



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

Technical Brief
April 2017

About E2A

The Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls Project (E2A) is USAID’s global flagship for strengthening family planning and reproductive health service delivery. The project is designed to reduce unmet need by scaling up best practices to ensure that women and girls receive—and use—quality services through all stages of the reproductive lifecycle. Focusing on the promotion of global support for reduction of unmet need through the scale-up of proven best practices in family planning and reproductive health, E2A promotes gender equality, healthy reproductive health behaviors, and the development of compelling evidence for family planning use in accordance with national and international guidance and frameworks, including: the Global Strategy for Women’s, Children’s and Adolescents’ Health; Ending Preventable Child and Maternal Deaths; and FP2020. An eight-year Cooperative Agreement awarded in September 2011, E2A is led by Pathfinder International, in partnership with ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.

E2A and first-time parents/mothers:

E2A has been building a body of work on first-time parents (FTP) and first-time mothers since 2013, beginning with a literature review, which highlighted the lack of programs dedicated to this vulnerable population. In 2014, E2A led a consultative process with a range of experts, defining the basic rationale and conceptual framework for targeting FTP. E2A’s work over the past two years has focused on building experience and evidence on the practical ‘how to’ of implementing FTP programs. This has included documentation of a Pathfinder International project with young women and mothers in Burkina Faso, and integrating FTP interventions into ongoing E2A programs in Nigeria and Tanzania (as described in this brief). These programs have shown that targeted FTP interventions can reduce young first-time mothers’ social isolation and increase their knowledge of and access to sexual and reproductive health services.



Introduction

In developing countries, approximately 1 in 3 adolescent girls is likely to be married by age 18. Globally, 1 in 5 adolescent girls has given birth by age 18 and in the poorest regions, the rate is 1 in 3.ⁱ Several programs have sought to delay marriage and first pregnancies among young women to improve their health and well-being.ⁱⁱ However, few programs target first-time mothers and their partners—referred to as first-time parents (FTP)*—to increase contraceptive use and promote healthy timing and spacing of pregnancies (HTSP). HTSP encourages women to delay their first birth until at least age 18 and to space their subsequent pregnancies by at least 24 months following a birth.ⁱⁱⁱ Evidence shows that the 24-month interval results in healthier mothers and babies. However, many young women in sub-Saharan African countries experience early childbearing

Box 1: First-time mothers and parents

***First-time mothers** are defined as adolescents and young women below the age of 25 years who are pregnant or have one child. **First-time parents** are first-time mothers and their partners/husbands.

and rapid repeat pregnancies due to norms around fertility, large families, and gender; inaccessibility of quality family planning (FP) services; and providers’ assumptions and practices.

Increasing access to and use of contraception is critical to reducing maternal mortality and morbidity in sub-Saharan Africa, yet 67 percent of married adolescents in sub-Saharan Africa who would like to space pregnancy for at least two years are not using any contraceptive method.^{iv} There is an urgent need to help young women, especially first-time mothers, to access

Box 2: Tanzania, national indicators

Population: 44.9 million

Population ages: 45% under 15

Total fertility rate: 5.4

Modern contraceptive prevalence, married women & girls:

15-19 years: 13.3%

20-24 years: 29.9%

Modern contraceptive prevalence, unmarried women & girls:

15-19 years: 33.1%

20-24 years: 53.9%

information and services that will allow them to make informed choices about their fertility, health, and well-being, as well as the health and well-being of their infants.

This technical brief describes the Evidence to Action (E2A) Project's FTP interventions in Shinyanga District (of Shinyanga Region), Tanzania, from July 2015 to September 2016.

Context

Tanzania's population is characterized by multiple challenges to improving sexual and reproductive health (SRH), including high fertility, minimal use of modern contraception, and significant unmet need for FP. Young women's SRH vulnerabilities are exacerbated by their inability to access FP/SRH information and services, including their limited mobility and financial resources, service providers' negative attitudes toward their uptake of services, and a lack of autonomy. Among all unmarried sexually active adolescent girls and young women, 33.1 percent of those 15-19 and 53.9 percent 20-24 years are using modern contraception; those rates decline to 13.3 percent among married 15-19-year-olds,¹ and 29.9 percent among married 20-24-year-olds.² More than half of young women in Tanzania are either mothers or pregnant with their first child by age 19.

