

KEY INSIGHTS FOR FIRST- TIME PARENT PROGRAMS

Lessons from implementing
first-time parent interventions
to improve health and gender
outcomes in three countries



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EVIDENCE TO ACTION PROJECT

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 addresses the reproductive health care needs of girls, women, and underserved communities around the world by increasing support, building evidence, and facilitating the scale-up of best practices that improve family planning services. Awarded in September 2011, E2A ends in March 2021. E2A is led by Pathfinder International, in partnership with Expand-Net, IntraHealth International, and PATH.

AUGUST 2020

INTRODUCTION

From 2014 to 2020, the Evidence to Action (E2A) Project, funded by USAID, made it a priority to improve health outcomes for first-time parents (FTPs)—defined as young women under the age of 25 who are pregnant with or have one child and their male partners. E2A's focus on FTPs was triggered by efforts to understand the diversity of youth reproductive health (RH) experiences and needs. Each year, at least 12 million girls aged 15–19 years give birth in developing countries, and millions more young women become mothers by the time they are 25 years old. These young first-time mothers (FTMs) are at increased risk of poor pregnancy, delivery, and child health outcomes—a situation compounded by multiple factors that limit their access to timely health information and services. Additional life uncertainties, particularly those related to education and economic options, also affect if, when, and how FTPs are able to take action on health concerns.

Despite these vulnerabilities, young FTPs have been historically overlooked by adolescent and youth family planning (FP) and RH programs—a global gap confirmed by E2A's 2014 review of available literature. As young women and men who have begun having children,

their needs often extend beyond the scope of adolescent and youth programs. Similarly, the issues young parents face are not typically included in broader programs aimed at women of reproductive age or even at married youth. E2A saw a clear need for programs that deliberately focused on FTPs—both to ensure the health of the couple and influence the wellbeing and health of their first child and any subsequent children. E2A also recognized the importance of engaging FTPs' mothers and mothers-in-law to build parental support for FTP health actions. Given this multi-generational programming potential, E2A set out to reach FTPs in multiple contexts with health and gender interventions and, in doing so, gathered new evidence on effective programming for this subset of youth.

The FTP experience is complex—from the many, sequenced FP, RH, and maternal, newborn, and child health (MNCH) needs that arise, to the changing expectations, relationships, and responsibilities that accompany parenthood. To help young people navigate the FTP lifestage, E2A designed and implemented multi-faceted programs in three countries: Burkina Faso, Nigeria, and Tanzania. Adapted for different local contexts, our core FTP program applied lifestage and socio-ecological lenses to design community- and facility-based interventions with FTMs/FTPs, their key influencers, and their communities (including health providers) to address the many health needs and related social and gender issues that affect FTPs' knowledge, attitudes, communication, decision making, and healthcare use. Evidence from E2A's projects show that tailored interventions enable FTPs to achieve better health and gender outcomes for themselves

and their new families—from increased voluntary uptake of modern contraceptive methods, to improved gender attitudes about household roles and decision making.



MAREN VESPIA (TANZANIA)

ILLUSTRATIVE RESULTS ACROSS THREE COUNTRIES

E2A's FTP Projects in the Eastern Region of Burkina Faso, Cross River State Nigeria, and the Greater Mahale Ecosystem of Tanzania contributed to improvements in health and gender outcomes, including:

IN BURKINA FASO...

- FTMs reported increased awareness of ANC, including the importance of seeking services early in pregnancy. In Phase 2 of FTP programming, 76% of participants received their first ANC visits in the first trimester of pregnancy, an increase from 62% of women who had already given birth at baseline.
- Healthy timing and spacing of pregnancy (HTSP) and FP knowledge and attitudes improved for young FTMs and their husbands. Data from the second phase of programming shows that the rate of current FP use among women who had given birth increased from 18.9% to 45.7% during the course of the intervention.
- FTMs and their husbands noted improvements in couple communication about HTSP and FP, which then facilitated the decision to use a modern contraceptive method.
- Participants reported increased knowledge related to exclusive breastfeeding. The percentage of FTMs that breastfed their babies within an hour of birth increased throughout the project period.

IN NIGERIA...

- Birth spacing timeframes increased from baseline to endline, indicating that FTPs now intend to wait three or more years before having another child.
- Current voluntary use of modern contraceptive methods increased significantly over the course of the intervention—from 26% to 79% among non-pregnant FTMs, and from 44% to 81% among male partners.
- FTMs who reported having discussions with their partner about FP (regardless of marital/union status) doubled from baseline (41%) to endline (80%), while male partners who reported having discussions about FP with their partner increased significantly—from 69% to 91%.
- Gender-equitable attitudes towards household roles and decision making changed positively for both FTMs and male partners, even with a relatively short intervention period.
- Both FTMs and male partners demonstrated improved knowledge and attitudes about infant care and parenting attitudes and behaviors.

IN TANZANIA...

- Voluntary use of modern contraceptive methods increased—from 35% to 66% of FTM peer group members in Phase 1 and from 50% to 73% in Phase 2.
- Qualitative data indicated that understanding of HTSP and its benefits deepened over the course of the intervention for FTMs and their key influencers.
- In Phase 2 of FTP programming in Tanzania, there was an increase in the percentage of FTMs who indicated that the decision to use FP should be made jointly—from 69% at baseline to 81% at endline.
- The program exposed FTMs and their households to new population, health, and environment (PHE) ideas. Participation in Tuungane PHE activities increased among FTMs (8% to 32%), their husbands/partners (9% to 19%), and other members of their household (19% to 40%) from baseline to endline.
- FTM peer group members reported sharing their knowledge and experiences with others in their communities, suggesting a diffusion of key messages and ideas.

A FRAMEWORK FOR FTP PROGRAMMING

FTP programs in Burkina Faso, Nigeria, and Tanzania provided both the foundation and the testing ground for a new framework for FTP programming. FTPs vary by age, marital status, and other key characteristics, and their circumstances are shaped by many contextual factors, such as gender norms and health system capacity. But what they have in common—their first experience with pregnancy, delivery, and parenting—provides a valuable unifying construct for understanding their specific needs and building programs that advance their health and wellbeing.

Using FTPs' commonalities as a starting point, E2A developed the First-Time Parent Framework, which creates a space for examining the elements that typically characterize the FTP experience. E2A deliberately drew on concepts and models that are familiar to the FP and RH community—the life-course approach and the socio-ecological model. The framework applies these analytical lenses to:

- Define an FTP lifestage within the broader evolution of RH experienced over an individual's lifetime—from puberty to parenthood and beyond.
- Understand the broader FTP social system and the multiple interpersonal and structural factors and interactions that influence health choices and actions.

Using these two lenses, the framework explores the information and healthcare needs, inter-relational dynamics, and underlying gender and social norms that influence young parents' health and wellbeing over the course of the FTP lifestage. The life-course lens provides a sense of FTPs in time—how FTPs arrived at this moment in their reproductive lives and how this experience can shape their futures. The socio-ecological lens places FTPs within their social space—identifying the people, organizations, and norms that affect who they are and what they do. Together, these lenses help programmers form a multi-dimensional understanding of FTPs and their main concerns. All elements of the framework can be further contextualized based on available data and information (e.g., key health statistics, gender and social norms, etc.) to identify the country- or location-specific needs of new parents and opportunities for program intervention.

