the first project quarter and 239 FTMs were counseled in quarter five (Figure 4).

**Figure 4: Percentage of FTM counselled, new acceptors at community level, and referred to facilities by CHW**

<table>
<thead>
<tr>
<th>Proportion of 10-24 year old clients counseled by CHW who are FTM, in Shinyanga Region (n=2559)</th>
<th>Percentage of new or lapsed 10-24 yo clients initiated on non clinical FP methods by CHWs, by parity (n=494)</th>
<th>Percentage of new or lapsed 10-24 yo clients referred for facility based methods by CHW, by parity (n=363)</th>
</tr>
</thead>
<tbody>
<tr>
<td>62% First Time Mothers 38% Other Clients, 10-24</td>
<td>59% FTM 41% Other Clients, 10-24</td>
<td>60% FTM 40% Other Clients, 10-24</td>
</tr>
</tbody>
</table>
Contraceptive use among FTM at facility level

Figure 5 depicts the number of FTM opting for facility-based methods. The number of new or lapsed users referred for facility-based method doubled, from 41 FTM in the first quarter to 77 FTM in the fifth quarter. Also, consistent with qualitative findings, most FTM referred for a facility-based method were referred for an injectable. On the other hand, and in contrast with the qualitative findings, the number of FTM referred for LARCs remained low and stable throughout the program year with extremely few FTM accepting IUDs as compared to implants. It was registered that only 1 FTM was referred for an IUD, while 18 were referred for an implant.

**VII. Key Findings: Qualitative Process Documentation**

Through collective reflection and exchange among frontline implementers and services managers, the process documentation team identified several factors that influenced access to and utilization of FP/SRH services by FTM. The following sections summarize key findings, including what were identified as the best approaches for addressing FTM’s SRH needs.

**Trends in FP use among young girls and FTM**

Both CHWs and service providers noted a significant increase in the number of young women and FTM seeking FP services as well as those choosing LARCs. A higher incidence of young women choosing LARCs was observed in both new FP adopters as well as method changers, i.e. those who were on short-term FP methods such as injectables, but switched to LARCs.

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SDM, condoms and oral pills were provided to clients by CHW and not referred to a facility, if these were their choices.
“I personally noticed the increase of clients who need LARCs. I did not see anybody who wanted LARC methods such as IUDC before, but currently we have six clients with IUD.” (CHW)

“It’s true that most of women have shifted from using injectable method to Implanon compared to the past where they preferred injectable method. It is a big change because in the past it was difficult to get such clients who want Implanon.” (Service Provider)

Among reasons mentioned for the increase in use of LARCs was the fact that women who started using such methods became champions by informing other women in the community about the advantages of LARCs. It was reported that in the past almost none of the women used LARCs, hence, there were no real examples from which other women could learn.

Another striking finding in relation to trends in FP use among young women and FTMs, reported by both CHWs and service providers, was the fact that some parents started supporting and even escorting their daughters for FP services. Both CHWs and service providers said they hardly ever saw such scenarios in the past.

“For those who went for outreach about two months ago, there was one man who brought his two daughters (age 16 and 14 years) for FP services. These became good champions within their school.” (Service Provider)

“I personally experienced three parents bringing their children for the services. They were mothers of these clients. These children were secondary school students aged between 15-17 years.” (Service Provider)

In line with the second quote above, there was also a reported increase in the number of secondary school students seeking FP services as compared to previous years.

“Another thing that I consider as a change is the increase of secondary school students who want Implanon…you can now have 2 to 3 students per week as FP clients. The students are now free to use FP methods as compared to the past where they thought these FP services were spared for those who have families or those who have children.” (Service Provider)

**Structural Level Interventions**

Structural-level findings reflect the capacity of health providers to offer youth-friendly approaches and a full range of contraceptive methods, including LARCs, to FTMs and other young women.

**Service provision to FTMs**

When they offered FTMs FP/SRH services, service providers reported offering them: education on safe motherhood, including risks of teenage pregnancy; appropriate nutrition for babies, including breastfeeding techniques; and advice on regular check-ups for FTMs and their babies. In addition, service providers reported offering psychological support to young expectant mothers.

Service providers mentioned two key differences when attending married vs. unmarried young mothers. First, they reported stressing dual protection, i.e. condom use, among unmarried but not married mothers, and secondly, married women were counseled to bring their partners, while this was not usually the case
for unmarried women. They added that unmarried girls were very shy and did not want to be seen seeking FP services, while married girls were more confident in seeking FP/SRH services.

Service providers reported facing several challenges in attending FTMs for FP/SRH services. They said young unmarried girls and women under age 20 did not wish to be seen seeking FP services. Many did not want to spend much time at the facilities, which resulted in some of them leaving without being attended out of fear of being recognized. Some service providers reported tackling this challenge by trying to identify young girls seeking FP services at their facilities and attending them as soon as they could. Other service providers reported allowing young girls to schedule visits during late afternoon hours and on weekends when there were fewer people at the facilities. Although many girls and young women did not want to be seen or mix with adult FP clients, almost all facilities were reported as not having a dedicated room for adolescents.

Other challenges included: language barriers (some clients spoke Sukuma and service providers did not), and lack of IUD kits and sterilization equipment, at times posing risk of infection transmission.

Service providers also had to address the issue of family members who opposed their spouses and daughters using FP. To address this challenge, service providers reported requesting the clients to bring these family members to the facility. At the facility, such family members were educated on advantages of FP use, both generally and specifically to that client. Service providers said most of the time family members responded positively to this and expressed their support for their spouses and daughters using FP.

Through ongoing discussions with service providers, CHWs, MOH officials, and peer facilitators, the following additional challenges were reported facing FTMs when accessing FP/SRH services. Although the program worked to resolve these challenges through regular supportive supervision visits with providers, challenges remain and need to be addressed to sustain FP/SRH services for FTMs and scale-up to other regions:

- Girls were denied FP methods because they were too young and had never given birth
- Although contraceptive services are generally free, some young mothers reported leaving facilities without a method because they were asked to pay
- Health workers at facility level mocking girls, hence discouraging them from using FP service
- Bad language among service providers

<table>
<thead>
<tr>
<th>Respondents reported the following false beliefs/fears of communities which hinder FP use among FTMs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- One may not be able to conceive again after using contraception</td>
</tr>
<tr>
<td>- If one uses an injectable method, she will get a disabled baby once she becomes pregnant</td>
</tr>
<tr>
<td>- Many parents thought their daughters would become promiscuous if they used FP methods</td>
</tr>
<tr>
<td>- Implants may get lost within the body and cannot be removed</td>
</tr>
<tr>
<td>- Some young mothers feared that if they did not bear enough children as quickly as possible, they would be divorced or their spouse would marry another woman</td>
</tr>
<tr>
<td>- FTMs' fear of side-effects from contraceptive use.</td>
</tr>
</tbody>
</table>
“Another challenge is bad language of health service providers. I have received a lot of complaints about how my health providers treat these young people. They have all the trainings but they still misbehave.” (DMO)

“In the case of language, as what No.10 said… I have a vivid example although not here in Shinyanga, a girl was asked “does your mother know that you are here for FP service?” Even though at the end of the day she was provided with the method, she will think that the provider may tell her mother about it while she made it a secret.” (Service Provider)

**Collaboration with CHWs**

CHWs reported facing several challenges in terms of referring FTMs to facilities for FP/SRH education and services. They said that facilities to which clients were referred to obtain LARCs, were, at times, too far from FTMs’ homes making it impossible for them to go and obtain their method of choice. Some facilities did not have service providers trained in LARCs provision, and they reported frequent stock-outs of FP methods, including pills. They reported that when FTMs had not yet regained their menses (after giving birth) were referred for LARCs, they were denied services and told to wait until they regained their menses. One CHW told the following story:

> “There was a certain married girl aged 19 years. This woman was in lactation method of FP. After 6 months, she weaned her baby so she opted for the injectable FP method. Therefore, I referred her to the health facility. At the facility, the health provider told the girl to come back after starting her menstrual flow. This girl did not start her [menstruation] for a while and ended up conceiving unknowingly. Both the girl and her husband complained a lot because the pregnancy was unplanned.” (CHW)

CHWs also said referred clients complained of delays in being seen, and that service providers did not prioritize FP clients. They said some providers did not fill out the referral note that the client was to send back to the CHW who referred them. CHWs wished to get feedback on issues and challenges they discussed in their monthly meetings with service providers. They said that some issues needed to be relayed to higher-up officials, but they never received any feedback. Other service providers not trained by the program were reported giving very little or no support to the activities related to the FTMs strategy. Some told clients to wait for providers who received training through the program even when they were capable of providing the needed services.

**The Health System**

Implementation of services for FTMs was reported as being affected by several pre-existing health system challenges. It was reported that at some of the facilities, there were no qualified personnel to be trained on LARCs—even the in-charge was a clinical attendant. Some facilities that had trained/skilled providers in offering LARCs could not offer such methods, either due to frequent stock-outs of such methods or lack of the LARCs equipment, especially for IUD insertion.

In terms of training service providers, it was reported that, due to existing shortage of service providers, their involvement in the training significantly affected availability of services at their respective facilities.
Only one service provider was left at some of the facilities, while other facilities had to be closed when the few service providers were in trainings.