In the Shinyanga region, SRH indicators lag behind national averages. Women in

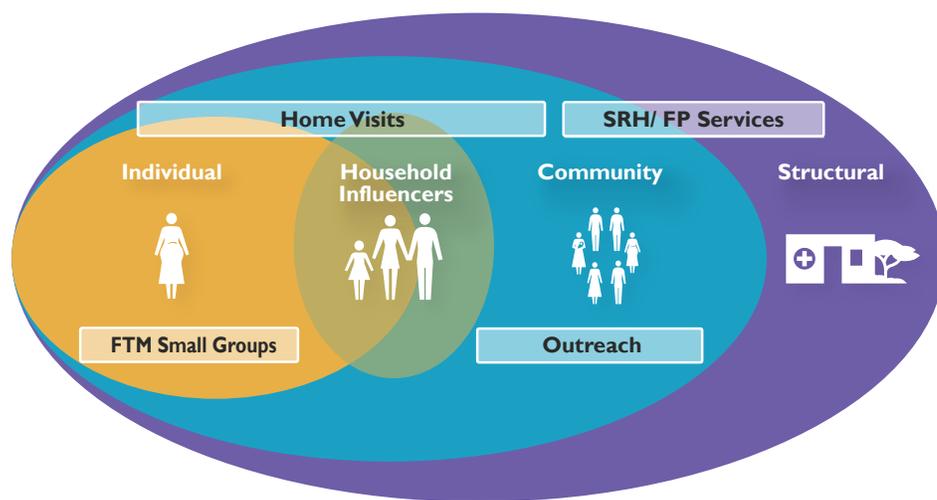
Shinyanga have more than 6 children in their lifetimes, and 34 percent of adolescent girls have begun childbearing. Shinyanga is a rural and largely Catholic community with inadequate health infrastructure, significant challenges to FP service delivery, and socio-cultural issues that impede women's access to FP services.³

Technical Strategy: Design and Implementation

E2A tested a three-pronged approach that worked at individual, community and structural levels to strengthen FP/SRH programming for young mothers in Shinyanga. The interventions sought to reduce unintended pregnancies by increasing the access of first-time mothers to a broader choice of contraceptive methods. The main objectives were to:

1. Improve facility-based providers' insertion and removal skills for long-acting reversible contraception (LARC),³ including infection prevention, at dispensaries and health centers, and their capacity to counsel first-time mothers on HTSP and contraception.
2. Improve the capacity of community health workers (CHWs) to create demand for and increase access to a comprehensive package of quality services, information, and counseling on HTSP among first-time mothers.
3. Create an enabling environment and sustainable conditions for provision

Figure 1. FTP interventions: socio-ecological model



¹ 15-19-year-olds will be referred to as adolescent girls in this brief.

² 20-24-year-olds will be referred to as young women in this brief.

³ LARC refers to implants and IUCDs.

Box 3: E2A's community-based FP program

E2A implemented the FTP interventions as part of Pathfinder International's ongoing community-based family planning project in Shinyanga District. The program, with funding from USAID/Tanzania and support from E2A, trained 230 existing CHWs to use a balanced counseling strategy to: counsel women on all contraceptive methods with support via a mobile application; provide non-prescriptive methods (including the newly introduced Standard Days Method); and make referrals to facilities for clinical methods. In addition, facility-based providers received training on the balanced counseling strategy to better supervise CHWs and handle the referrals.

of FP services, particularly for young mothers and FTP, through the Village Development Committee, community engagement of key leaders, and strengthening referral linkages between facilities and CHWs.

4. Strengthen coordination of systematic mobile outreach services by district and regional health authorities to enhance coverage and optimize utilization of resources, including integrating FP/SRH services with immunization days.
5. Support documentation and dissemination of FTP intervention strategies and contribute to scale-up within the district, region, and beyond.

The FTP interventions in Shinyanga

drew on lessons learned from Pathfinder International's previous FTP programming⁴ and were designed to intervene at all levels of the socio-ecological model: individual, community, and structural.

Individual Level

Small peer groups

Many first-time mothers in Shinyanga lack opportunities to build supportive social networks, as they enter into motherhood and take on household and childrearing responsibilities. Interventions therefore included monthly small peer groups facilitated by leaders who were first-time mothers themselves. Small peer groups provided 10-12 first-time mothers opportunities to exchange knowledge and experiences related to FP/SRH with their peers, fostering supportive social networks and social capital.

Peer leaders were selected by CHWs who are based in the community (not at facilities, as with E2A's FTP interventions in Nigeria).

The peer leaders were selected based on predetermined criteria, including: being a first-time mother under the age of 25, ability to speak in front of others, ability to read and write, residence in the same village, and being accepted by community members.