THE FTP LIFESTAGE

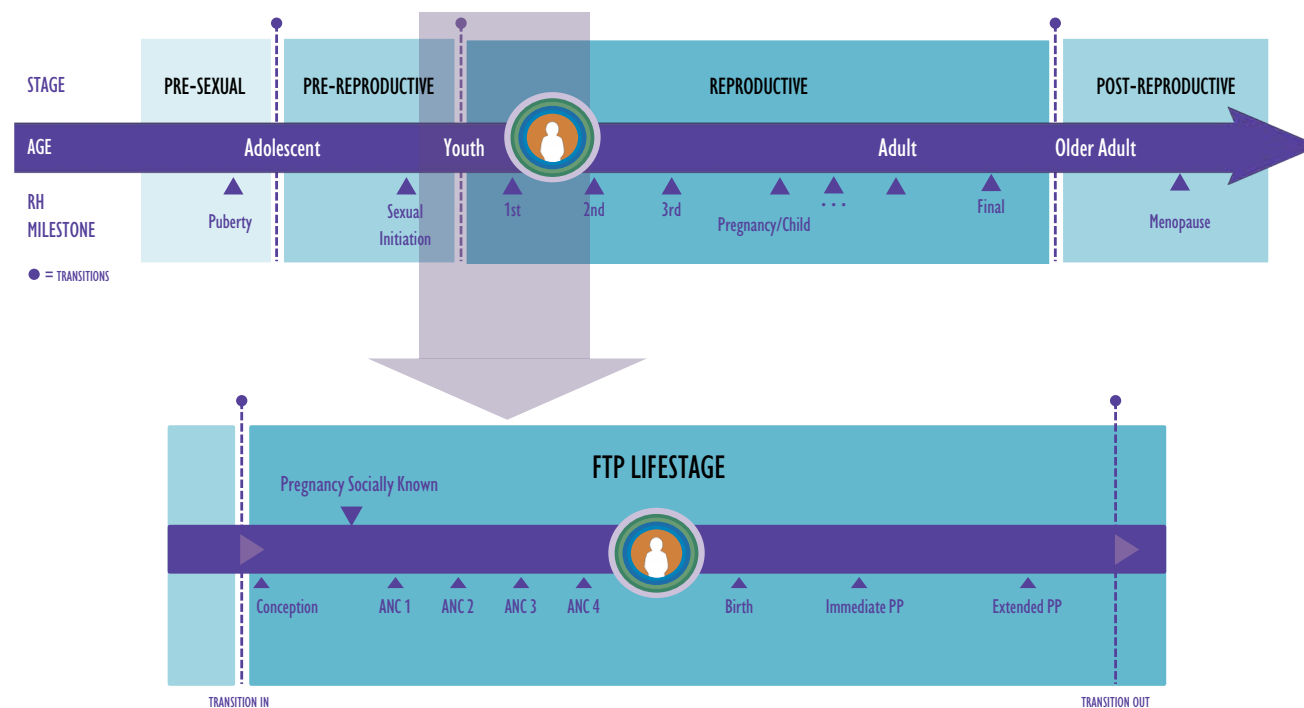
E2A defines the FTP lifestage as a 33-month interval that encompasses main health events—from conception through 2 years postpartum (or roughly 9 months for pregnancy to delivery, and another 24 months after birth) allowing for the minimal recommended interval for the healthy timing and spacing of the next pregnancy. The First-Time Parent Framework's life-course approach places the FTP experience within a lifetime of reproductive activity and provides a snapshot view of the main reproductive milestones and transitions that typically occur over an FTP's lifetime. Importantly, the framework also underscores the evolving and cumulative nature of an individual's RH needs as s/he moves from stage to stage.

A context-specific life-course lens, which takes into consideration the local epidemiological profile and cultural context of reproductive health-related behaviors (e.g., marriage/union patterns, age of sexual debut and first birth, prevalence of early marriage, etc.), helps program designers identify specific opportunities for RH and related interventions. This lens also highlights the importance of timely or phased interventions that support FTPs’ reproductive choices and actions and help them to safely and intentionally navigate through each stage. Finally, this approach also allows for a multi-generational perspective, which works with mothers-in-law and mothers of FTPs, as well as FTPs themselves, to address specific moments during their reproductive lives where interventions can make the greatest impact, not only for the FTP’s health, but also for the wellbeing of the next generation (e.g., infant care and feeding, positive parenting, and healthy spacing of the second and subsequent pregnancies).

The 33-month FTP lifestage, from conception through their first child’s second birthday, marks a critical transition into the childbearing phase of an individual’s life—encompassing the individual’s first experience with pregnancy, childbirth, and parenting.

Although we could look at this same 33-month interval for any pregnancy, the period marks FTPs’ initial experience with MNCH-related concerns and services, and often their initial interactions with the formal health sector. As such, FTPs are often unprepared to anticipate and act on their health needs. With many FTPs at risk of early childbearing and poor RH outcomes, it is particularly important to connect young parents to the health system as early as possible and ensure access to a continuum of FP, RH, and MNCH information and services throughout their lifestage.

THE FIRST-TIME PARENT LIFESTAGE



THE FTP SOCIO-ECOLOGICAL MODEL

In concert with the life-course lens, E2A applies a socioecological lens to examine the experience of young women and men as they move through the FTP lifestage. For young people in particular, RH choices and actions are heavily influenced by their own knowledge, capacities, and skills and the many other individuals, institutions, systems, policies, and underlying gender and social norms that surround them.

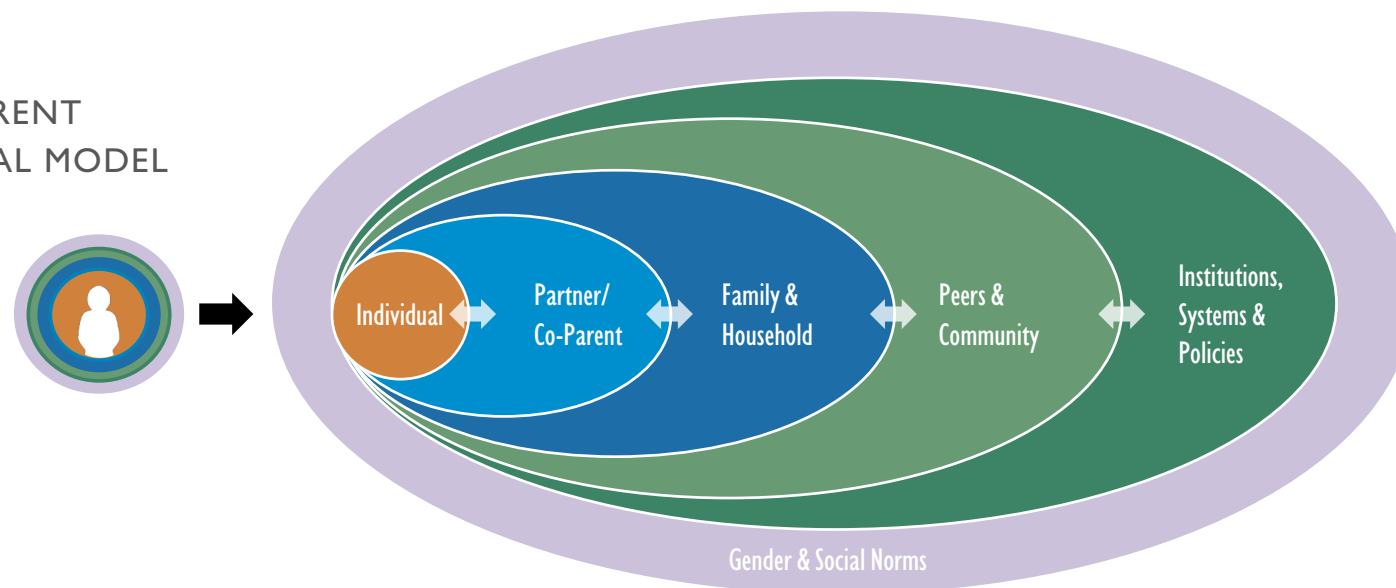
E2A consulted with a team of RH and gender experts to identify the five levels that make up the FTP socioecological universe:

- The individual FTM
- Their partner/co-parent

- Their families and household influencers
- Their peers and community
- The larger institutions, systems, and policies (including the health system)

In E2A's model, the five levels are embedded in a larger sphere of gender and social norms, which highlights how these norms fundamentally influence all relationships and interactions and often play a critical role in shaping the FTP experience. E2A's package of FTP interventions reached actors at each of the socio-ecological levels using multiple channels—small group education, home visits, responsive health services, and a more supportive environment—within the same geographical space in order to improve FTPs' health and gender outcomes and promote change within their communities.

THE FIRST-TIME PARENT SOCIO-ECOLOGICAL MODEL





LINDA SUTTONFIELD (BURKINA FASO)

PACKAGE OF INTERVENTIONS FOR FIRST-TIME PARENTS

The FTP Framework guided the design of E2A's package of community- and facility-based interventions to support FTPs. While the content and structure of these interventions varied by context, E2A's core programming was consistent across all project settings. The following table summarizes the main interventions implemented in E2A's FTP programming.