**Community Level**

Community-level findings reflect CHWs’ capacities in the following areas: 1) Conducting home visits to FTM’s homes to conduct balanced FP counseling with FTMs and their male partners, sensitize other household influencers, and provide short-term contraception and refer for LARCs; and 2) Raising awareness about FP and encouraging support for FTMs’ use of contraception at community level.

In the beginning of the Standard Days Method (SDM)/CycleBeads Project, CHWs reported conducting a census in their catchment area to collect information from each individual household. Afterward, they drew a village map that identified household location and characteristics. The map was reported as being very useful in identifying households and their location when conducting home visits. Depending on the household composition, CHWs reported using various approaches to speak to the household members. At times, they spoke to all the household members at once, such as when giving general health education, while at other times they separated various household members based on needs. CHWs stressed the importance of separating young mothers from their parents when educating them on FP/SRH issues, as most would not speak about such topics openly in front of their parents or in-laws.

CHWs said most family members—spouses, parents, in-laws, and other family members—were against young unmarried women using contraception, because they did not believe they should be having sex. Often, if they were married, as well, family members believed the young mother should be trying to have more children and not using contraception.

Among the family members, most opposition came from spouses of FTMs. CHWs used several approaches to deal with spouses of FTMs who were resistant to FP. First, CHWs reported trying to speak to and educate the spouse. If the spouse was still resistant, they would approach the FTMs when they brought their children to the RCH clinic for vaccination. CHWs reported informing FTMs at the clinic that choosing whether to use contraception was their right and that they would be the ones who would be affected by having closely spaced children.

CHWs reported using slightly different approaches when providing contraceptive education and services to unmarried vs. married FTMs. While all CHWs said, they would offer a married young mother contraceptive services without seeking for her spouse’s consent, almost all said it was crucial to obtain parental/guardian permission before offering similar services to unmarried young women. Although CHWs said parental permission was crucial for visits with unmarried young women, almost all CHWs said they would provide her with FP/SRH education and services if her parents were not at home at the time they visited the household; this approach, however, proved unsuccessful, as most of such young unmarried girls would not make their own decisions when it came to FP use.

CHWs said the main difference in attending young mothers with one child compared to those with many children was that those with one child needed more extensive counseling, since their need for more children made them more resistant to adopting FP methods. CHWs reported that young mothers with more children were more accepting and understood the FP/SRH messages easily.
CHWs gave the following recommendations in terms of delivery of community-based services.

**Home Visits**

- Ask the client which family members they wish to involve
- Never give clients false promises that cannot be fulfilled, as it makes them lose trust and thereby discontinue use of services
- Observe confidentiality, in terms of discussions with clients and what the client has told the CHW
- Use vivid examples when educating families about the consequences of poor timing and spacing of pregnancies, including positive and negative scenarios
- Start conversations by telling the family what they are doing right before mentioning things they need to improve
- Visit households at ideal times and stick to a schedule; for example, do not visit at night and do not be late
- If you are a male CHW, do not sit near someone’s wife, and if you are a female CHW, do not sit near someone’s husband
- Arrive in a presentable way, including dressing appropriately and being polite
- Conduct follow-up visits with clients, particularly to ensure that any concerns, e.g., side effects, are discussed

**Leveraging Community Platforms**

- Provide FP/SRH education through community leaders, including village executive officers, ward executive officers, and religious leaders in their meetings with community members, as family members attend such meetings
- Distribute brochures and posters about FP/SRH at key community points
- Educate women who bring their children for vaccination during outreach vaccination services on advantages of HTSP
- Engage famous elderly men as another route for reaching community members, especially other older men, with FP/SRH education

**Reaching Men**

- Visit men’s groups, e.g. boda boda stands, cafes, pool tables, etc., to provide FP/SRH education
- Request men be present during the home visit discussions
- When men escort their wives for RCH clinic, educate them on FP and child spacing
- When men come to collect condoms, teach them about FP issues
- Use village meetings as a key opportunity for reaching men
- Reach young men, aged 14-20 years, through the formation of male adolescent and youth clubs, like the peer groups for the girls

"False promises should be avoided when you visit the household. We do not provide other FP methods like Injections or IUCD, so, telling a woman you ‘ll provide transport which you can’t, should be avoided.” (CHW)
Service providers said that they greatly appreciated the CHWs, saying they provided a good link between themselves and the community. In addition to CHWs referring clients for the LARCs, service providers reported engaging CHWs to announce dates for outreach clinics. Service providers also reported playing a role of closely supervising the services offered by CHWs. They added that whenever a CHW provided any FP method to a client, the service providers could follow through their mobile phones and see all the services that were offered by the CHWs. CHWs would also call the service provider (calls were paid for by the Standard Days Method (SDM)/CycleBeads Project) when he/she referred a client, and for advice on delivery of FP services.

Service providers reported having monthly meetings with CHWs and other facility staff where concerns were discussed. CHWs brought reports to their supervisors (service providers) monthly; service providers reported reviewing the work done by the CHW in that month and providing feedback. When service providers were asked how they maintained good collaboration with CHWs, they said that they made sure that they responded to their challenges on time and that CHWs got their allowances on time. One service provider reported going a step further and initiating a CHWs’ fund that was reported being very useful by the CHWs when they needed money to repair their bicycles and even during family emergencies.

**Individual Level**

Individual-level findings reflect the engagement of FTM as peer facilitators to lead activities with groups of FTM that explore their decision-making processes related to HTSP, contraceptive choice, and gender dynamics.

**Recruitment and Training**

Peer facilitators reported facing several challenges while recruiting peer group participants. The main challenge reported by almost all peer facilitators was resistance from family members, particularly spouses, parents, and mothers-in-law, who prohibited their wives, daughters, and daughters-in-law, respectively, from attending the peer group meetings. Peer facilitators reported being asked many questions by household members, who wanted to know exactly what the peer group participants would be discussing. It was reported that when spouses, parents, and in-laws were informed that discussion topics would include FP issues, some expressed concern, and others would not allow their wives and daughters to attend the meetings. Some parents claimed that their daughters would become prostitutes if they received information on FP, while in other households, family members linked use of FP with conditions such as infertility, and giving birth to disabled children. Peer facilitators reported facing more negative reactions in households with less educated household members compared to those with more educated household members. However, some of the parents who expressed such concerns still allowed their daughters to join the groups after the peer facilitators explained how their daughters would benefit from the meetings.

Other challenges reported by peer facilitators related to recruitment were: some potential group participants demanded compensation for attending the peer group meetings, and some individuals that
requested participation did not meet the set criteria for peer group participation (women under 25 years old who were either currently pregnant or had only one child). On the other hand, peer facilitators had group members who were neither pregnant or with children, or in rare cases, men. Further discussions established that young unmarried men wanted to join the peer groups instead of married men. Presence of men was reported to affect openness among participants during the discussions initially, but later made the discussions even “hotter” as described by a peer facilitator:

“At first women were afraid to discuss some issues with men but I told them to be free as we were both learning. Currently, they are very free and they can discuss anything. By the way, the discussion is now hotter in the presence of both sexes.”

Some peer facilitators mentioned wrong timing as one of the challenges they faced during inviting potential group participants — some said they could not join the meetings until the harvest season was over. Finally, a few peer facilitators failed to reach some of the households due to distance (the program did not provide them with any means of transport).

Being a single FTM among peer facilitators was not reported as a challenge in recruiting married young mothers. It was found that all the groups had both married and unmarried participants, irrespective of the peer facilitator’s marital status.

In terms of their own training, peer facilitators reported that, while the training curriculum and most training materials were for married couples, most (around 90 percent) of the peer facilitators were unmarried. This was reported to pose a huge challenge, so it was recommended that all the training materials should be revised to have contents that accommodate both married and unmarried FTMs.

**Planning and Facilitating Peer Group Discussions**

Almost all peer facilitators reported meeting with their groups once a month; one peer facilitator reported meeting her group members twice a month after participants requested the change. Overall, attendance for the meetings was fair, with almost all the peer facilitators reporting having at least more than half of their group participants attending every meeting. Peer facilitators added that the main reasons reported for inability to attend the meetings were: being busy with farming and cash-generating activities, and fear of husbands and in-laws.

Peer facilitators said they usually agreed on the date for the next meeting at the end of each meeting with their group participants. Several said they reminded some of the group participants when the meetings approached, either through their mobile phones or by visiting them physically at their homes. Since they could not remind everyone, they reported giving priority to the following categories of group members: those who did not show up during the previous meetings, those living with their in-laws, those still attending classes, and non-student members aged 12 to 15 years. Such reminders were reported to improve attendance for the above categories of participants.

Peer facilitators reported having conducted the meetings in school classrooms, under a tree, at the village executive officer’s office, at their supervisors’ (CHWs’) homes, and at open places near playgrounds.
Peer facilitators reported several challenges in relation to planning and facilitation of the group meetings. The main challenge reported by almost all peer facilitators was their limited ability to respond to many of the more technical questions on FP raised by their group participants. All peer facilitators reported seeking for help from their supervisors (CHWs) when they were asked difficult questions that they could not answer, in which case they arranged for him/her to attend the next meeting and respond to all the pending questions. Most of the difficult questions raised by group participants were related to FP methods, including questions on various side effects and myths on contraceptives. Secondary to this challenge, peer facilitators requested to receive a comprehensive training on all contraceptive methods, and arrange for more time to discuss detailed information so that they could confidently educate their peers.