Peer leaders met regularly in different venues in the community to develop knowledge and skills related to HTSP, FP, SRH, positive parenting skills, gender-equitable relationships, and human rights. In addition, the training covered facilitation skills, tips on

how to organize small peer groups and how to use small group activity cards, which were adapted from the GREAT⁵ project.

Peer leaders invited other first-time mothers to their groups by walking from house to house, meeting them at church and mosque, and reaching out to them at the health clinic and on their way to the market. Peer leaders reported that more than half of group participants attended every meeting, and the ones who were absent were usually tied up in farming or were experiencing adversity to their participation from their husbands and in-laws. CHWs regularly provided supportive supervision to the peer groups, often responding to difficult questions raised by group participants. Besides the monthly one-on-one meeting with the peer leaders to discuss their challenges in facilitating the group discussions and to collect data from the group sessions, CHWs also met with the peer groups to respond to their questions about contraceptives and provide more information about services. On these occasions, CHWs also individually counseled some young mothers and referred them to health facilities for LARC.

Box 4: Small peer groups

114 first-time mothers facilitated 155 peer groups

1,891 first-time mothers participated in the peer groups⁶

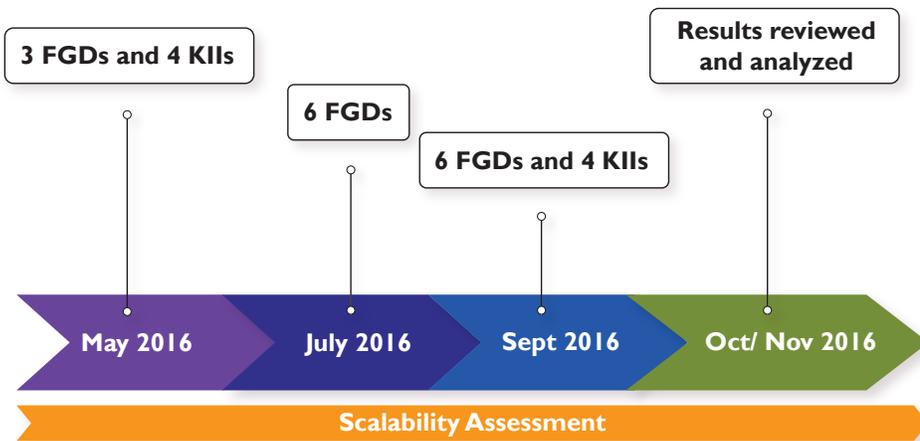
- 369 ages 10-14
- 498 ages 15-19
- 1,024 ages 20-24

⁴ Pathfinder's previous FTP programming includes: the PRACHAR (Promoting Change in Reproductive Behavior of Adolescents) Project in Bihar, India; the GREAT (Gender Roles, Equality & Transformations) Project in Northern Uganda; and the Young Married Adolescents Project in Burkina Faso.

⁵ The GREAT (Gender Roles, Equality and Transformations) Project was led by the Institute for Reproductive Health of Georgetown University and implemented by Pathfinder International and Save the Children in Northern Uganda.

⁶ The indicator on number of young women participating in small peer groups was collected on a quarterly basis and thus women who participated multiple times over the course of the project would be counted in multiple quarters. The final quarter of data (July-September 2016) is therefore presented here rather than the cumulative number of participants throughout the life of the project.

Figure 2. Qualitative data collection process



E2A established referral networks with which the peer groups could connect, including:

- Nutrition counseling and services for pregnant women, infants, and children
- Prevention of mother-to-child transmission of HIV services
- HIV counseling, testing, treatment and care
- Gender-based violence services

Home visits

E2A improved the capacity of 64 CHWs (from the 230 CHWs already engaged by E2A/Pathfinder’s community-based FP program), which covered 147 villages in Shinyanga District Council, to conduct home visits and counseling on FP/SRH and HTSP with first-time mothers and key influencers, including husbands and in-laws. During home visits, CHWs shared information about contraception, HTSP, and encouraged communication between couples about

fertility choices and household decision-making related to FP. They also continued to provide condoms and pills, counsel on Standard Days Method and Lactational Amenorrhea Method, and refer to health facilities for LARC.

E2A staff selected the 64 CHWs and the in-charge of health facilities based on their literacy, responses to questions, and enthusiasm for the work with first-time mothers. CHWs participated in training on rights-based, youth-friendly, and gender-sensitive approaches to FP/SRH/HTSP. The trainings were based on adapted versions of Pathfinder International’s training modules on conducting home visits and counseling for young married women and FTP, and key influencers.⁷ CHWs met monthly at health facilities with facility-based supervisors and collected pills and condoms from facilities when they needed them.