E2A FTP INTERVENTIONS

INTERVENTION	DESCRIPTION	SOCIO-ECOLOGICAL LEVEL
FTM PEER GROUPS	FTM small groups, facilitated by peer leaders and supported by community volunteers (CVs) or community health workers (CHWs), explore a range of topics relevant to FTMs throughout the lifestage, including antenatal care (ANC) and skilled delivery, exclusive breastfeeding, HTSP and FP, contraceptive choice, decision making, and gender dynamics.	Individual Peer and Community Gender and Social Norms
MALE PARTNER GROUPS	CVs/CHWs facilitate small group activities with male partners/co-parents of FTM peer group members to promote understanding about safe pregnancy and birth, explore fatherhood and parenting, explore couple's communication and decision making related to HTSP and contraceptive choice, and foster more gender-equitable attitudes and relationships. Joint couples' sessions that bring FTMs and their male partners together to discuss key health and relationship issues should also be considered, as was done in E2A's FTP program in Burkina Faso.	Partner/Co-parent Peer and Community Gender and Social Norms
OUTREACH WITH OLDER WOMEN AND COMMUNITIES	CVs/CHWs lead informational sessions with key influencers, including mothers and mothers-in-law, to build support for positive FTP health action related to pregnancy, childbirth, infant health and nutrition, and contraceptive use.	Partner/Co-parent Family and Household Peers and Community Gender and Social Norms
HOUSEHOLD VISITS	CVs/CHWs visit FTM households to deliver counseling and healthcare tailored to the FTM's stage of pregnancy or early parenthood using existing Ministry of Health (MOH) or project-developed tools.	Individual Partner/Co-parent Family and Household Gender and Social Norms
COMMUNITY AND FACILITY HEALTHCARE	The implementing project team provides support to community- and facility-based health providers through training, mentorship, and supervision, and orients them on the needs of FTPs and the best ways to engage them.	Individual Partner/Co-parent Family and Household Peers and Community Systems and Policies Gender and Social Norms
DATA GENERATION	The implementing project team generates data on both implementation and FTP health- and gender-related results through a range of possible methods, including qualitative and/or quantitative baseline/endline activity, health data collected through paper-based forms or a mobile application, health facility data, and monitoring reports.	Individual Partner/Co-parent Family and Household Peers and Community Systems and Policies Gender and Social Norms

DESIGNING PROGRAMS FOR FTFS—KEY INSIGHTS FROM E2A'S EXPERIENCE




In the pages that follow, we share eight insights garnered from E2A's experience designing and implementing programming for FTFS, highlighting the most important lessons learned across our projects. Each insight provides background on the issues involved, including the specific challenges or opportunities that are unique to FTFS and key points to consider when designing and implementing FTFS programs. We also share examples from E2A projects that highlight the importance of each insight in shaping effective FTFS programs.






MAREN VESPIA (TANZANIA)



8 KEY INSIGHTS FOR FTP PROGRAMMING FROM E2A EXPERIENCE IN 3 COUNTRIES

Over the course of implementing FTP projects in multiple settings, E2A gained valuable experience with the “how to” (and occasionally, the “how not to”) of FTP programming. Project experience, implementer feedback, and—most importantly—input provided by FTPs themselves highlighted several programming elements that are unique or different from traditional FP/RH or youth programming when applied to this transitional lifestage. This guide presents the foundational thinking that informed E2A’s FTP programming and the eight key programming insights that capture the most important lessons learned from programming experience in Nigeria, Burkina Faso, and Tanzania.

-  **1 Generate information and data** about FTPs to inform programmatic efforts and build the global evidence base
-  **2 Define the characteristics** of the FTPs your program will address and determine what types of interventions, content, and activities are most appropriate
-  **3 Be strategic about which outcomes to prioritize,** being realistic about which outcomes you will have the opportunity and capacity to address

-  **4 Address the non-health needs** of FTPs, including education, income generation, and livelihoods, by developing tailored interventions or linking to ongoing programming
-  **5 Determine how best to engage the husbands/partners** of FTMs, taking into consideration factors like their diversity, their alignment with FTM activities, and the improvement of outcomes for men as partners and fathers
-  **6 Identify and engage** household and family members who influence FTP options
-  **7 Include community-based interventions,** such as home visits and small group education, that link FTMs to key individuals and resources
-  **8 Address underlying gender norms** and power dynamics by integrating gender-synchronized and gender-transformative approaches into FTP programs



SEUN ASALA (NIGERIA)

INSIGHT 1



GENERATE INFORMATION AND DATA ABOUT FTPS

Programs should gather and generate qualitative and quantitative data on FTPs to inform their efforts and build the global evidence base.

Effective programs rely on good data and information about their target audience to design interventions that respond to their specific needs and address their barriers to good health. However, this can present a challenge when it comes to programming for FTPs—in most countries, there is little or no available information specific to this subset of youth. Most government health information systems are not able to present data disaggregated by both age and parity, so it is difficult to pinpoint FTP health needs and healthcare use patterns. As the FTP lifestage marks a transition into parenthood and adulthood, existing data on adolescents, youth, and adults may not adequately capture or delineate the needs of young people as they move from one category to another. Finally, the data that is available is often at a national or regional level. While this information is valuable, it may not provide a nuanced understanding of the local contexts and health issues that shape the FTP experience—from the demographic and socio-economic characteristics of FTPs, to how and when they access healthcare, to the gender and social norms that influence their health behaviors.

Given this situation, it is vital that programs gather and/or generate data about FTPs to inform intervention design and build the global database. If projects have time and resources, formative assessments are ideal, but even limited efforts (e.g., working with MOH colleagues to review facility registers) can provide useful information to help define FTPs, prioritize FTP health issues, and shape interventions.

Some key areas to explore include:

- Epidemiological, demographic, and socioeconomic information on FTMs and their husbands/partners/co-parents
- Relationship patterns with co-parents/other partner(s)
- Influencers of FTPs who determine FTP health actions
- Resources/support available to FTPs for health and life needs
- Availability of, access to, and use of health information and services (by type and by health issue).

While this insight focuses on formative data, projects should also track results and implementation lessons learned. FTPs are a new focus for adolescent and youth programming, so this type of information is essential for moving the field forward.

FTP PERSPECTIVES

“How will I manage [to become] head of the family? ... How will I get strong enough to feed him [the baby] and feed myself and the mother?”

—MALE PARTNER, IN-DEPTH INTERVIEW, NIGERIA

LEARNING ABOUT FTFS IN NIGERIA

E2A's project in Cross River State, Nigeria was our first opportunity to conduct a full formative assessment of the health and broader life situations of FTFS. Although we were already working with health providers and community partners on the ground, we knew little about young FTFS in project communities. A review of health facility registers and in-depth interviews and focus group discussions with FTFS, their influencers, and project implementers brought new issues to our attention:

- Both unmarried and married FTMs reported having unplanned pregnancies
- FTP lifestage was characterized as a time of uncertainty across all life issues (e.g., home situation, relationships/partnerships, livelihoods, education)
- Limited use of health facilities, especially among unmarried FTMs and those with unplanned pregnancies
- Low use of modern contraceptive methods, despite high support for birth spacing
- Limited health agency of FTMs, with partners and parents (especially mothers) often making health decisions for FTMs and their children



ABDOUL BALDE (BURKINA FASO)

INSIGHT 2



DEFINE YOUR FOCUS— FTMS OR FTTPS

FTPs are not a homogenous group, so it is important for program designers to understand the defining characteristics of the FTPs they will work with, and then determine what types of interventions, content, and activities are most appropriate.

FTPs are all having their first experiences with pregnancy, delivery, and parenting, which provides a valuable unifying construct for anticipating their needs and building programs that promote their health and wellbeing. However, FTPs (like any population) are diverse—they vary by demographic and socio-economic characteristics (e.g., age, marital status, education) and by contextual factors that shape their transition to parenthood (e.g., gender norms, health system capacity). Given the general lack of data on FTPs, it can be difficult to know exactly who your FTPs are, or how their diversity warrants different programming content or approaches. While investing in formative data and outlining realistic outcomes will help sharpen the focus, E2A’s experience has defined several sub-categories of FTM/FTP groups to consider when designing your program.