“I faced a challenge of being unable to answer some questions. My members were very active and they asked many questions. So, I had to ask the health care provider (meaning community level care provider or CHW) to help answering them.” (Peer Facilitator)

Other challenges mentioned by peer facilitators regarding planning and facilitating peer group meetings included:

- Lack of funds for transport and communication costs during planning of the group meetings, particularly for inviting/reminding participants about the meeting
- Lack of time to better hone group facilitation skill
- Lack of working tools for running the peer group sessions, such as books, fliers with pictures, and teaching models for easy demonstration
- Lack of materials for participants to read to obtain more information on what they were being taught
- Lack of copies of the activity cards so participants could easily follow what was taught (only the peer facilitators had the cards)
- Lack of exercise books and pens for participants to note what was being discussed
- Lastly, peer facilitators sometimes did not receive any feedback on the challenges that they reported to their supervisors in their monthly reports, which was reported as discouraging. Some peer facilitators reported re-writing the same challenges every month hoping that one day they would get a positive feedback

**Experience Using Activity Cards**

All peer facilitators reported using GREAT\(^n\) activity cards to facilitate their group meetings. They said that the cards were very useful, clear, and easy to use. Several admitted prioritizing cards about FP issues. They reported liking cards that started by telling stories

\(^n\) These activity cards were originally developed for the Gender, Roles, Equality, and Transformations (GREAT) Project, led by Georgetown’s Institute for Reproductive Health, and co-implemented by Pathfinder.
followed by questions. They claimed that such cards were very easy to use, as the stories were interesting and easy to understand. When asked about challenges in relation to using the activity cards, they said that while most of the cards were well understood, they needed more training before they could use cards on FP methods. Some admitted skipping some cards, such as those on such as cards on injectables and IUDs, because they were afraid that they would not be able to answer questions. They mentioned that the Swahili language used in some cards was difficult for peer facilitators to translate into their local language. Several peer facilitators reported challenges asking older group members to act out dramas in activity cards, although younger FTMs and students liked the dramas. Peer facilitators reported that none of the topics were uncomfortable to discuss with their group members. They added that they did not face any discomfort from their group participants in relation to the topics depicted in the cards.

VIII. Conclusion and Recommendations

There was an established agreement among all respondents for this documentation that the program had a great added value to the already existing CHW activities in the area to reach young girls and FTMs with FP/SRH information and services. Peer facilitators were reported as being very instrumental in reaching this age group with FP/SRH information and linking them to CHWs and service providers. Both CHWs and service providers added that previously, it was very difficult for them to reach this age group, but since the start of the peer groups, peer facilitators have facilitated linkages between them and young girls. All the CHWs and service providers participating in the FGDs reported having observed an increase in the number of young clients seeking FP services as compared to the past, and all reported having attended young clients who were referred by peer facilitators. Furthermore, both CHWs and service providers reported a growing preference for LARCs among young women and FTMs compared to the past. Several CHWs reported having referred several young mothers for LARCs to facilities offering such services.

“I think there is a great added value in having this innovation. Because some of the CHWs are older people, when they go and face these young mothers they sometimes feel shy to tell them everything. But if a peer speaks with them, it becomes easier for them to express themselves. So, using peer youth is good as they are free to each other.” (DRCHC)

Both service providers and CHWs greatly appreciated the training they received on how to effectively offer FP/SRH services to young women and FTMs. They added that the received training was very useful in fulfilling the specific needs of the different subgroups of young women and FTMs that they attended for FP/SRH services. Furthermore, the training offered to service providers on LARCs was reported as having encouraging several facilities that did not offer LARCs to start offering such methods, which brought such services even closer to the users. Both findings from the qualitative and quantitative components of the FTMs program evaluation showed an increase in use of LARCs overall, and among FTMs as compared to the years preceding the program. The reports of having more facilities offering LARCs was also praised by the district health managers:

“Some of the facilities were not providing these services before because there were no skilled personnel, but these people have covered many facilities in training of health care providers. This has helped a lot to increase accessibility of these services.” (DMO)
Enhanced collaboration among CHWs, service providers, and regional/district health managers through strengthened services supervision and coordination systems was also reported as having improved access to quality FP/SRH services, including to FTMs. On the other hand, spouses and in-laws remained the two biggest barriers towards FP use among married FTMs, while some parents of unmarried girls slowly started supporting and even escorting their teens for FP services.

The following are several key recommendations derived by E2A and Pathfinder considering the findings described in this report:

**Ensure peer facilitators have requisite knowledge, support, and tools to effectively lead peer groups:** To help them better respond questions from their peer group participants, peer facilitators said they wanted to receive comprehensive training to learn about all contraceptive methods as well as better facilitation skills so that they can confidently educate their peers. Peer facilitators mentioned that some FTM households were too far to reach, especially without any means of transport. They also said FTMs were busy with cash-generating activities, sometimes leading to poor attendance at peer group meetings. Peer facilitators recommended that the program provide them with means of transport and incorporate income-generating activities for the young women, such as loan funds or other entrepreneurship activities, which would reduce dependence on the fathers of children of FTMs. Peer facilitators reported that the activity cards which used stories to prompt questions were easy to use and understand, while the cards that prompted group members to act out dramas were liked by younger FTMs and students, but disliked by older youth and pregnant women. They mentioned that they could have used additional tools, such as books, fliers or flip charts with pictures, and teaching models for demonstration. They cited the need to have all tools in local languages. To reach distant households and facilitate their work, peer facilitators should be provided with bicycles and mobile phones (or credits for their phones) to facilitate communication among themselves, their group participants, and their supervisors (CHWs).

**Address barriers to FTMs using FP/SRH services:** Peer facilitators said their group members reported several barriers to use of FP/SRH services that need to be addressed for effective implementation of interventions for FTMs: judgement by community and family members, fear of side-effects, long distances to healthcare facilities, lack of resources for transport and services, poor treatment by providers, and beliefs in myths and misconceptions related to FP.

**Tailor messages and services to meet the needs of different groups of young women/FTMs:** CHWs reported two messages as effective in advising young unmarried girls to consider a contraceptive: 1) the method would help avoid unplanned pregnancies and increase chances of successfully completing education; and 2) descriptions of complications associated with teenage pregnancies, including risk of death. Three key messages were reported as effective in advising young married women to consider a contraceptive: 1) having time to work and contribute to family income, including helping the mother-in-law and/or mother in household and farm activities; 2) giving the couple enough time for their children and themselves; and 3) advising about the consequences and costs related to teenage pregnancies among spouses and in-laws. In terms of service provision, many young women told peer facilitators they preferred to receive FP/SRH services from younger and female providers rather than their older, male counterparts. They expressed a strong need for confidentiality, both from the service provider and from the point of service provision, which they preferred not to be accessed by adult clients simultaneously.
Improve collaborative mechanisms between CHWs and service providers: CHWs expressed need for collaboration with facility-based providers in two ways: giving priority to FP clients as other clients, and filling referral notes of clients so they could be returned to the CHWs and examined for feedback on their experiences receiving services.

Ensure well-equipped health facilities, including adequate commodities, training, and client confidentiality: Some service providers reported lack of IUD kits and insufficient sterilization equipment. Additionally, some facilities did not have service providers trained in LARCs provision. Many FTMs did not want to spend much time at the facilities because they feared being seen, resulting in some leaving without being attended. Some service providers reported tackling this challenge by identifying young girls seeking FP services and attending them as soon as they could. Other service providers reported allowing young girls to come during late afternoon hours and on weekends.

Engage family members and male partners to reach FTMs with FP/SRH services: Peer facilitators, CHWs, and service providers mentioned resistance from family members, including parents, spouses, and in-laws, as a main barrier to young women’s utilization of FP/SRH services. Among the established reasons for such opposition were myths and misconceptions about contraception, and the idea that their wives, daughters, and daughters-in-law would become prostitutes if they used contraception. Therefore, it was necessary for community-based interventions to focus on FP/SRH education and discussion of outdated social norms. Recommended approaches proposed for reaching various family and community members with FP/SRH education include: providing FP/SRH education through community and religious leaders, distributing brochures and posters with FP/SRH messages, educating women who bring their children for vaccination, and engaging respected elderly men to teach older men about FP/SRH. Among family and community members, the most opposition to FP came from men, particularly spouses of FTMs. To reach young men aged 14-20 years, consider creating male adolescent and youth clubs, like the peer groups for the girls. These would reach young males with FP/SRH education before they start families. The FTMs strategy should also pilot the feasibility of running groups with both sexes.

IX. Scalability Assessment

All too often, pilot projects or small-scale health interventions that show impressive results encounter difficulties when attempts are made to bring them to scale. One reason for this challenge is that the requirements for scaling up the intervention are rarely considered during the pilot or test phase. Although the FTMs program did not have a specific objective to scale up to other sites, it aimed to facilitate learning and adapt the approach that was scalable to other districts and regions in future. Given this, a scalability assessment was conducted along with the process documentation to ascertain the potential for possible future scale-up and where necessary adaptations were to the approach to increase its scalability.

The FTMs scalability assessment was guided by the ExpandNet’s BWEIM Framework, which includes a checklist for program designers to conduct a rapid assessment of the potential scalability of a project that is being planned, proposed, or is in the process of being implemented. The tool invites users to reflect on a series of questions related to 12 recommendations. When many elements in the checklist are assessed as positive, the scalability potential of the project is likely to be high, bearing in mind that some elements
should be accorded more weight than others; for example, the relevance of the intervention for the context.