Community Level

At the community level, several strategies were implemented to increase demand

for FP services and build support for FP/SRH services for FTP among community influencers.

Advocacy meetings with community leaders

CHWs conducted community mobilization activities, engaging with community and opinion leaders (ward leaders, religious leaders, etc.) to influence social norms to favor increasing young women’s access to FP/SRH services. This led to community and opinion leader who provided FP/SRH education during community meetings attended by family members of first-time mothers.

Immunization outreaches

CHWs participated in integrated immunization outreaches to create opportunities to counsel on and provide FP/SRH services.

Structural

Provision of FP/SRH services to FTP

E2A built the capacity of facility-based providers to offer a broad contraceptive method mix, including LARC, in facilities where they already worked and through outreaches to underserved facilities. E2A selected health facilities that had no providers or just one provider trained on LARC provision. The facilities were in areas where E2A had trained CHWs to conduct home visits, sensitize and engage communities toward acceptance of FP/SRH services for young mothers, and refer them to health facilities, when needed.

E2A trained 40 health providers from

⁷ Available at: <http://www.pathfinder.org/publications/providing-rh-services-to-young-married-women-first-time-parents-in-w-africa-training-for-community-health-workers/>; <http://www.pathfinder.org/publications/small-group-facilitation-for-young-married-women-and-first-time-parents-in-w-africa-training-for-facilitators/>; <http://www.pathfinder.org/publications/small-group-facilitation-for-young-married-women-and-first-time-parents-in-w-africa-training-for-facilitators/>

39 different facilities and dispensaries on insertion and removal of IUCDs and implants, emphasizing infection prevention and refreshing their FP counseling skills on the importance of dual protection, HTSP, offering youth-friendly services, and being in full compliance with relevant USAID and Government of Tanzania guidelines. In their counseling sessions with young mothers, health providers focused on safe motherhood, including risks of teenage pregnancies; appropriate nutrition for babies, including breastfeeding technique; and advice on regular check-ups for first-time mothers and their babies. In addition, service providers offered psychosocial support to young expectant mothers, linking them to other available community services and initiatives.

E2A trained the 40 providers on the mobile phone-based balanced counseling strategy employed by E2A/Pathfinder's community-based FP project in Shinyanga (see Box 3) so that they could supervise the CHWs and follow up. The phone-based application is an algorithm that provides prompts for effective counseling on all methods including LARC. Additionally, the phone-based application has robust data collection and reporting capabilities that monitor, track, and report CHWs' activities including provision of methods. Throughout the intervention period, the E2A project manager, and MOH service managers provided continuous, on-the-job re-enforcement and updates for service providers on FP counseling and service provision during joint supportive supervision visits and monthly meetings

between facility-based providers and CHWs.

Enhance mobile outreach services

E2A strengthened the capacity of district and regional health authorities to coordinate mobile outreach services to enhance coverage and optimize utilization of resources, including integrating FP/SRH services within immunization days. Quarterly coordination meetings brought together district and regional health authorities and relevant partners involved in mobile outreach activities.

Project Monitoring and Documentation Methods

The process documentation was guided by learning questions to assess how the approach was implemented, including aspects of the project 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 the 12 recommendations of the of ExpandNet's *Beginning with the end in mind* (BWEIM) framework.^{vi} The BWEIM framework provides a quick overview of the scalability of a project that is being planned, proposed, or implemented.

Through focus groups discussions (FGDs) and key information interviews (KIIs) with various key project implementers, the process documentation team assessed, at three points in time, the extent by which the 12 recommendations outlined in the BWEIM framework were considered during the design and throughout implementation.⁸ By holding the FGDs at three points in time, they were instrumental in allowing the project to: correct information about contraceptive use among peer leaders, and

Table 1. Documentation activities, their objectives and type, and number of individuals interviewed under each activity⁹

Process Documentation Objective	Participants Category	Respondents	Activity	Sample Size ⁵
Explore experiences of, challenges, opportunities and lessons learned from implementing the technical strategy.	Frontline project implementers	Peer Leaders	FGD	6 FGDs = 35 unique participants
		Community Health Workers	FGD	6 FGDs = 36 unique participants
		Service Providers	FGD	6 FGDs = 33 unique participants
Gather perceptions of the technical strategy among MOH officials and their recommendations toward successful implementation of the strategy, including ways of increasing sustainability and scalability to other districts and regions.	MOH officials	-Regional Medical Officer -District Medical Officer -District Reproductive and Child Health Coordinator	KII	6 KIIs = 3 unique participants
Document Pathfinder's experience of implementing the strategy, including barriers and facilitators.	Pathfinder staff	Pathfinder' Project Coordinator	KII	2 KIIs = 1 unique participant