E2A put FTMs at the center of most programs, largely because it is the young mother who is most directly affected by the health issues being

addressed and tracked. As it was often difficult to anticipate who and how many would want to participate in the program, activities brought together FTMs of different ages, marital statuses, and education levels (which also simplified implementation costs and efforts). Across countries, this approach worked well—FTMs reported that they appreciated being able to share experiences and learn from their diverse peers, and participation levels were consistent across FTMs. That said, findings from several project evaluations and studies suggest that having separate approaches and/or content for some FTMs or FTPs may be important in some contexts.

- **Pregnant vs. postpartum FTMs:** Given the relatively short duration of pregnancy (9 months), most communities will have more FTMs in their postpartum phase (which the E2A project defines as up to 24 months following delivery). It is easier to program for this phase as key health behaviors like HTSP and contraceptive use will become relevant for all FTMs at some point, and there is generally more time and flexibility for projects to intervene. For pregnant FTMs, these concerns may feel distant and they may prefer activities that address their more immediate needs. While E2A peer groups addressed the same topics with all FTMs and relied on other activities (e.g., home visits) to provide information and services more tailored to individual health needs, other programs may choose to vary interventions and/or content (or the sequencing of topics) to more closely parallel the timing of health issues for different FTMs.
- **Married vs. unmarried FTMs:** In some contexts, childbearing occurs primarily within marriage (e.g., Burkina Faso), while in others, the marital or relationship status of FTMs can be quite



ABDOUL BALDE (BURKINA FASO)

varied and fluid. E2A projects in Nigeria and Tanzania had a significant proportion of program participants who identified as being unmarried or single, and research in both countries shows that partner relationships often continued to evolve during the FTP lifstage. The FTP experience for married and unmarried women can differ greatly, especially in terms of individual reproductive agency and resources or support for health action. In some contexts, childbearing outside of marriage is stigmatized, which may have implications for mixing married and unmarried FTMs in the same activity. Programs may need to vary intervention approaches and content to better respond to the different needs and circumstances of married and unmarried FTMs.

UNDERSTANDING THE DIFFERENT NEEDS AND PRIORITIES OF MARRIED AND UNMARRIED FTMS IN TANZANIA

In March 2020, E2A conducted a study with FTP program participants to better understand their experiences adopting a contraceptive method. While some aspects were common among different FTMs, important variations emerged between those who were married or in a stable relationship and those who were unmarried at the time of contraceptive uptake—particularly in terms of their motivation for adopting FP. For many unmarried FTMs, the uncertainties about their relationships and life situations influenced their decision to use contraception. Having an unplanned pregnancy with their first child proved to be an important trigger for using FP after the child’s birth, as they did not want to repeat an experience that strained relationships with their parents and partners and created financial and other life hardships. Married FTMs focused more on the broader, long-term benefits of HTSP and FP for themselves, their partners, and their families as motivational factors. Using a contraceptive method not only allowed the FTMs and their husbands to plan the number and timing of their children, but also helped them achieve other life goals, notably developing economic and livelihood pursuits. Study findings suggested to E2A that additional activities and content should be included in FTP programs to more fully address the varied interests of unmarried and married FTPs.

- **Individual FTMs vs. FTP couples:** The FTP lifestage provides a special opportunity to work with men and women as couples and co-parents who are working together to set and achieve health goals. However, FTMs may not be in stable relationships or may not want to involve their partners. In Nigeria and Tanzania (where many FTMs were unmarried), the projects first worked with the FTMs and then engaged their husbands/partners separately, with participants’ prior approval. Even where most FTMs were married or in stable relationships, our projects typically worked with individual members of the couple separately (on the same topics), giving each time to learn new information, share experiences with peers, and reflect on their situations. Projects should think through options that are most appropriate and safe for the FTMs and/or FTPs they want to reach. (The issue of husband/partner engagement is explored further to the left.)

FTP PERSPECTIVES

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

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



TAGAZA DJIBO (BURKINA FASO)

INSIGHT 3



BE STRATEGIC ABOUT WHICH OUTCOMES TO PRIORITIZE

Given the number of health- and gender-related issues that arise during a relatively short time for FTPs, programmers need to prioritize the outcomes they will have the opportunity and capacity to address.

The FTP lifstage encompasses almost all MNCH/RH/FP health concerns over 33 months, as well as the changing expectations, relationships, and responsibilities that accompany parenthood. Ideally, FTP programs would help young parents navigate the entire lifstage, ensuring that they receive timely and accurate information, support, and healthcare as they journey through various milestones in health, relationship, and parenthood. The health concerns that arise during this lifstage—pregnancy, childbirth, FP and HTSP, newborn and child health, breastfeeding, and young child nutrition, among others—can largely be anticipated, but they vary in terms of time-sensitivity (e.g., at a fixed point vs. a flexible period of time), complexity (e.g., steps involved), and place of intervention (e.g., home-based vs. facility-based). Meanwhile the gender, relationship, and parenting issues can

be also vary wildly across individuals, couples, families, peers, providers and community. While FTP programs would ideally address the full range of health, relationship, and parenting outcomes for FTPs and include a variety of activities that address social and gender norms as well as linkages to quality health care, potential program outcomes must be balanced with practical project concerns, such as available time, adequate funding, and ability to track results.

Most projects will need to select a subset of health and other outcomes to address. When considering which outcomes to prioritize, programmers should think through the FTP issues related to the health, relationship, and parenting behaviors, and balance these with the time, resources, and local capacity available for the project to intervene in a timely, quality manner. The following considerations will affect prioritization of outcomes:

- When the outcome occurs in the FTP lifestage and the window of time for an FTP to act
- Any gender or social norms that influence FTP behaviors and access to healthcare
- Complexity of the desired health behavior, especially if resources or support from others are needed

- Broader social or community norms that influence the environment for positive health action
- Health system capacity to provide healthcare for FTPs





KATY MIMNO (BURKINA FASO)

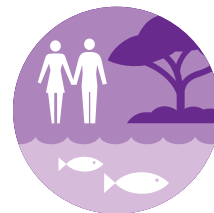
RE-THINKING PROGRAM OUTCOMES IN BURKINA FASO

E2A's experience in Burkina Faso is a good example of the challenge in pinpointing the right outcome. Given local health gaps and priorities, E2A identified early uptake of the first ANC visit (i.e., during the first trimester) as a key health behavior and outcome for its FTP program. Working through CHWs, the project was able to identify young FTMs early in their pregnancy. But the window to complete ANC 1 is short—just a few months—and by the time FTMs had been identified and activities started, that window had already closed for many participants. The situation was compounded by local traditions that restrict communication about a first pregnancy until certain rituals are completed (typically after the first trimester). This meant that additional time and effort was needed to work with household gatekeepers and influencers to build support for the couple to access ANC early. As a result, the project was unable to influence this particular outcome as originally planned and had to re-think how best to improve ANC outcomes.



AMI VITALE FOR THE NATURE CONSERVANCY (TANZANIA)

INSIGHT 4



ADDRESS THE NON-HEALTH NEEDS OF FTPS

Young people beginning parenthood and adulthood have a range of pressing needs related to education, income generation, and livelihoods, which FTP projects should address either by developing tailored interventions or linking to ongoing programming.