The process documentation consultant completed the checklist with the FTMs Program Coordinator, the results of which were then shared with Pathfinder and E2A Headquarters staff for additional reflection. The following section summarizes the findings from the scalability assessment, according to the 12 recommendations set out in ExpandNet’s BWEIM.

**Engage a participatory process involving key stakeholders.**

Participatory approaches that involve government representatives, current or future implementers, beneficiary groups, and other key stakeholders facilitates ownership and commitment for an intervention. They also ensure shared decision making, which can lead to increased support among stakeholders for scale-up. Pathfinder engaged several key stakeholders throughout the FTMs project, including:

- **Region and district health officials, including the RMO, DMO, and DRCHC:** Prior to implementation, the FTMs program plan was shared through an existing technical working group meeting that happens quarterly; the meeting acts as a forum to inform regional and district health officials, as well as other NGOs, about the new and ongoing projects to solicit their inputs. The implementation progress has been shared in that meeting and challenges discussed. The regional health management team (RHMT) and council health management team (CHMT) members were also involved in the following activities for the program: planning and implementing trainings; monitoring and supervision; and tackling of challenges encountered during implementation, including challenges of supplies at the facility level. The regional and district health officials interviewed as part of the process documentation admitted being sufficiently involved in the program from introduction in the district and throughout its implementation.

- **Frontline implementers (peer facilitators and CHWs):** The program recruited and trained peer facilitators who were also FTMs. They served as champions who mobilized and sensitized other young mothers on issues related to HTSP through their monthly peer group meetings. The program also recruited and trained CHWs in offering youth-friendly FP/SRH services. These were involved in offering the various services to the FTMs and they supervised the activities run by peer facilitators. Moreover, discussions among both the peer facilitators and CHWs during the process documentation contributed to the intensive qualitative monitoring and learning process that informed project adaptations.

- **Service providers:** The program trained the MOH service providers in youth-friendly service provision. They provide SRH services, including FP services, to FTMs referred at their routine care delivery points by CHWs and peer facilitators. Service providers also supervised the services offered by CHWs.

- **Village leaders:** They were involved in selection of both the CHWs and peer facilitators in their areas, and were updated on all the ongoing project activities.

**Ensure the relevance of the proposed innovation.**
Interventions should only be scaled up if they address important public health problems, have the potential for significant public health impact, are based on available evidence of efficacy, and are feasible in the local settings where they will be implemented. As demonstrated earlier from this report, findings from discussions among respondents for this documentation, including MOH officials, indicate that the program tackles key SRH challenges not only in the program area, but also in greater Tanzania: high TFR, low mCPR and high unmet need for FP. Therefore, the program responded to felt needs in Shinyanga region, and had important relevance to efforts for improving SRH.

Furthermore, the program was based on sound evidence from Pathfinder’s previous program experience working with young married women, specifically the FTP and Young Married Women for HTSP Project in Burkina Faso. The technical strategies from this project were adapted to the Tanzanian context, building on evidence of their effectiveness.

Reach consensus on expectations for scale-up.

Despite that, the FTMs project in Shinyanga did not include a specific objective to scale up the intervention to other areas during the program’s lifespan, efforts were made to ascertain the extent by which regional and district health officials thought that the program was potentially sustainable and could be scaled-up to other districts and regions. A meeting conducted by Pathfinder in September 2016, and data analysis, established that the RHMTs and CHMTs were committed to sustain the project, including providing monthly incentives for CHWs using results-based financing (RBF) funds. Moreover, since peer groups do not utilize any costs, the MOH officials said these would be sustained for obvious reasons. For these reasons, all interviewed regional and district health officials said that the program could be easily scaled up to other districts and regions. In addition to above, Pathfinder did intentionally consider scalability in the design by incorporating a scalability assessment during project implementation.

Tailor the innovation to the sociocultural and institutional settings.

Interventions aligned with socio-cultural and institutional settings, values, and local traditions are more likely to be adopted broadly by stakeholders for sustainable scale-up. The FTMs program in Shinyanga district was built on previous Pathfinder’s experience in India, Guinea and Burkina Faso, as well as from E2A’s documentation process in Burkina Faso. The situational analysis in Shinyanga depicted that FTMs were mostly unmarried, unlike in other countries. Also, Shinyanga District is a rural and Catholic area, so training materials were adapted to the context.

Moreover, activities were run within the MOH system and utilized both MOH service managers and service providers in the provision, supervision and monitoring of the services, as described earlier. In addition, all the documents that were being utilized by CHWs and service providers in providing services to FTMs, including screening questions, were adopted from the HMIS, hence, they are in line with the existing system. In this sense, the project included in its approach to FTM the health system mechanisms that were already in place. On the other hand, in bringing new tools and approaches focusing on the specific needs of FTM, the program contributed to improved quality of service delivery.

“The introduction of FTMs project in Shinyanga will be helpful because one of the main problems in Shinyanga is teenage pregnancies which results to massive school girls’ dropout.” (RMO)
The qualitative monitoring methodology used for project monitoring and documentation created space and flexibility for routine critical reflection about the design of the project with frontline implementers to facilitate adaptations in response to sociocultural constraints or opportunities. The process documentation highlighted negative attitudes and myths on FP among mothers, male partners and the in-laws of the girls as the biggest sociocultural barrier to young mothers’ adoption of contraception. If the project were to be scaled up, it would be important to incorporate effective approaches for reaching these people with FP/SRH education and behavior-change strategies.

*Keep the innovation as simple as possible.*

Generally, the simpler an intervention, the more easily it can be implemented at a larger scale. The FTMs project in Shinyanga had three main components: 1) provision of FP/SRH information and services at the community by CHWs; 2) small peer groups for young women to create demand for the services; and 3) increased access to FP services to young women at health facilities. The project was designed, from the start, to run with the minimum cost possible. The project provided a minimal allowance to the CHWs, while peer facilitators were not paid. Moreover, all the project activities were run within the existing MOH system, utilizing supplies that were being provided by the MOH.

However simple they appear, these three components require an integrated, systemic, and systematic implementation, supervision, and monitoring process. It is possible in low-resource environments, but if the stakeholders are not fully committed it can compromise the quality of the intervention and its potential for scale-up. In Shinyanga, the process documentation established several challenges in relation to the simplicity of the project — among them, the limited knowledge and ability of peer facilitators to provide the needed education by their peers, in addition to poor training and limited working tools. Moreover, the supply side (health facilities) proved to be the most complex as a lot of challenges were reported at this level. Referred clients faced many challenges at health facilities, while referring CHWs encountered difficulties in tracking referrals due to poor collaboration among service providers.

If the FTMs project is scaled up in the future, further reflection will be required to simplify/improve the service-delivery component of the technical strategy. Efforts will need to be put into place to ensure effective linkages between the community-level interventions and the static health facilities. Several recommendations have been made regarding how to make peer groups more effective and appealing to FTMs.

*Test the innovation in the variety of sociocultural and institutional settings where it will be scaled up.*

Testing interventions in settings similar to where they will potentially be scaled up is important for planning future scale-up efforts. The FTMs innovation was tested in the type of service-delivery points and institutional settings in which it would be scaled up, like the health facilities and community. However, the innovation was only implemented in one district of one region and only in a fraction of wards. On the other hand, a high need for scale-up to other districts of Shinyanga was established through discussions among regional and district officials. The FTMs program may need to be tested/adapted in other settings before it can be scaled up at large.
**Test the innovation under the routine operating conditions and existing resources constraints of the health system.**

Testing an intervention in routine operating conditions of the Tanzanian public health system, and keeping externally provided contraceptive services that are not generally available to a minimum, can help to ensure its potential scalability. The FTM program in Shinyanga was implemented under routine Tanzanian MOH operating conditions with minimal additions. The program provided a minimal allowance to the CHWs while peer facilitators were not paid. On the other hand, contraceptive security remains a concern in Tanzania. Therefore, ensuring access to FP commodities might be a resource constraint if the intervention were brought to scale. It is important to note that introducing the program under the routine operating conditions of the Tanzanian health system highlighted several constraints that may limit access to and quality of youth-friendly SRH services, including: a limited number of providers who are trained in youth-friendly services, high workload of service providers, and lack of privacy and confidentiality at health facilities for young clients. Establishing a strong relationship with the MOH and supporting them to address these constraints would be important for scale-up.

**Develop plans to assess and document the process of implementation.**

Documenting how a project is implemented, through both qualitative and quantitative methods, can generate useful data to determine the requirements for implementing the project at a larger scale. In recognizing the dearth of evidence about programs for FTM and the potential for improving implementation through participatory documentation methodologies, Pathfinder and E2A placed strong emphasis on rigorous process documentation in Shinyanga, both quantitatively and qualitatively. While the quantitative methods were used to capture the performance in terms of the FTM reached with FP services, the qualitative methods were utilized to document the implementation processes, including factors that facilitated and hindered effective implementation. Lessons learned by engaging frontline implementers in an iterative process of reflection were used to refine some of the project activities/procedures during the pilot. The process documentation findings will inform project scale-up to other regions and districts.

**Advocate with donors and other sources of funding for financial support beyond the pilot stage.**

Scale-up requires financial resources that extend beyond the demonstration phase. Data analysis and meeting decisions confirmed that the RHMTs and CHMTs were committed to sustain the program, including providing monthly incentives for CHWs using RBF. Moreover, since peer groups do not utilize any costs, the MOH officials said these would be financially sustained, though the need of the continuation of technical assistance was a concern. All the interviewed regional and district health officials also said that the program could be easily scaled up to other districts and regions by including the minimal programmatic costs in districts comprehensive council health plans (CCHPs).