**One FGD was composed of the same participants that were followed up and interviewed at all the three points of information-gathering activities; a second group of CHWs, health providers, and peer leaders at the midpoint; and a third group at the end. For KIIs, similar individuals were interviewed during the first and last site visit.*

⁸ Due process was conducted to ensure ethical clearance for this data collection. The PATH Research Determination Committee deemed that the data collection was not considered research and therefore did not require full IRB approval. Full IRB approval would have been needed if beneficiaries were included in the FGDs. Due to the short timeframe for the interventions and budget limitations, E2A therefore focused on qualitative feedback from frontline implementers.

⁹ Refer to appendices in full documentation report on E2A website, available in June 2017.

support CHWs to engage young unmarried mothers and their parents as well as young married mothers and their partners and in-laws. Documentation through the FGDs also alerted the project manager about stock-outs of IUCDs and equipment for insertion of IUCDs. Also, some health providers' perceptions discussed during the FGDs could be addressed by facilitating their

contact with first-time mothers.

The FGD and KII guides included questions to assess the perceptions about the project among various implementers. Both FGDs and KIIs created a space for collective reflection, critical thinking, and joint problem-solving, including refining the technical strategy, where necessary. Eighteen FGDs

were conducted with frontline implementers, including health service providers, CHWs, and peer leaders, and eight KIIs were conducted with Pathfinder staff, and regional and district Ministry of Health (MOH) representatives.

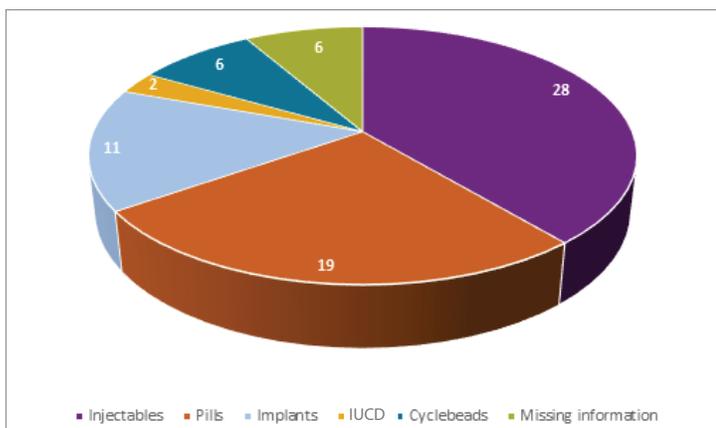


Project Results

Quantitative Results

Through the project, 1,339 adolescent girls and young women received FP counseling by trained CHEWs at the community and facility levels.¹⁰

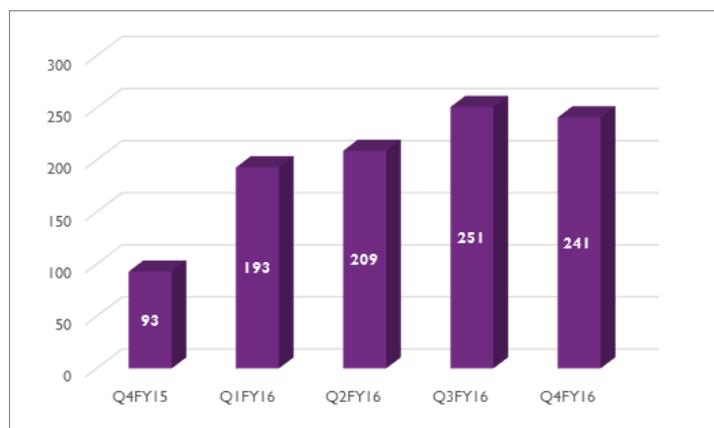
Graph 1: Number of first-time mothers who reported newly adopted FP methods through peer groups