The preceding insights have largely focused on helping FTPs meet their immediate health needs. Given the wide range of MNCH/FP/RH issues that arise during the FTP lifecycle, even addressing all the health needs can be a challenge for projects. However, FTPs have other (non-health) needs that can directly or indirectly affect their health and wellbeing. For many FTPs, the transition to parenthood (especially if the pregnancy was unplanned) may have suspended or disrupted their education and/or livelihood options. With the added responsibility of caring for a child, it can be difficult for FTPs to cope with new demands on their time, energy, and finances, which can, in turn, hinder their ability to act on health needs in a timely manner. Ideally, FTPs should have access to holistic programming that addresses health and non-health priorities, particularly livelihood and income-generation activities. It is important for projects to think through possible multisectoral responses—either by designing non-health interventions

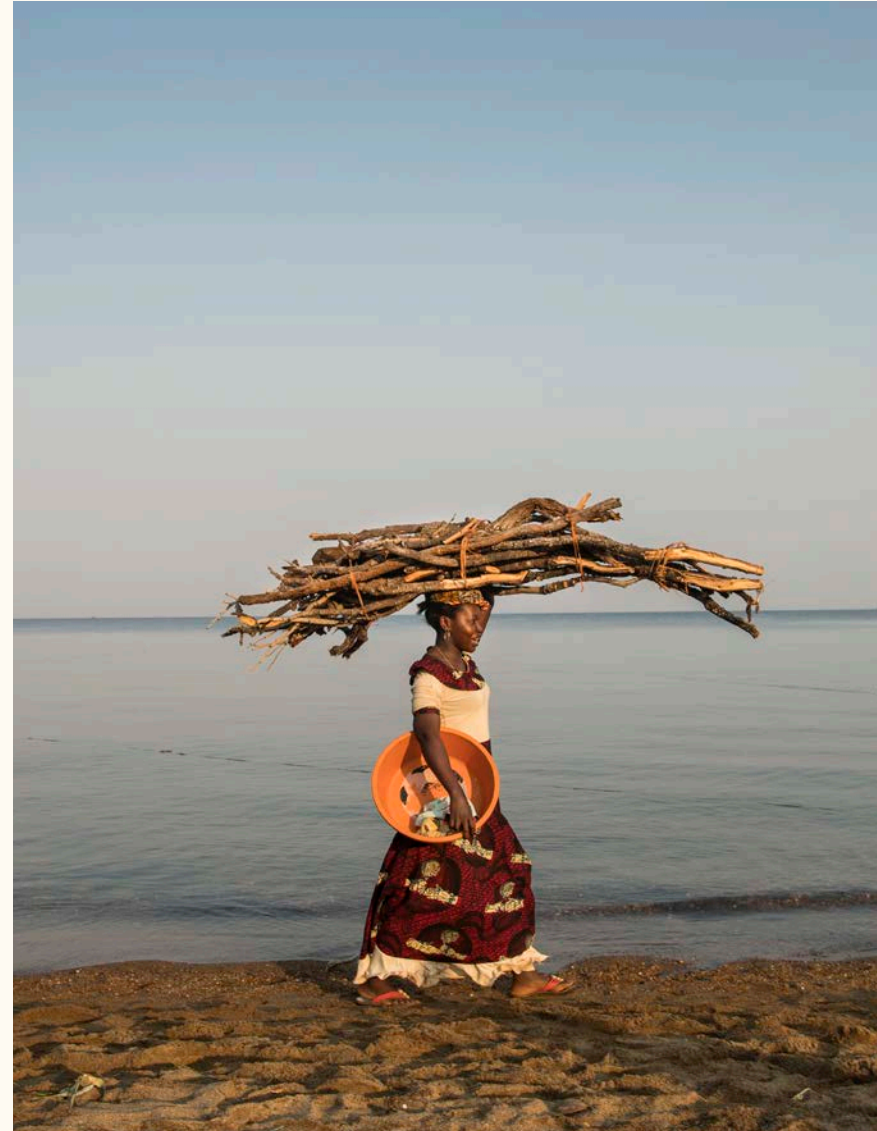
or by connecting FTPs to other existing initiatives that can help them safely navigate the FTP lifestage.

E2A has had limited experience with multisectoral programming for FTPs and, in general, this type of programming can be a challenge if resources are limited and/or there are few complementary programs on the ground (e.g., an ongoing entrepreneurship training program). However, experience in Tanzania and input from FTMs/FTPs across projects point to a few important issues to consider when integrating non-health issues into FTP programs.

- **Diverse needs:** Immediate and long-term needs may vary for different types of FTPs. For example, unmarried FTMs in Tanzania were focused more on meeting immediate needs, whereas married FTMs were focused on planning for their families and longer-term priorities. Married FTMs' priorities reflect their relative security (as compared to unmarried FTMs) associated with being in a more stable relationship and possibly also their status of being a socially accepted wife and mother. Understanding these differences will help projects prioritize what specific non-health services and support are needed.
- **Immediate economic needs:** FTMs/FTPs engaged in E2A programming repeatedly noted their need for economic opportunities—from livelihood training, to entrepreneurship support, to savings groups/mechanisms—to help them meet immediate financial needs. Ideally, FTP interventions would be linked to ongoing programs offering economic opportunities. However, these programs must be appropriately structured (or adaptable) to include young FTMs/FTPs, who may have limited skills or resources. Establishing or linking to group-based options (e.g., group income-generating activities) may also be important, especially where individual FTMs are not comfortable acting on their own.
- **Educational options:** For many FTPs (and particularly for young FTMs), parenthood marks an early end to their education. In some contexts, they may lack the basic literacy and numeracy necessary to succeed in their life plans. Linking to programs that allow FTPs to resume or continue education (either within or outside the formal education sector) is particularly important.
- **HTSP/FP as a launchpad for broader life planning:** E2A project experience has highlighted the opportunity presented by working with FTPs (especially those who are married) to plan for their family—not only with regard to the number and timing of children, but also with regard to other important areas of their lives, such as their economic wellbeing. For young people just beginning their family lives, having access to information and tools that help them plan for the long term seems to be particularly useful and welcome. Projects interested in supporting FTPs should consider interventions that facilitate couple's joint planning for all aspects of their lives, including but not limited to their reproductive intentions.

CONNECTING FTFS TO POPULATION, HEALTH, AND ENVIRONMENT ACTIVITIES (PHE) IN TANZANIA

E2A's FTP project in Tanzania was part of a larger PHE effort that comprised multiple health and non-health interventions for the broader community, including savings banks, climate-smart agriculture groups, and model PHE households. Working through community-based resource persons, the FTP project added activities to orient FTMs and their partners on PHE concepts and to connect them to ongoing PHE activities. Over the course of the five-month project, the percent of FTMs participating in PHE activities increased from 8% to 32%, and many were able to apply PHE best practices (e.g., safe hand washing techniques) in their own homes. At the same time, the project team realized that PHE interventions were not always structured to include FTMs who did not have the necessary assets (e.g., owning their own household) or financial resources to participate. The project is working to design PHE elements that are less resource-intensive but still relevant and beneficial for young FTMs. By connecting to these activities, FTMs can expand their PHE knowledge and skills, address some immediate livelihood needs (e.g., through better farming and fishing practices), and build toward being full program participants in the future.



INSIGHT 5



DETERMINE HOW BEST TO ENGAGE THE HUSBANDS/ PARTNERS OF FTMS

Given the potential for male engagement to improve outcomes in the FTP lifestage and beyond, programmers should thoughtfully engage male partners, taking into consideration factors like their diversity, their alignment with FTM activities, and the improvement of outcomes for men as partners and fathers.

It is important for FTP programs to think through how they can engage the husbands, partners, or co-parents of FTMs. Male engagement can be challenging for any MNCH or FP/RH program, especially in contexts where social norms (e.g., beliefs that men should not be deeply involved in MNCH issues) or competing priorities (e.g., migration for employment) hinder men's interest and ability to participate in activities. In FTP programming, there are several additional points to consider when determining which men to include and how. As noted earlier, an FTM may not have a partner, or he may not be consistently involved in her life. Male partners can be an even more diverse group than FTMs in terms of age (no fixed age range, as

with FTMs), marital status, education and economic levels, and even parity (they may have children with other partners). All of these can influence the perspectives, needs, and resources they bring to the FTP experience. Given the vulnerabilities of FTMs, who often have limited control over the health decisions that most immediately affect them, it can also be daunting to ensure that male engagement activities are aligned with the needs and interests of FTMs.