**Prepare to advocate for necessary changes in budgets, policies, regulations, and other health system components.**

Successful scale-up of health interventions may require changes to policies, laws, regulations, standards, service protocols, and other health system components. Discussions of the inclusion of CHWs budget in CCHPs were started during implementation and are ongoing. Mainstreaming youth-friendly approaches at
health facilities was proposed through the trainings provided to health service providers. Moreover, to tackle the problem of FP methods stock-outs, Pathfinder and other stakeholders are working on improving forecasting and the proper use of request and requisition tools. On the program. This would mean that for the technical strategy to be institutionalized and scaled-up, it would need strong advocacy by MOH partners for SRH (and maybe other ministries) for such policies to change (refer section on policy-related challenges above for referred policies).

**Develop plans for how to promote learning and disseminate information.**

Embedding a learning agenda within pilot projects not only generates evidence of effectiveness, but also allows program stakeholders to refine how the program is implemented. This can help to facilitate future scale-up. The intensive qualitative monitoring and documentation process that was carried out by E2A and Pathfinder was designed in this spirit. The program conducted systematic documentation of the intervention using qualitative methods that complemented the routine quantitative data collected by CHWs and health providers. The process documentation produced practical information that would offer guidance for potential future scale-up efforts. There is a plan to disseminate the findings from the FTMs process documentation in a meeting with all stakeholders (MOH and other partners) where lessons will be presented and plans for scale-up made.

**Plan on being cautious about initiating scale up before the required evidence is available.**

ExpandNet’s final recommendation is to avoid prematurely scaling up an intervention before sufficient evidence is available to justify its expansion. The program did not include a specific objective for a full scale-up during the programmatic lifespan. On the other hand, the intensive process monitoring and documentation provides rich qualitative data to support possible future scale-up efforts. The additional quantitative data in terms of changes in uptake of contraceptive services and improved birth-spacing practices among young married women and FTMs would bring value to justifying possible future scale-up efforts. Pathfinder did initiate discussions among regional and district health officials regarding potential scale-up and it is envisaged that collected evidence and recommendations in this report would facilitate potential scale-up of the intervention to other regions and districts.
X. References

XI. Appendices

*Interview and Focus Group Discussion Guides*

### FGD Guide for Community Health Workers

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### Information to Participants

My name is __________________ and I am working on behalf of Pathfinder International in Tanzania. We would like to talk to you about the processes of and lessons learnt from the implementation of the first time mothers (FTMs) project in Shinyanga. The project is using process documentation to answer key questions about the experience of implementing its technical strategy to reach young married women and first time mothers (FTMs). Findings from these discussions will inform technical supportive supervision and facilitate evidence-based collaborative problem-solving between frontline implementers (yourselves and small group leaders), project implementing partners, and project managers. At the end of the project, process documents will also help implementers to understand the key moments and decisions that affected your ability to implement the strategy, as well as to develop lessons learned and recommendations for future implementers. The discussions will last about 45min to one hour. There are no right or wrong answers and we just want to learn from you and from your ideas and experiences. All of the answers you give will be confidential and will not be shared with anyone outside this group, other than members of our assessment team. You don’t have to be in the FGD, but we hope you will agree to answer the questions since your views are important. If I ask you any question you don’t want to answer, just let me know and I will go on to the next question or you can decide to leave the discussions at any time.

Are you willing to participate in the discussions?

**Obtain Consent for Voice Recording** from all participants who agree to be part of the discussions before beginning the discussions.

Exclude all potential participants who does not agree to be part of the discussions.
TAPE RECORDING CONSENT: During the discussions, I will be taking notes to record the main ideas we discuss. However, so that I do not have to worry about getting every word down on paper I will also be tape recording the whole session. Please do not be concerned about this, our discussion will remain completely confidential and will ONLY be used for this study.

Do you agree to have the discussions tape-recorded?

[IF PARTICIPANTS CONSENT TO BE RECORDED DURING THE DISCUSSIONS, SAY THE FGD LOCATION, PARTICULARS/CODE AND DATE AT THE START OF THE RECORDING]. Then, fill each participant’s information in the table 1 below and let each sign.

SET RULES:

▪ Remind respondents of the need for mutual respect and that only one person should speak at a time
▪ Ask respondents to speak louder to facilitate recording
▪ If participants have phones, ask them to switch off their cell phones as it may interfere with their concentration and sound quality
▪ Give participants numbers which they would use instead of their names during the discussions.

ICE BREAKER:

▪ Ask participants to introduce themselves
▪ Then ask them to briefly say what they like to do on their spare time!

START RECORDING AND INITIATE DISCUSSIONS BY ASKING QUESTIONS NO. 1

TABLE 1 – PARTICIPANTS BACKGROUND INFORMATION

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GROUP DISCUSSION QUESTIONS

PART I: GENERAL EXPERIENCES OF CONDUCTING HOME VISITS

1. Please describe your current activities with the LARCs/FTMs project?
Probes;
- Do you conduct any home visits with young women, including first time mothers (FTMs)?
- Do you distribute contraceptives? If yes, which ones?
- When do you refer to the health facilities?

2. How do you effectively plan and run your home visits?
Probes;
- How do you select the households to visit?
- Do you prioritize some households than others, if yes how and why?
- How often do you conduct home visits?
- How many home visits do you usually do each day?
- How often do you visit the same home?
- Do you visit some homes more frequent than others? If yes, why?
- Is there any information that you need about the household you plan to visit before conducting the home visit? If yes, what information and why is it important?
- Do you collect any information/data on FTMs when conducting home visits? If yes, what information/data do you collect?
- How do you collect the information/data above? Where do you take the data you collect? How is the collected data used?
- Do you receive data from elsewhere (probe; for data from FTMs if not mentioned).
- Have there been any challenges in collection of data, its storage and use? If yes, what are they and what has been done to address them?

3. Please describe your experience conducting home visits?
Probes;
- Can you describe how a typical home visit goes e.g. how exactly do you do it? Who is usually around when you provide FP/SRH education? Do you give this information to household members individually or as a group? In any case, how do you decide on the chosen approach?
- Are there any differences when conducting home visits to homes with young mothers who have one child compared to those with no children or many children? If yes, what are the differences?
- Are there any differences when conducting home visits to homes with unmarried compared to married young mothers? If yes, what are the differences?

4. Can you describe your experiences with family members in the homes of the young mothers that you visit?
Probes;
- What is your experience with their male partners, mothers-in-law, co-wives etc.?
- Are there specific considerations that should be taken in mind when conducting home visits to young mothers and/or engaging their family members? If yes, what are they?

5. Are you aware of any preferences among young mothers, including FTMs regarding who should provide them with SRH education and services, including contraceptive services?
Probes;
- Are there any preferences regarding sex of the CHW or service provider? Please explain.
- Are there any preferences regarding the age of the service provider? Please explain.
- What contraceptives are preferred by first time mothers? Do you know why?

6. Are there any preferences among different family members regarding how home visits should be conducted and how SRH education and services should be provided to young mothers? If yes, what are the preferred approaches? Who prefers the mentioned approach?

PART II: CHALLENGES ENCOUNTERED DURING HOME VISITS AND STRATEGIES FOR ADDRESSING THEM

7. What challenges are you experiencing in conducting home visits with young mothers (and their partners and families)?
Probes;
- What challenges do you face among male partners of young mothers during home visits? What are the key strategies that you use in addressing them?
- What challenges do you face among the mothers-in-law of young mothers during home visits? What are the key strategies that you use in addressing them?
• What challenges do you face among the co-wives of young mothers during home visits? What are the key strategies that you use in addressing them?
• What challenges do you face among mothers of FTMs?
  - Many mothers do not allow their daughters to use contraceptives despite that they have already given birth, do you know why?
  - Is there any difference in comfortability regarding contraceptives use among mothers of FTMs who are married vs. those who are unmarried?

8. What have you found to be **good strategies for engaging various family members** when conducting home visits at homes with young mothers? Please explain your answer.
   **Probes:**
   - What have you found to be good strategies for effectively engaging **male partners** of young mothers? Can you give me some examples? Are similar strategies effective for engaging educated vs. non-educated, and younger vs. older men?
   - What have you found to be good strategies for effectively engaging **mothers-in-law** of young mothers? Can you give me some examples?
   - What have you found to be good strategies for effectively engaging **co-wives** of young mothers? Can you give me some examples? Are similar strategies effective for engaging older vs. younger co-wives?

9. What are the effective strategies for engaging the community level influencers e.g. religious leaders and community leaders?
   - What challenges are you experiencing in engaging community level influencers? What strategies have you been using to address them?

10. What were the topics that were most appreciated during home visits?
    • By family members e.g. husbands, mother-in-law, co-wives, mothers of FTMs
    • By first time mothers

11. What have you found to be the most useful information/message in convincing FTMs to use family planning during the home visits? Which messages had high impact?
12. What have you found to be the **high impact messages** in gaining support for HTSP/FP among the various family members of young mothers e.g. mother in laws, husbands, co-wives etc.
   **Probes:**
   - Which messages were more effective with older husbands and which were more effective with younger husbands?