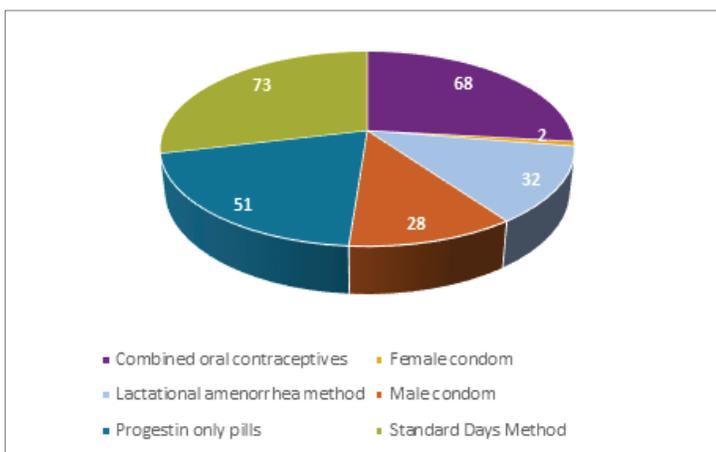
Graph 1: The peer groups reported in this graph were led by the 20 peer leaders who participated in the third round of process documentation (September 2016). The 20 peer groups had 293 participants in total, and slightly more than half of group participants 176 (60.1%) were using a contraceptive when they joined the groups. Of the remaining 117 participants who were not using a contraceptive when joining the groups, 72 (61.5%) had begun using contraception by September 2016. All peer leaders reported having at least 1 new FP adopter in their groups, ranging from 1-8. First-time mothers preferred injectables (28), followed by pills (19). The type of contraceptive adopted was not reported by 6 first-time mothers all belonging to the same peer leader. Surprisingly, there was no difference in the number of new FP adopters in groups led by peer leaders who reported having ever used contraceptives as compared to those who had never used contraceptives. On the other hand, some peer leaders who had never used contraception said it was a bit difficult for them to counsel girls to use contraceptives while they did not, and some reported having to hide that they were not using contraceptives to encourage their participants to be more open to adopting a method.

Graph 2: In one year, 2,615 women, 10-24 years, received FP counseling from CHWs during home visits; of these, 987 (37.7%) were first-time mothers. The number of first-time mothers who received FP counseling increased throughout the intervention period: 93 first-time mothers were counseled during the first project quarter as compared to 241 first-time mothers during the last quarter.

Graph 2: Number of first-time mothers, 10-24 years, who received FP counseling from CHWs during home visits



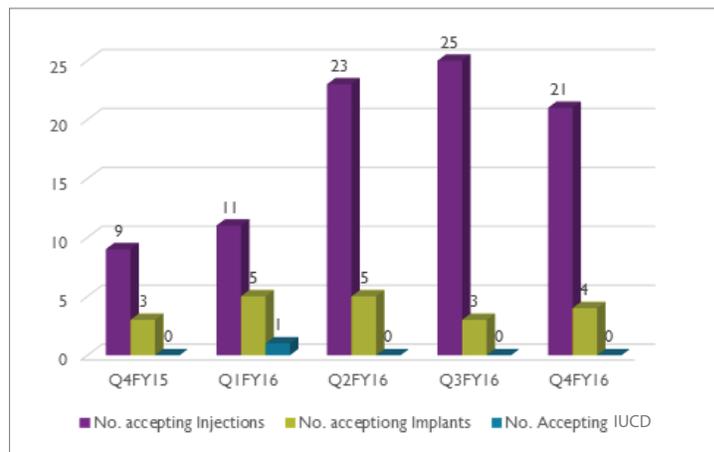
Graph 3: Number of first-time mothers initiated on nonclinical FP methods by CHWs



Graph 3: Of the 630 women who newly accepted a method from CHWs, 254 (40.3%) were first-time mothers, with the preferred short-term method being oral contraceptive pills.

Graph 4: Of the 280 young women referred for a facility-based method, 110 (39.3%) were first-time mothers. Although the numbers are low, there was an increase of first-time mothers accepting a facility-based method, from 12 in quarter one to 25 in quarter four. Most first-time mothers referred for a facility-based method reported choosing injectables. The number of first-time mothers accepting and referred for LARC remained low throughout the project period, with 20 accepting implants and only one choosing an IUCD.

Graph 4: Number of first-time mothers who were referred to facility-based FP methods



¹⁰ Given that there is no baseline comparison for the data, we cannot conclude from the quantitative results that contraceptive uptake increased among the target population, nor that uptake of certain methods increased from baseline to endline.

Qualitative Results¹¹

In addition to the quantitative results, the FGDs and KIIs resulted in qualitative findings. The main themes are conveyed by the quotes below.

Peer leaders instrumental in connecting young women with FP/SRH services

This was the first FTP-focused initiative in Shinyanga region. All respondents, through the FGDs and KIIs, concurred that the interventions enhanced CHWs' and facility-based providers' abilities to reach girls and first-time mothers with FP/SRH services. Peer leaders facilitated linkages between the providers and the young clients, and all CHWs and providers said they observed an increase in number of young clients seeking FP services, as compared to the past. All of them also reported having attended to young clients referred by peer leaders.