Despite these challenges, FTM programming presents an important opportunity to work with men, not only to improve outcomes for this lifestage, but potentially for the longer-term health and wellbeing of the whole family. Projects should identify intervention approaches and content that are both meaningful for the husband/partner as an individual and mutually beneficial for the couple. Many elements of such programming will be context- and situation-specific (e.g., health priorities and gender norms—again, investing in formative data collection about these men and the dynamics that influence FTP relationships and health outcomes is worthwhile.) The following should be factored into programming, based on local context and program capacity.

- **Sequence of interventions with FTMs and partners:** It is important that FTMs are comfortable with planned male engagement activities, especially given the potential vulnerabilities that they face. E2A has often staggered interventions, beginning with FTMs to give them time to understand the issues being addressed and make an informed decision about whether or not

to include their partners in the project. Alternatively, there is value in working with both partners (either separately or together) from the outset so that both are exposed to the same issues at the same time.

- **Diversity of husbands/partners:** E2A did not develop different interventions for different sub-sets of men (e.g., older vs. younger men, married vs. unmarried). In general, this did not prove to be a barrier to men sharing with and learning from one another. However, in some contexts, men may not be comfortable exploring sensitive issues with men of a different age or socio-economic level, which may have implications for how interventions are structured.
- **Men as new fathers:** E2A found that many of the husbands/partners of FTMs were themselves young first-time fathers. For them, this lifestage marked their transition into being recognized as an adults and ‘men,’ and they were interested in exploring issues related to gender norms and fatherhood, in addition to health issues. Finding issues that were immediately relevant to them and their FTP experience was important to keeping them engaged in activities.
- **Men as partners of FTMs:** Being supportive partners to FTMs as they cope with different health issues is a critical role for men during the FTP lifestage. Activities should build men’s understanding of the relevant health behaviors and services and address their questions and concerns. E2A also found that encouraging men to reflect on what it means to be a “partner” and the quality of their relationships was meaningful to them.

Both were important to help men think through how they could support health actions that were mutually beneficial.

- **Men as FP Users:** FTP programs should also engage men as FP users themselves, working to address their reproductive health concerns and needs as well as those of their female partners, for the benefit of the entire family.
- **Outcomes for husbands/partners/co-parents:** E2A largely tracked project results through FTMs, namely adoption of health behaviors and use of services. Such data, however, does not clearly show the impact of engaging husbands/partners in FTP programming or provide insights into which aspects of the FTP lifestage are most improved by this engagement. Setting and measuring outcomes that are specific to men as individuals and as part of a couple would build the global knowledge base on how best to involve men for the benefit of the whole family.

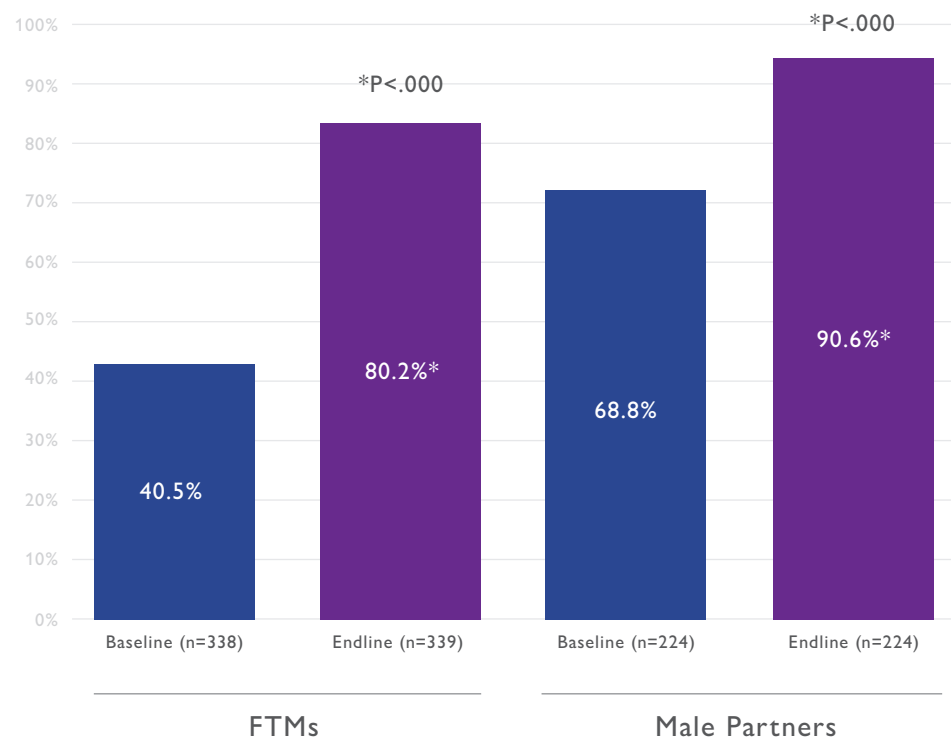
FTP PERSPECTIVES

"What I want for my child's future is to see my child become a prominent somebody in society. If I did not have the opportunity, I will do everything possible to make my child have the opportunity."

—MARRIED FIRST-TIME FATHER AND MALE GROUP MEMBER, NIGERIA

SNAPSHOT: RESULTS IN NIGERIA

Percent who have discussed FP with their partner as a way to space children in the past three months, by participant group and baseline/endline



In Nigeria, a statistically significantly higher proportion of FTMs and male partners at endline had discussed FP with their partner as a way to space children in the past 3 months, as compared to at baseline.

USING A PEER-TO-PEER APPROACH TO ENGAGE MEN IN NIGERIA

Formative findings highlighted the importance of men's influence on FTM health actions, as well as on their own uncertainties and needs as partners and fathers. The project therefore included a small group activity that provided health information to male partners and also explored the underlying gender norms that influence men's roles and relationships within the home. Initially, men were reluctant to participate in activities that were felt to be "unmanly." The project team quickly adjusted the recruitment approach and used male motivators (primarily the husbands/partners of FTM peer leaders) to reach out to other men. This peer-to-peer approach worked well, as male partners were more comfortable discussing the proposed activity and also appreciated knowing someone who would be in the group. While CHWs led the sessions, male motivators helped to encourage attendance and maintain order throughout the intervention. In a few instances, they also helped to counter negative attitudes from other men in the community about the male partner groups. Ultimately, nearly all of the men participated in every session, and endline results were strong across all indicators of interest—from increased contraceptive use to gender-equitable attitudes.

INSIGHT 6



ENGAGE HOUSEHOLD AND FAMILY MEMBERS WHO INFLUENCE FTP OPTIONS

FTPs' actions and behaviors are heavily influenced by a range of gatekeepers in their families and households. Determining who those influential actors are and how they affect key FTP practices is an important step in designing interventions to engage these influencers strategically and effectively.

The experience of becoming a parent for the first time is one that involves many people beyond the young mother- and father-to-be. Family and household members often play an important role in providing valuable guidance and support for young FTPs. As such, these individuals—especially older female relatives—can heavily influence (both positively and negatively) FTPs' health options and actions. For example, mothers of unmarried FTMs often provide practical and financial support throughout the lifestage, which may affect the healthcare the FTM can use. The mothers-in-law of FTMs are influential for both FTMs and their husbands/partners. As

gatekeepers of family traditions and wellbeing, mothers-in-law often determine which health behaviors and actions are acceptable for the younger generation. Gender and power dynamics can also limit FTMs'/ FTPs' ability to express their preferences, ask for support, or challenge influencers' opinions and decisions. Conversely, influencers can be powerful allies who support FTMs/FTP to achieve the reproductive and health outcomes they want for themselves and their children.

Given the complex health issues and interpersonal dynamics of the FTP lifestage, programmers have an important opportunity to identify and engage key influencers to build a common understanding of FTP needs and choices, and ideally foster more equitable relationships that enable FTPs to use their voices in matters that affect their health and family. Again, formative data is valuable in helping to identify the main influencers for priority health behaviors, especially since different people may affect different outcomes (e.g., the FTM's mother may influence ANC, but her mother-in-law may influence infant feeding practices). Across E2A projects, the mothers and mothers-in-law of FTMs have consistently been identified as critical influencers during the FTP lifestage. Several other insights have also emerged that should be factored into interventions that engage FTP influencers.