**PART III: FIRST TIME MOTHERS PROJECT**

13. Recently, Pathfinder had introduced another component to support FTP- the small groups with young mothers. Please tell us how this process is evolving in your village.
14. Do you feel there is any additional value that the peer groups are adding to the home visits that you have been conducting or do you feel homes visits and peer groups achieve similar results and only one needs to happen in a given area? Please explain your answer?
15. Please describe how peer group leaders and participants for the small peer groups were recruited.
   **Probes:**
   - Are there any other ways that these could be selected? If yes, which ways and why did you opt for the approach you used instead?
   - Were there any challenges in recruiting peer group leaders? If yes, what were they and how did you address them?
   - Were there any challenges in forming the FTMs small groups? If yes, what were they and how did you address them?
16. Are there any other challenges specific to this project?
17. Are there any additional strategies that could have brought value to the project?

**PART IV: TRAINING AND SUPPORTIVE SUPERVISION**

18. Can you tell me how were you prepared to conduct these activities?
   **Probes:**
   - Did you receive any training?
   - What were you trained on?
   - Do you feel that the training you received was sufficient and made you well prepared to attend FTMs? Please explain.
   - Reflecting back on the training you received through this project and on the experience of conducting home visits or supervising small peer group sessions, how could the training you received be strengthened for future projects?
19. Do you receive any support for the activities you conduct? If yes from whom?

**Probes:**
- Do you receive any support from Pathfinder staff? If yes, which support and how frequent do you receive it?
- Do you receive any support from the health care providers? If yes, which support and how frequent do you receive it?
- Do you receive any supervision? If yes, who supervises you? How often?
- Is there any additional support you feel you need to be better conduct home visits? (Note- if they just talk about needing money/per diem/t-shirts, etc., then probe to find out if they are other non-material needs like training, supervision, tools, etc)

20. That was my last question, is there anything else that you would like me to know in relation to what we have been discussing?

**FGD END TIME:** _______ [HRS]_______ [MIN]
Are you willing to participate in the discussions?

**OBTAIN CONSENT FOR VOICE RECORDING** FROM ALL PARTICIPANTS WHO AGREE TO BE PART OF THE DISCUSSIONS BEFORE BEGINNING THE DISCUSSIONS.

EXCLUDE ALL POTENTIAL PARTICIPANTS WHO DOES NOT AGREE TO BE PART OF THE DISCUSSIONS.

**TAPE RECORDING CONSENT**: During the discussions, I will be taking notes to record the main ideas we discuss. However, so that I do not have to worry about getting every word down on paper I will also be tape recording the whole session. Please do not be concerned about this, our discussion will remain completely confidential and will ONLY be used for this study.

Do you agree to have the discussions tape-recorded?

*IF PARTICIPANTS CONSENT TO BE RECORDED DURING THE DISCUSSIONS, SAY THE FGD LOCATION, PARTICULARS/CODE AND DATE AT THE START OF THE RECORDING*. Then, fill each participant’s information in the table 1 below and let each sign.

**SET RULES:**

- Remind respondents of the need for mutual respect and that only one person should speak at a time
- Ask respondents to speak louder to facilitate recording
- If participants have phones, ask them to switch off their cell phones as it may interfere with their concentration and sound quality
- Give participants numbers which they would use instead of their names during the discussions.

**ICE BREAKER:**

- Ask participants to introduce themselves
- Then ask them to briefly say what they like to do on their spare time?

START RECORDING AND INITIATE DISCUSSIONS BY ASKING QUESTIONS NO. 1

**TABLE 1 – PARTICIPANTS BACKGROUND INFORMATION**

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GROUP DISCUSSION QUESTIONS

PART I: GENERAL EXPERIENCES OF ATTENDING YOUNG MOTHERS FOR FP/SRH SERVICES

21. Please describe your current activities with the LARCS/FTMs project?
   Probes:
   • Do you provide FP/SRH services to young women, including first time mothers (FTMs)?
   • What else do you do in the LARCS/FTMs project?
   • Do you see any particular value in offering FP/SRH counseling and services to young mothers? If yes, what are they? If not, why?

22. Please describe your experience attending young married women, including FTMs, for FP/SRH services?
   Probes:
   iv. Can you describe how a typical consultation for FP/SRH services happens among young mothers? Where are they usually attended? Is there anybody that is usually present? Who? How long do they have to wait before receiving the services?
   v. What are the key approaches you use on counselling young mothers? Are the approaches different from counselling other women?
   vi. What contraceptives do young mothers prefer? Are the preferences the same whether they are married or unmarried? How do you feel about young mothers’ preferences of contraceptives?
   vii. What kind of methods do you offer to young mothers? (If they don’t say that they offer short acting methods and long acting methods, ask why not?) Are your decisions on which FP methods to offer the same for married compared to unmarried young mothers?
   viii. What do you think are the other specific needs of young mothers, in particular FTMs, regarding FP/SRH services?

23. Are there any differences when providing FP/SRH services to young married women who have one child compared to those with no children or many children? If yes, what are the differences?

24. Can you describe your experiences with family members of the young mother that you attend for FP/SRH services?
   Probes:
   • What is your experience with their male partners, mothers-in-law, co-wives etc.?
   • Are there specific considerations that should be taken in mind when providing FP/SRH services to young mothers?

25. Are you aware of any preferences among young mothers, including FTMs, regarding:
   i. Who should provide them with FP/SRH information and services?
   ii. Sex of the service provider?
   iii. Age of the service provider?

26. Are there any preferences among different family members regarding how FP/SRH education and services should be provided to young mothers? If yes, what are the preferred approaches? Who prefers the mentioned approach?

27. What have you found to be the most useful information/message in offering FTMs to use family planning during the consultations for FP/SRH services? Which messages had high impact?

28. What have you found to be the high impact messages in gaining support for HTSP/FP among the various family members of young mothers e.g. mother in laws, husbands, co-wives etc.
   Probe:
   • Which messages were more effective with older husbands and which were more effective with younger husbands?

PART II: CHALLENGES ENCOUNTERED IN ATTENDING YOUNG MOTHERS FOR SRH SERVICES AND STRATEGIES FOR ADDRESSING THEM

29. What are the main challenges that FTMs aged 15-24 years get in accessing FP/SRH services, and how can we address them?
30. What challenges are you experiencing in attending young mothers for FP/SRH services?
   Probes:
   • Are there any challenges you are facing from their male partners? If yes, what are they and what are the key strategies that you use in addressing them?
• Are there any challenges you are facing from their mothers and mothers-in-law? If yes, what are they and what are the key strategies that you use in addressing them?
• Are there any challenges you are facing from their co-wives? If yes, what are they and what are the key strategies that you use in addressing them?

31. What have you found to be good strategies for engaging various family members when providing FP/ SRH information and services to young mothers? Please explain your answer.

Probes:
• What have you found to be good strategies for effectively engaging male partners of young mothers? Can you give me some examples? Are similar strategies effective for engaging educated vs. non-educated, and younger vs. older men?
• What have you found to be good strategies for effectively engaging mothers and mothers-in-law of young mothers? Can you give me some examples?
• What have you found to be good strategies for effectively engaging co-wives of young mothers? Can you give me some examples? Are similar strategies effective for engaging older vs. younger co-wives?

32. What are the effective strategies for engaging the community level influencers e.g. religious leaders and community leaders?
• What challenges are you experiencing in engaging community level influencers? What strategies have you been using to address them?

33. What are the providers’ attitudes and values towards FTMs and their partners’ fertility, and contraception?
• What strategies can be used to facilitate all providers to demonstrate appropriate, nonjudgmental, and comprehensive counseling for FTMs regarding their reproductive health?

PART III: FIRST TIME MOTHERS PROJECT

34. Recently, Pathfinder had introduced another component to support FTP- the small groups with young mothers. Please tell us your involvement in this process.

35. Do you feel there is any additional value that the peer groups are adding to the home visits that CHWs have been conducting or do you feel homes visits and peer groups achieve similar results and only one needs to happen in a given area? Please explain your answer?

36. Are there any other challenges specific to this project?
37. Are there any additional strategies that could have brought value to the project?

PART IV: TRAINING AND SUPPORTIVE SUPERVISION

38. Can you tell me how were you prepared to attend young mothers, including FTMs, for FP/ SRH information and services?

Probes:
• Did you receive any training?
• What were you trained on?
• Do you feel that the training you received was sufficient and made you well prepared to attend FTMs? Please explain.
• Are you comfortable in offering LARCs to young mothers? Why?
• Reflecting back on the training you received through this project and on the experience of attending FTMs for FP/ SRH services, how could the training you received be strengthened for future projects?
• Did the training made any difference in the way you attend young mothers? How?
• Do you have any concern about providing FP/ SRH counseling and services to young mothers? If yes, what are they? If not, why?
• What do you think about offering young mothers LARCs? Are your thoughts the same if the young mother is married vs. not? Please explain your answer?
• Do you have any concerns offering LARCs to young mothers, including FTMs? If yes, what are they? Are your concerns similar if the young mother is married vs. unmarried?

39. Do you receive any support for the services you provide? If yes from whom?

Probes:
• Do you receive any support from Pathfinder staff? If yes, which support and how frequent do you receive it?
• Do you receive any support from other health care providers? If yes, which support and how frequent do you receive it?
• Do you receive any supervision? If yes, who supervises you? How often?
• Is there any additional support you feel you need to be better equipped to attend young mothers for FP/SRH services? (Note: if they just talk about needing money/per diem/t-shirts, etc., then probe to find out if they are other non-material needs like training, supervision, tools, etc)

40. That was my last question, is there anything else that you would like me to know in relation to what we have been discussing?