"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." - District Reproductive and Child Health Coordinator

Trainings useful in addressing specific FP/SRH needs of first-time mothers

CHWs and service providers expressed appreciation for the trainings they received toward offering FP/SRH services to young women and specifically focusing on first-time mothers. The trainings with service providers on LARC insertion and removals were essential to offering young women in Shinyanga a full range of contraception. Providers reported that the training offered

on LARC allowed several facilities to initiate LARC provision.

"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." - District Medical Officer

Lessons Learned and Recommendations

The implementation and documentation of the FTP interventions in Shinyanga revealed several lessons and recommendations that can be applied to reach young women, including first-time mothers and their partners, with FP/SRH services.

Test the inclusion of peer groups for young men in intervention strategies.

Several peer leaders reported that young men had requested to join their groups. Two peer leaders accepted and almost half of the participants in their group were males. The two peer leaders said that soon after having males join the groups, female participants were very shy, but later on, having both sexes made the discussions more interesting. Peer groups that include both sexes should be pilot tested for feasibility.

Ensure peer leaders have sufficient support to lead small peer groups.

Although peer leaders were supported by CHWs, they reported that they often felt the need to be better prepared to answer questions posed by their group, including those related to side effects and myths. They therefore asked to receive a comprehensive training with more time to learn about all contraceptive methods, so that they can confidently educate their peers. Giving peer leaders access to the mobile app on the

balanced counseling strategy used by CHWs should be considered during any future FTP interventions in Shinyanga.

In terms of the tools they used, peer leaders reported liking the activity cards that started by telling stories followed by questions. They said the cards were very easy to use, and the stories were very interesting and easy to understand, although some of the cards that included acting out dramas could be challenging. They emphasized the need to make sure all tools are in the local language, as some Swahili words were hard to translate, and suggested the support of additional tools such as books and flip charts with pictures.

Consider incorporation of income-generating activities into small peer groups.

Peer leaders said they faced challenges due to the transport costs they and small group members had to cover to attend meetings. In addition, attending meetings took away their time for income-generation activities. They therefore recommended incorporating some income-generating activities, such as loan funds or other entrepreneurship activities, into small peer groups, which would ultimately make them more independent and contribute to preventing adolescent pregnancies.

Address inhibitive social norms through engagement of family members.

Opposition of family members, including parents, in-laws, and spouses, to young women's use of contraception was a major barrier to first-time mothers adopting a contraceptive method. Many family members lacked knowledge on the advantages of contraception and HTSP

¹¹ Two main limitations related to the process documentation methods used were: (i) the documentation team did not have the opportunity to speak to the first-time mothers themselves and solely relied on reports of peer leaders. It would have been interesting to hear from first-time mothers regarding their attitudes and experiences related to their participation in peer groups; and (ii) potential bias related to self-reporting of FP use among first-time mothers who were small peer group members.

and believed myths and misconceptions prevalent in their communities. Several CHWs reported that when family members were educated on the importance of FP to young girls and the effects of adolescent pregnancies, most allowed them to speak to their girls, even if they were younger than 14 years.

Community meetings organized by village executive officers, ward executive officers, and religious leaders are a promising platform for providing FP/SRH education to family members. Programs should work closely with these leaders to establish mechanisms incorporating FP/SRH education. Some CHWs reported that being introduced at these meetings provided a good platform for facilitating their visits to households. Other proposed approaches for reaching family members with FP/SRH education were: educating women who bring their children for vaccination during outreach vaccination services; reaching groups of men to provide them with FP/SRH education (e.g., boda boda stands, cafes); and using the opportunity when men escort their wives to the facilities to educate them on FP and child spacing. To reach young men aged 14-20 years before they start families, respondents proposed having male adolescent youth clubs, like peer groups for the first-time mothers.

Tailor messages for young married and unmarried women and girls.

CHWs reported that two key messages encouraged young unmarried girls without children to adopt a FP method: 1) Avoiding unplanned pregnancies increases their chances of successfully completing their education and attaining their life dreams, and 2) There are many possible complications

associated with teenage pregnancies, including death. CHWs reported three key messages that encouraged young married women to adopt a FP method. These were related to: 1) Having time to work and contributing to the family income, including helping the mother-in-law with household and farm activities, 2) Having enough time for their children and themselves, and 3) Knowing spouses and in-laws were worried when they were informed about the consequences and costs related to teenage pregnancies.¹²

CHWs also reported that it was more difficult to counsel married women and women with only one child on FP as compared to unmarried women and women with many children. In-laws and spouses had great influence over the fertility decisions of married women, while women with only one child wanted more themselves.