- **Strategic engagement:** E2A has found that it can be difficult to reach some influencers, especially if there are competing priorities that limit their time (e.g., older women who have business or farming commitments). It is important to focus activities for key influencers on strategic health gaps and concerns, particularly on those that touch on deeply held cultural and gender norms or require practical support (e.g., financial resources).

- **Cultural practices regarding first birth/child:** In some cultures, there are specific practices related to a first child, such as traditions about where to give birth or where a new mother and infant will live during the first few months after birth. Influencers are often the gatekeepers of these practices. By developing activities with key influencers that address cultural practices that may not be beneficial to the health of the FTM or the newborn, programs can increase influencer support for positive FTM health actions and reduce barriers to healthcare use.
- **Conflicting views:** Influencers may have different opinions about health issues (e.g., different views on infant feeding practices), which can leave FTMs/ FTPs caught in the middle. Activities that allow influencers to share about and debate these issues—and, ideally, arrive at consensus—are helpful. E2A has primarily pursued this type of activity through discussion sessions designed for older women relatives. We have also found that home visits by CHWs are useful in managing conflicts at the household level,

particularly when CHWs represent an impartial voice who can advocate on behalf of the FTP.

- **Positive norms related to children:** In most cultures, the birth of a child is a positive family event. This is a powerful foundation to build on when advocating with influencers for the health and wellbeing of the FTM/FTP and the new child.



STRATEGIC ENGAGEMENT WITH HOUSEHOLD GATEKEEPERS IN BURKINA FASO

During the Phase 1 of FTP programming in Burkina Faso, the project team identified three health behaviors that were tied to deeply held sociocultural norms and family traditions: seeking ANC early in a pregnancy (tied to cultural taboos on sharing news about pregnancies), practicing exclusive breastfeeding (tied to traditional feeding practices), and using modern contraceptive methods to achieve HTSP (tied to social norms about fertility and family size). The project team realized that to make progress on these three outcomes, they would need to rethink how they engaged household gatekeepers. Husbands were among these gatekeepers, but influential older relatives (especially mothers-in-law) were found to be particularly important, as they controlled FTMs' access to information and services and upheld socio-cultural norms and family traditions. In the Phase 2 of the project, the team focused influencer engagement on the three outcomes, spending less time on health behaviors for which there was already support (e.g., ANC in general, delivery at a health facility) and more on exploring the deeply held beliefs that had implications for the health and wellbeing of the new mother and baby. Shifting such beliefs takes time, but having a strategic focus helped streamline gatekeeper engagement to hone in on issues that were most important and relevant to them and created the possibility of rethinking norms that might otherwise go unchallenged.



TAGAZA DJIBO (BURKINA FASO)

COMMUNITY PERSPECTIVE

“There have been a lot of difficulties, because if you want to select someone, you have to go to the person’s family. You have to see their husband first. If you don’t see her husband, you have to see her mother-in-law or father-in-law. Because nowadays, you can’t register someone... without [the family] knowing why you came to select her. So, you have to inform the family.”

—COMMUNITY HEALTH WORKER, 35 YEARS OLD, BURKINA FASO

INSIGHT 7



INCLUDE COMMUNITY-BASED INTERVENTIONS THAT LINK FTMS TO KEY INDIVIDUALS AND RESOURCES

Given FTPs' limited prior engagement with the health system and other resources to support the variety of new issues they are experiencing, a range of community- and home-based outreach activities can build crucial linkages to and trust in health providers, facilities, and other sources of accurate information and support.

FTPs need timely and quality health information, counseling, and healthcare across a wide range of health issues—from ANC, to nutrition, to safe delivery services, to multiple postpartum services for the mother and infant (e.g., FP, immunizations). In many countries, such services, including information about health behaviors that are practiced at home (e.g., exclusive breastfeeding), are primarily available at health facilities. Relying on facility-based services presents challenges for FTPs. They are young and many have had little or no

previous experience with the formal health sector, so they may feel uncomfortable in facilities that are used primarily by adults or children. FTPs likely have little information or previous experience with the health issues involved and may not be aware of the services they need (especially preventive services). Many FTMs/FTPs also lack the decision-making power to obtain services independently, especially if they require financial resources for transport or fees. Gender and power dynamics within the FTP couple or household can limit if, when, and how an FTM is able to use healthcare. Finally, social norms (e.g., stigma associated with having a child outside of marriage, taboos tied to sharing news about pregnancy outside the household until it is viable) can also prevent FTPs from accessing healthcare and other essential services in a timely manner, if at all.

For these reasons, it is critical to include community-based interventions, such as home visits and small group education, that complement facility-based service delivery when programming for FTPs:

- **Identify FTMs/FTPs: FTPs can often be difficult to find.** They may not be linked to the health system or other institutions (e.g., school) and can be isolated within their households. Community networks (e.g., community leaders, health workers, peers, etc.) are essential to identifying FTPs and connecting them to services and programs as early as possible.
- **Provide tailored and timely information, counseling, support, and healthcare (including referrals) throughout the FTP lifestage:** This is a critical function of community-based interventions, as FTPs need a continuous flow of services over a long period of time. Interventions that can be synced to the FTPs'

specific needs as they progress through the lifestage will help ensure timely uptake of services or adoption of health behaviors.

- Engage partners and other household influencers:**
Typically, MNCH/FP/RH facilities are accessed only by women, which often means that other actors (especially husbands/partners) who are influential and involved in the FTMs' health issues are not being reached. Interventions that go into the community and/or the home represent an important opportunity to engage partners and influencers to build their health knowledge and support and help address barriers to accessing services (including gender and power dynamics).
- Build linkages to and trust in health providers/facilities:**
FTPs have little previous experience with the health sector and may have strong reservations about using health facilities. Community-based interventions—especially if conducted by trained community-based resource persons who are linked to the formal health system—can help build trust in the health system that goes beyond the FTP lifestage. This should also be coupled with orientation, training, or mentorship to facility-based providers to ensure they are able to provide youth-friendly services and aware of young FTPs' unique needs.

E2A's FTP program included multiple types of community-based interventions (including FTM peer groups and men's groups), but across projects, home visits by CHWs (or a similar cadre) have consistently been critical to fulfilling the functions noted above. Recent studies by other projects working with FTPs reinforce the finding that home visits are an essential, effective component of FTP



MAREN VESPIA (TANZANIA)

programs. Importantly, feedback from FTMs and their husbands/partners showed that they valued having time with a trained CHW to address their specific needs and any questions about problems they faced. Home visits are time-consuming and require strong facilitation and communication skills, so projects should invest in ensuring that community-based resource persons have the capacity to conduct quality home visits that are synced to FTP needs.

SEUN ASALA (NIGERIA)



COMMUNITY PERSPECTIVE

“We worked together as a team, as CHWs, Peer Leaders, and PHE Champions . . . sometimes I go to the meetings to assist the peer leader and clarify some issues even when I am not scheduled to attend. For instance, when peer group members are asking about side effects of family planning contraceptive and peer leader aren’t able to respond.”

—CHW SUPPORTING THE TUUNGANE FTP PROGRAM,
KAPANGA VILLAGE

TWO APPROACHES FOR IMPLEMENTING COMMUNITY-BASED INTERVENTIONS

E2A implemented a variety of community-based interventions that relied on locally based resource persons to conduct activities and provide tailored counseling and services for FTPs. In most countries, E2A worked with CHWs within the MOH system, adding FTP-related tasks to their existing workload and providing a nominal travel allowance. In Nigeria, however, E2A worked with a local community-based organization to identify, train, and deploy unemployed, certified Community Health Extension Workers (an official MOH cadre). These CHEWs were given a monthly stipend (approximately USD 55 per month) and travel allowance to conduct FTP activities. Given the high levels of skill and time needed, this approach worked very well—creating a pool of higher-caliber community-based resource persons who could dedicate all of their time to FTP activities. It also proved to be a positive arrangement for the CHEWs, giving them new skills, valuable experience, and increased exposure both in their communities and the MOH, which helped to further their professional development. While this approach has implications for the cost and longer-term sustainability of FTP interventions, the strong results achieved over a relatively short time highlight the benefits of working through community-based resource persons with the motivation, skills, and time needed to fulfill their pivotal role.