FGD END TIME: _______ [HRS]_______[MIN]

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**FGD GUIDE FOR PEER FACILITATORS**

**DATE OF FGD:** _____/____/_______ [DD/MM/YYYY]

**FACILITATOR NAME:** _____________________________________________________________

**NOTES TAKER NAME:** __________________________________________________________

**FIELD SUPERVISOR NAME:** _______________________________________________________

**FGD START TIME:** _______ [HRS]_______[MIN]

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**GEOGRAPHIC AND SITE INFORMATION**

**REGION NAME:** _________________________________________________________________

**DISTRICT NAME:** ______________________________________________________________

**WARD NAME:** _________________________________________________________________

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**INFORMATION TO PARTICIPANTS**

My name is __________________ and I am working on behalf of Pathfinder International in Tanzania. We would like to talk to you about the processes of and lessons learnt from the implementation of the first-time mothers (FTMs) project in Shinyanga. The project is using process documentation to answer key questions about the experience of implementing its technical strategy to reach young married women and first time mothers (FTMs). Findings from these discussions will inform technical supportive supervision and facilitate evidence-based collaborative problem-solving between frontline implementers (yourselves and community health workers), project implementing partners, and project managers. At the end of the project, process documents will also help implementers to understand the key moments and decisions that affected your ability to implement the strategy, as well as to develop lessons learned and recommendations for future implementers. The discussions will last about 45min to one hour. There are no right or wrong answers and we just want to learn from you and from your ideas and experiences. All of the answers you give will be confidential and will not be shared with anyone outside this group other than members of our assessment team. You don't have to be in the FGD, but we hope you will agree to answer the questions since your views are important. If I ask you any question you don't want to answer, just let me know and I will go on to the next question or you can decide to leave the discussions at any time.

Are you willing to participate in the discussions?

**OBTAIN CONSENT FOR VOICE RECORDING** FROM ALL PARTICIPANTS WHO AGREE TO BE PART OF THE DISCUSSIONS BEFORE BEGINNING THE DISCUSSIONS.
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▪ Give participants numbers which they would use instead of their names during the discussions.

ICE BREAKER:

▪ Ask participants to introduce themselves
▪ Then ask them to briefly say what they like to do on their spare time?

START RECORDING AND INITIATE DISCUSSIONS BY ASKING QUESTIONS NO. 1

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GROUP DISCUSSION QUESTIONS
PART I: GENERAL EXPERIENCES OF ORGANIZING AND CONDUCTING PEER GROUP DISCUSSIONS

41. Please describe your current activities with the FTMs project?
   Probes;
   • Do you organize peer group discussions among first time mothers (FTMs)?
   • Do you facilitate peer group discussions among first time mothers (FTMs)?
   • What else do you do?

42. Please tell me more about the small groups you are facilitating?
   Probes;
   xii. How many people are in your group?
   xiii. How were the participants selected?
   xiv. What challenges did you experience in forming the groups? Did anybody at the community helped you to form the groups?
   xv. What worked well and did not work well in forming the groups?

43. Please describe your experience facilitating the small group discussions?
   Probes;
   xvi. How do you/plan to invite participants for the meetings?
   xvii. How do you carry out the discussions?
   xviii. How long does the meetings last?
   xix. How often do you meet?
   xx. What themes/topics has your group discussed so far?

44. Have you used the activity cards?
   • If have used the activity cards, please share your experience using the cards? Were there any challenges? If yes, what are they and what was done to address them?

PART II: CHALLENGES ENCOUNTERED DURING FACILITATION OF SMALL GROUP DISCUSSIONS

45. What were the challenges that were reported by young mothers in your groups?
46. What are the main challenges faced by FTMs in their daily lives generally?
   • Probe on; couples’ communication and decision making in contraception use.
47. What are the key challenges faced by FTMs from their male partners, mothers-in-law, co-wives? How has they been addressing them?
48. Would you like to share a very important situation that happened in the group that you are facilitating that you think would be good for other facilitators to know?
49. Was there a situation that happened in the group that you were facilitating that you felt uncomfortable to discuss? What was it and why did you feel uncomfortable?
50. Do FTMs discuss their SRH preferences with their significant others? If yes, whom do they tell what? If not, why?
51. What other support do FTMs in your small group need?
52. Is there anything that you would like to highlight that you have learned with facilitating the groups with other young mothers?
   Probe;
   Do you feel sufficiently equipped to offer the additional support needed by the peer groups? Please explain your answer?

PART III: TRAINING AND SUPPORTIVE SUPERVISION TO PEER GROUP LEADERS

53. Can you tell me how were you prepared to conduct these activities?
   Probes;
   • Did you receive any training?
   • What were you trained on?
   • Do you feel that the training you received was sufficient and made you well prepared to attend FTMs? Please explain.
   • Reflecting back on the training you received through this project and on the experience of facilitating small peer group sessions, how could the training you received be strengthened for future projects?

54. Do you receive any support in the activities that you conduct? If yes from whom?
   Probes:
   • Do you receive any support from CHWs? If yes, which support and how often do you receive it?
• Do you receive any support from the health care providers? If yes, which support and how frequent do you receive it?
• Do you receive any support from Pathfinder staff? If yes, which support and how frequent do you receive it?
• Do you receive any supervision? If yes, who supervises you? How often?
• Is there any additional support you feel you need to be better facilitators of the small groups? (Probe to find out if they are other non-material needs like training, supervision, tools, etc.)
• How can the project better support small groups?

55. How do you collaborate with health care providers, CHWs and Pathfinder staff in the activities that you conduct?
   Probes;
   • Are there any challenges regarding the existing collaboration approaches?
   • Is there anything that could be done better? If yes, what could be improved?

56. Are there any other challenges specific to this project?
57. Are there any additional strategies that could have brought value to the project?
58. That was my last question, is there anything else that you would like me to know in relation to what we have been discussing?

FGD END TIME: ________ [HRS]________ [MIN]

KII GUIDE FOR REGIONAL AND DISTRICT HEALTH MANAGERS

DATE OF FGD: ________/_____/_______ [DD/MM/YYYY]

INTERVIEWER NAME: ______________________________________________________

FIELD SUPERVISOR NAME: ________________________________________________

INTERVIEW START TIME: ________ [HRS]________ [MIN]

GEOGRAPHIC AND SITE INFORMATION

REGION NAME: ____________________________________________________________

DISTRICT NAME: _________________________________________________________

WARD NAME: ____________________________________________________________

INFORMATION TO PARTICIPANTS

My name is __________________ and I am working on behalf of Pathfinder International in Tanzania. We would like to talk to you about the processes of and lessons learnt from the implementation of the first-time mothers (FTMs) project in Shinyanga. The project is using process documentation to answer key questions about the experience of implementing its technical strategy to reach young married women and first time mothers (FTMs). Findings from these discussions will inform technical supportive supervision and facilitate evidence-based collaborative problem-solving between frontline implementers (CHWs and small group leaders), project implementing partners, and project managers. At the end of the project, process documents will also help implementers to understand the key moments and decisions that affected your ability to implement the strategy, as well as to develop lessons learned and recommendations for future implementers. The discussions will last about 45min to one hour. There are no right or wrong answers and we just want to learn from you and from your ideas and experiences. All of the answers you give will be confidential and will not be shared with anyone other than members of our assessment team. You don't have to participate in this study, but we hope you will agree to answer the questions since your contribution is very important to this documentation. If you agree to participate, you can ask me to explain anything you don’t
PART I – PARTICIPANTS BACKGROUND INFORMATION

2. What is your professional qualification?
3. What is your current position?
4. How long have you been working on the current position?
5. What are your main roles and responsibilities at your current position?

PART II: KNOWLEDGE ABOUT AND INVOLVEMENT IN THE FIRST TIME MOTHERS PROJECT IN SHINYANGA

6. Recently, Pathfinder International besides having supported service providers’ training in LARCs, had introduced another component to its Expanding Method Choice project to support first time mothers (FTMs) to effectively space their subsequent pregnancies and live healthy SRH lives - through small groups with other young mothers.
   • Are you aware of this innovation?
   • Were you in anyway involved in the design of the project? If yes, can you tell me how?
   • Have you been involved in the implementation of the project? If yes, can you tell me how?
   • Do you think you have been sufficiently involved in this project? Why do you say so?

7. Do you feel there is any additional value that the peer groups are adding to the home visits that CHWs have been conducting or do you feel homes visits and peer groups achieve similar results and only one needs to happen in a given area? Why do you say so?
   • What do you think is the additional impact that the small groups may be able to achieve that the home visits by CHWs are less likely to achieve?

8. How have you been collaborating with Pathfinder staff towards successful implementation of the LARCs/FTMs project in Shinyanga?
   • Are there any challenges regarding the existing collaboration approaches?

9. Reflecting on your collaborative efforts to promote HTSP among young mothers FTMs through supply-side interventions at facility level (including service quality improvement, values clarification regarding AYSRH, etc.), what barriers/challenges have you observed?
10. Reflecting on your collaborative efforts to promote HTSP among young FTMs through supply-side interventions at policy level, what barriers/challenges have you observed?
11. Reflecting on your collaborative efforts to promote HTSP among young FTM through supply-side interventions at facility level (including service quality improvement, values clarification regarding AYSRH, etc.), what successes or positive changes have you observed?

understand at any time during our conversation and if I ask you any question you don’t want to answer, just let me know and I will go on to the next question.