Ensure FP services meet the needs of first-time mothers, with a focus on confidentiality of services and inclusion of young female providers.

Documentation of the interventions in this region shows that first-time mothers have two main preferences for SRH/FP service provision: they want the services to be confidential and they prefer that the services are provided by young, female providers like themselves. Confidentiality is important to young women and first-time mothers, both in terms of knowing her provider will not tell her family member(s) and being able to access services in private spaces. Providers reported that students and unmarried young women were shy and did not want to be seen seeking FP services. Providers mentioned that they often identified these young girls at the facility and provided

them services as soon as possible. They also allowed them to come in during late afternoon hours and on weekends when fewer people are at the facility.

According to documentation of the interventions in Shinyanga, long distances to health facilities, having to pay for FP services, offensive language used by service providers, and long wait times at health facilities also inhibited the uptake of contraception among first-time mothers. Some CHWs and facility-based providers were reported as denying FP services to certain categories of first-time mothers, including younger girls and postpartum mothers who had not yet regained their menses. Regarding encouraging younger girls to use FP services, several respondents recommended having posters at health facilities that depict young people using FP methods. Most posters depict pictures of older and/or married couples.

To further facilitate access to services, the programs must tackle other systemic challenges, including frequent stock-outs of contraceptives and lack of equipment at facilities, such as IUCD insertion kits, reported by service providers during FGDs. Service providers who were not part of the E2A interventions at the 39 facilities were reported as giving very little or no support to the activities related to first-time mothers. Some told clients to wait for providers who received training through E2A for services they could provide while others did not fill the referral forms for clients, which were reported as being important for feedback to the CHWs. For successful implementation, it is crucial to involve all service providers.

¹² In Tanzania, all pregnant mothers younger than 18 are considered high-risk clients who cannot deliver at a lower-level facility because of complications that might arise and might not be tackled at that lower level of care. Therefore, all young mothers are referred to higher-level facilities for delivery. On the other hand, higher-level facilities are usually far from villages, increasing families' concern about costs for travel.

Conclusion

FTP have long been neglected by FP/SRH programs. There is increasing recognition about the imperative to increase FTP access to contraceptive information and services for HTSP. Research shows that pregnancies spaced at least 24 months apart provide best outcomes for mother, child, and family, yet contraceptive use remains low among young women in Shinyanga region and across Tanzania. The FTP interventions in Tanzania demonstrated that a package of targeted activities for FTP, with components at health facilities and in communities, has potential to influence acceptance and use of contraceptive services among first-time mothers. The interventions respond to pressing SRH needs in Tanzania and therefore remain relevant for communities across the country.

This pilot intervention was designed by E2A to generate evidence that can be applied to inform potential scale-up. Results from the qualitative documentation offer useful insights about the technical and practical

elements to consider for scale-up. The quantitative data indicate several trends related to awareness and use of FP services, but were insufficient to generate solid evidence about the effectiveness of the approach on increased FP uptake and HTSP.

The scalability assessment conducted by E2A and Pathfinder suggests that the technical strategy is well suited for potential scale-up, either to other districts of Shinyanga region or other regions of Tanzania. The assessment revealed that the interventions—which were based on evidence from Pathfinder’s experiences with interventions for FTP and young married women in Burkina Faso, India, and Guinea—have the potential to address an important public health challenge in Tanzania and could have considerable impact on SRH in the country. The assessment also revealed that the FTP interventions were aligned with the sociocultural and institutional settings in Shinyanga. For example, through its situational analysis, E2A realized that unlike in other countries, first-time mothers are mostly unmarried

in Shinyanga, so reaching unmarried first-time mothers was integral. Interventions were designed to be part of the existing public health system, engaging MOH service managers and providers in provision, supervision, and monitoring of services. Additionally, the qualitative monitoring methodology allowed E2A to be flexible and to routinely reflect about the design of the project with frontline implementers and make adaptations.

Despite the promise for scale-up in Tanzania, before the project can effectively operate within routine operating conditions and the Tanzanian health system’s existing resources, several modifications need to be made, particularly in how services are offered to first-time mothers. For example, Tanzania’s Ministry of Health will need support to address systemic constraints related to the delivery of youth-friendly SRH services. The male-engagement interventions proposed in this brief should also be piloted.



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