INSIGHT 8



ADDRESS UNDERLYING GENDER NORMS AND POWER DYNAMICS

Given the new relationship and power dynamics often associated with the FTP lifestage, as well as its range of new transitions, challenges, and stresses, program designers should consider integrating gender-synchronized and gender-transformative approaches into FTP programs.

From ideals of motherhood and fatherhood to attitudes related to access to and use of healthcare, underlying gender norms and power dynamics shape the FTP experience. As indicated in many of the previous insights, young FTMs are particularly hindered by norms that limit their reproductive options and create power imbalances within relationships with partners, influencers, and the health system. Given the impact these can have on the health of the mother and baby, as well as the wellbeing of the entire family, it is essential for projects to include activities that stimulate reflection on restrictive norms and power inequities, and catalyze new ways of thinking about how individuals, couples, households, and communities can work together

to advance gender and health outcomes. FTP programs also offer a tremendous opportunity to build on positive norms around motherhood, fatherhood, and children. For example, to value having and caring for children is a cultural universal, which provides a common foundation for pursuing health and gender outcomes that benefit both FTPs and their children. FTP projects have a particular opportunity to use a gender-synchronized approach, defined as “working with men and women, boys and girls, in an intentional and mutually reinforcing way, to challenge restrictive gender norms, catalyze the achievement of gender equality, and improve health.”

In thinking through programming options, program designers should consider several unique aspects of the FTP lifestage. First, in many contexts, becoming a parent marks the transition into adulthood, during which gender norms and power dynamics can shift accordingly. For example, young women who typically have little status within the family may gain power as they become mothers (at least in areas like household and childcare decisions). During this transitional phase, relationships, experiences, and norms are often fluid, and this fluidity should be factored into gender programming for FTPs.

Second, the FTP lifestage can be very stressful for all individuals involved, not only given the multiple health needs that arise, but also due to disruptions or changes in other areas of life (e.g., education, relationship status). New demands (e.g., an increased need for time and financial resources to support a child) can strain relationships and recent program experiences suggest that FTMs may face increased risk of intimate partner violence. While evidence in this area is still

evolving, such findings underscore the importance of skillfully and carefully addressing gender and power dynamics in FTP programming to ensure the safety of participants, especially young FTMs.

By (E2A's) definition, FTMs are young, and project experiences have shown that their husbands/partners may also be young first-time fathers. As such, many have not previously reflected on gender norms or experienced some of the specific power dynamics that arise in the lifestage (e.g., a pregnant FTM will not yet know how power dynamics in her family will influence her options regarding contraceptive use). Gender and power are difficult concepts for most people, including young people, to understand, and E2A's experience across countries has highlighted several program elements that have worked well for introducing and engaging with these concepts:

- **Use of participatory activities:** Given FTPs' age and limited experience, participatory activities (e.g., games, stories, Q&A) are critical tools that allow them to reflect on gender and power dynamics and how these influence their lives. This approach is standard in youth programming, but tailoring activities to reflect the unique characteristics of the FTP lifestage is a key adaptation.
- **Peer engagement:** Bringing young FTMs together to explore gender and power issues has been effective across projects. FTMs benefit from knowing that others are facing similar situations, as well as from hearing how other young women have addressed these challenges.
- **Communication, negotiation, and decision-making skills:** Many FTPs have not had an opportunity to develop good communication skills or learned how to think through different

options and consequences. These are basic life skills that can be tailored to FTP-specific situations, and will also carry over into all areas of their lives.

- **Managing conflict:** Related to the above points, FTPs also need skills in problem solving and managing conflicts, especially when there is a lack of agreement on a particular health (or life) decision. Again, it is important to note that issues of intimate partner violence and gender-based violence may arise during the FTP lifestage, so programs should ensure that they can provide or link to additional support and services as needed.

COMMUNITY PERSPECTIVE

"Decision making—I have always thought that it's only the man of the house that has the final decision. But when Pathfinder came, they made me understand that family decisions are for the two spouses."

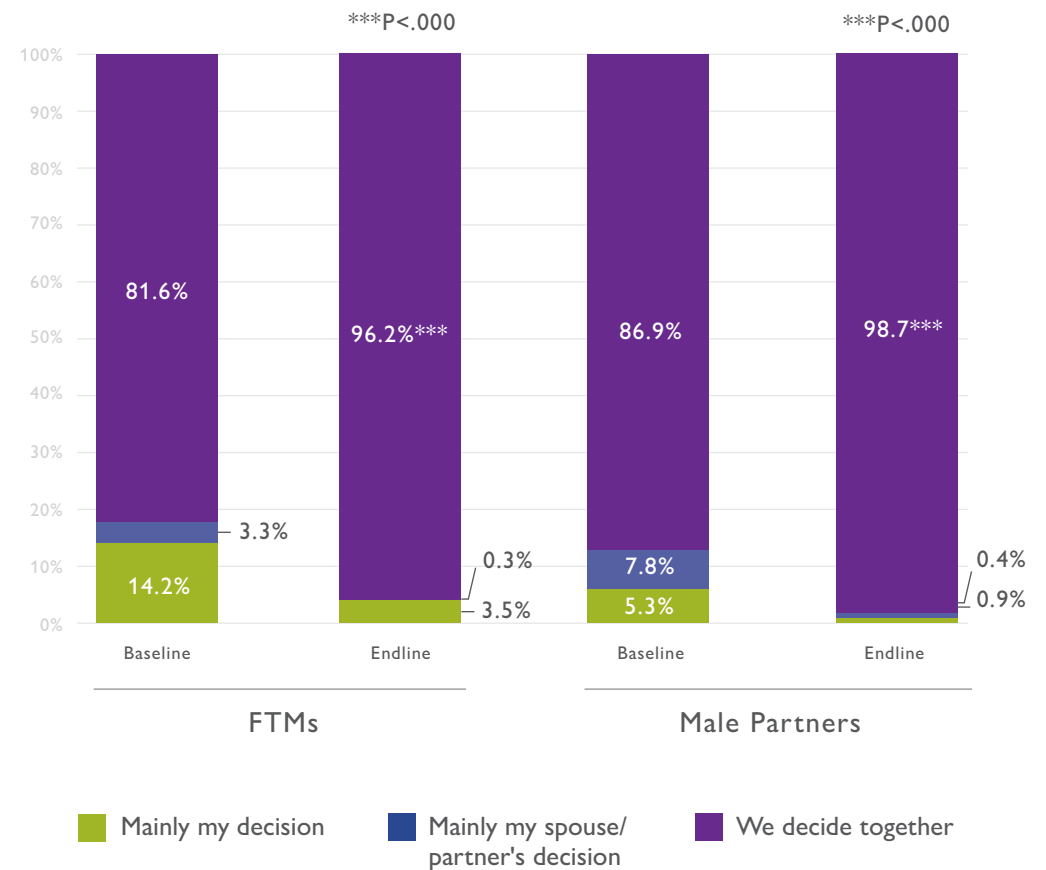
—CO-HABITING FIRST-TIME FATHER, NIGERIA

USING A GENDER-SYNCHRONIZED APPROACH IN NIGERIA

E2A's project in Nigeria was our first opportunity to explore gender norms and power dynamics with FTMs and their husbands/partners in a synchronized manner. Given the fluidity of partnerships among project FTPs, the team worked separately with the young women and men to rethink restrictive gender norms and power dynamics, as well as to reflect on different ways of working together for the mutual benefit of the couple. FTPs responded positively to these activities, and both FTMs and their partners noted that communication and managing conflict were particularly important issues to address. Although the project lasted only four months, evaluation results showed significant positive shifts in gender attitudes related to household roles and decision making among both FTMs and their partners. This suggests that couples-oriented interventions or joint activities can work well—even in a context where many FTPs are not in formal unions or living in the same household. Even periodic touchpoints that allow FTMs and male partners to share important issues being raised in their separate groups could be an effective approach to helping FTPs learn, share, and advance together.

SNAPSHOT: RESULTS IN NIGERIA

Decision making responsibility regarding using FP, by baseline, endline, and participant group



More resources, tools, and insights on our work with first-time parents are available at
E2APROJECT.ORG/FTPS



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