Are you willing to be interviewed?

IF RESPONDENT AGREES TO BE INTERVIEWED, OBTAIN CONSENT FOR VOICE RECORDING AND BEGIN THE INTERVIEW.

IF RESPONDENT DOES NOT AGREE TO BE INTERVIEWED, END THE INTERVIEW.

TAPE RECORDING CONSENT: During the discussions, I will be taking notes to record the main ideas we discuss. However, so that I do not have to worry about getting every word down on paper I will also be tape recording the whole session. Please do not be concerned about this, our discussion will remain completely confidential and will ONLY be used for this study.

Do you agree to have the discussions tape-recorded?

[IF THE RESPONDENT AGREES TO BE RECORDED DURING THE INTERVIEW, SAY THE INTERVIEW LOCATION, PARTICIPANT ID AND DATE AT THE START OF THE RECORDING]

SIGNATURE OF INTERVIEWER: ______________________________________ DATE: _____/_____/______ [DD/MM/YYYY]
12. Reflecting on your collaborative efforts to promote HTSP among young FTM through supply-side interventions at policy-level, what successes or positive changes have you observed?

PART III: CONSIDERATIONS FOR SCALING UP

13. If this project was to be scaled up to other regions and districts of Tanzania, which individuals would need to be involved in regions and districts? Can you propose the best approaches for involving them?
14. Given the financial and human-resource constraint, is implementation of this innovation feasible within the Tanzanian health system? If not, what would need to happen for it to be feasible?
15. What else would need to happen for this innovation to be feasibly scaled up within the existing Tanzanian health care system?
16. That was my last question, is there anything else that you would like me to know in relation to what we have been discussing?

INTERVIEW END TIME: _______ [HRS] _______ [MIN]

KII GUIDE FOR PATHFINDER PROJECT MANAGERS

DATE OF FGD: _______ / ____ / _______ [DD/MM/YYYY]

INTERVIEWER NAME: ____________________________________________

FIELD SUPERVISOR NAME: ________________________________________

INTERVIEW START TIME: _______ [HRS] _______ [MIN]

GEOGRAPHIC AND SITE INFORMATION

REGION NAME: ____________________________________________

DISTRICT NAME: ____________________________________________

WARD NAME: ____________________________________________

INFORMATION TO PARTICIPANTS

My name is __________________ and I am working on behalf of Pathfinder International in Tanzania. We would like to talk to you about the processes of and lessons learnt from the implementation of the first-time mothers (FTMs) project in Shinyanga. The project is using process documentation to answer key questions about the experience of implementing its technical strategy to reach young married women and first time mothers (FTMs). Findings from these discussions will inform technical supportive supervision and facilitate evidence-based collaborative problem-solving between frontline implementers (CHWs and small group leaders), project implementing partners, and project managers. At the end of the project, process documents will also help implementers to understand the key moments and decisions that affected your ability to implement the strategy, as well as to develop lessons learned and recommendations for future implementers. The discussions will last about 45min to one hour. There are no right or wrong answers and we just want to learn from you and from your ideas and experiences. All of the answers you give will be confidential and will not be shared with anyone other than members of our assessment team. You don’t have to participate in this study, but we hope you will agree to answer the questions since your contribution is very important to this documentation. If you agree to participate, you can ask me to explain anything you don’t understand at any time during our conversation and if I ask you any question you don’t want to answer, just let me know and I will go on to the next question.

Are you willing to be interviewed?
PART I – PARTICIPANTS BACKGROUND INFORMATION
17. What is your professional qualification?
18. What is your current position at Pathfinder International?
19. How long have you been working on the current position?
20. What are your main roles and responsibilities at your current position?
21. What is your main roles and responsibilities in the first-time mothers (FTMs) project in Shinyanga?

PART II: EXPERIENCE IMPLEMENTING THE FIRST TIME MOTHERS PROJECT
Now, I would like to speak to you about the processes of and your experience so far from the implementation of the FTMs project in Shinyanga.

22. May you please describe the activities that have been implemented so far in line with the implementation of the LARCS/FTP project in Shinyanga?
   For each activity probe for the following:
   - Who have been involved in the activity?
   - What has been the main aims of the activity?
   - Whether the activity is ongoing?

23. If not mentioned; can you briefly describe the different kinds of training that have been offered so far, the type of individuals trained and their role for the LARCS/FTMs project?
   Probes;
   - In a nutshell, what has been the main goal and content of trainings offered to these individuals?
   - Do you feel that the trainings they received was sufficient for them to effectively perform their tasks? Why do you say so?
   - Are there any other trainings that are scheduled to happen in future in line with implementation of the FTMs project? If yes, what training, for which individuals and for what purpose?

24. Can you describe how CHWs and peer group leaders for the FTMs project were recruited?
   Probes;
   - What were the most important consideration/criteria when recruiting CHWs and peer group leaders for the FTMs project?
   - Were there any challenges in recruiting them? If yes, what were the challenges and how were they addressed?

25. Can you describe how were the participants for the small groups selected?
   Probes;
   - Were there any challenges in forming the small groups? If yes, what were they and how did you address them?

26. Are there alternative ways that CHWs, small group leaders and small group participants could have been selected? If yes, what are they and why did you opt for the approach that you used to select them?

27. Please describe how the small peer groups are evolving in different villages?

28. Overall, so far, what has worked well and what has not in forming and running the small groups?
Probes:
- Have the small groups so far reported any challenges in relation to using the activity cards?
- How effectively were the activity cards adapted to the context of Tanzania before being used?
- Are there any other challenges?

29. Do you feel there is any additional value that the peer groups are adding to the home visits that CHWs have been conducting or do you feel homes visits and peer groups achieve similar results and only one needs to happen in a given area? Why do you say so?

30. What have been done to involve community level influencers e.g. religious leaders and community leaders?
   Probes:
   - At which point where they involved?
   - How has the engagement with community leaders been going?

PART III: CHALLENGES ENCOUNTERED AND STRATEGIES FOR ADDRESSING THEM

31. What are the key challenges facing CHWs and small peer groups in different villages? How have you been addressing them?

32. Are there any specific challenges faced in working with CHWs with different background characteristics e.g. men vs. women, married vs. single, those using contraception vs. not.

33. Are there any challenges regarding the contraceptive supply (ensuring a steady supply and access to contraceptive methods)? If yes, what strategies is being used to overcome this challenge?

34. Reflecting on your efforts to promote HTSP among young FTM through supply-side interventions at facility level (including service quality improvement, values clarification regarding AYSRH, etc.), what challenges or negative changes have you observed?

35. Reflecting on your efforts to promote HTSP among young FTM through supply-side interventions at policy-level (such as pre-service training), what challenges or negative changes have you observed?

36. Are there any other challenges specific to this project?

37. Are there any additional strategies that could have brought value to the project?

PART IV: TRAINING AND SUPPORTIVE SUPERVISION

38. Can you tell me how were you prepared to conduct these activities?
   Probes:
   - Did you receive any training?
   - What were you trained on?
   - Do you feel that the training you received was sufficient and made you well prepared to effectively play your role in this project? Please explain.
   - Reflecting back on the training you received and on your experience working in this project, how could the training you received be strengthened for future projects?

39. Do you receive any support for the activities you conduct? If yes from who?
   Probes:
   - Do you receive any support from Pathfinder staff? If yes, which support and how frequent do you receive it?
   - Do you receive any support from the MOH representatives/officials? If yes, which support and how frequent do you receive it?
   - Do you receive any supervision? If yes, who supervises you? How often?
   - Is there any additional support you feel you need to be better do your work for the FTM project?
   - How do you feel about project management between the country level teams, Pathfinder HQ, and E2A?

40. Do you provide any support to CHWs and peer group leaders? If yes, what support do you provide and how often do you provide it? (probe for mentoring, supervision etc.).

41. What collaborative mechanisms exist between Pathfinder staff, CHWs, health care providers and peer group leaders working for the FTM project?
   - Are there any challenges regarding the existing collaboration approaches?
   - Is there anything that could be done better to maximize the combined impact of home visits, peer groups and facility-based youth friendly SRH services? If yes, what could be improved?

42. What collaborative mechanisms exist between pathfinder staff and MOH officials?
   - Are there any challenges regarding the existing collaboration approaches?
43. Reflecting on your efforts to promote HTSP among young FTP through supply-side interventions at facility level (including service quality improvement, values clarification regarding AYSRH, etc.), what successes or positive changes have you observed?

44. Reflecting on your efforts to promote HTSP among young FTP through supply-side interventions at policy-level (such as pre-service training), what successes or positive changes have you observed?

PART V: CONSIDERATIONS FOR SCALING UP: USE THE WHOLE “beginning with the end in mind” checklist for this section

45. If this project was to be scaled up to other regions and districts of Tanzania, which individuals would need to be involved in regions and districts? Have these individuals been involved in the design and implementation of the pilot in Shinyanga? Can you give me examples of this?

46. Has input to the project been sought from a range of other stakeholders (e.g. policy-makers, program managers, providers, NGOs, beneficiaries)? Can you give examples on this?

47. Given the financial and human-resource constraints, is implementation of this innovation feasible within the Tanzanian health system? If not, what would need to happen for it to be feasible? What is currently being done to facilitate this to happen?

48. That was my last question, is there anything else that you would like me to know in relation to what we have been discussing?

INTERVIEW END TIME: ______ [HRS] ______ [MIN]

ExpandNet Scaling-up Framework