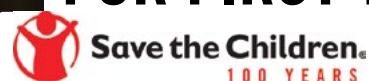




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BEYOND THE ABCS OF FTPS: A DEEP DIVE INTO EMERGING CONSIDERATIONS FOR FIRST TIME PARENT PROGRAMS



INTRODUCTION

There is growing recognition of the importance of working with young (aged 24 and younger) first time parents (FTPs) to improve health and development outcomes. Globally, 1 in 5 young women (aged 20–24) were married as children, and approximately 16 million 15–19 year olds and 770,000 10–14 year olds give birth each year in developing regions [1, 2]. A major cause of death among adolescent girls worldwide is pregnancy-related complications. Mothers and babies are healthier if there is at least 24 months between the last birth and next pregnancy. However, in many countries, birth intervals are shorter among the youngest mothers, and use of postpartum family planning (PPFP) is lower for adolescent mothers (aged 15–19) compared to all women of reproductive age [3]. The closely spaced birth of a second child to an adolescent mother can perpetuate a cycle of poverty and inequity, since in many countries, rapid repeat pregnancies are most common among poor, less educated and rural communities.

At the same time, a first pregnancy or birth is a pivotal opportunity to shape norms and practices that can contribute to long-term health and well-being. A growing number of initiatives have sought to meet the specific reproductive and maternal health needs of FTPs. Through these experiences, several building blocks for effective FTP

ESTABLISHED BUILDING BLOCKS FOR FTP PROGRAMS

- **Apply a socio-ecological lens** recognizing that factors at individual, couple, family, community, and systems levels influence FTPs' decisions. Include interventions to reach FTPs, key influencers, and communities.
- **Tailor programs to age, marital status, and other characteristics of the FTP**, including planning for exposure to multiple interventions within and across life stages.
- **Apply a gender-synchronized approach**, engaging FTPs of both sexes with gender-transformative interventions.
- **Improve access to quality, responsive health services**, including a full range of contraceptive methods.

programming have emerged (see text box). However, as FTP programs advance, new learning and insights are rapidly emerging. To best meet the needs of FTPs, it is critical to capture these new insights and quickly apply them to programming and research. To support this, in 2018, the Bill & Melinda Gates Foundation commissioned Save the Children to conduct a review to examine new and emerging considerations from recent research and programs related to FTP's reproductive and maternal health, with a particular focus on family planning (FP). This technical brief presents the main findings and considerations that emerged from the review.

METHODOLOGY

Save the Children conducted a review of available resources alongside key informant interviews to identify emerging considerations in FTP research and programming. Use of online search engines identified articles using search terms related to FTPs in low- and middle-income countries (LMICs) and Boolean operators. Save the Children also searched websites of international organizations and research initiatives to identify relevant documents. The search resulted in 115 peer review and grey documents published since 2013, including articles, reports, briefs and PowerPoint presentations.¹ Resources were analyzed using inductive and deductive coding with *Atlas.ti* to identify and consolidate findings into key themes. Save the Children also conducted interviews with 10 researchers and program implementers² engaged in FTP-related research or programs in LMICs to validate emerging themes and gather further insights from recent or ongoing initiatives.

FINDINGS: EMERGING CONSIDERATIONS FOR FTP PROGRAMMING

“As gender inequality is a primary driver of early marriage and early and rapid repeat childbearing among young women, future programs aiming to increase contraceptive use among young married women should more robustly address the gender inequitable attitudes, behaviors and norms underlying contraceptive behavior and the intersectional vulnerabilities, such as poverty and lack of educational opportunities, that young married women face.”[4]

behavior-change efforts towards transforming broader normative environments. Individuals may personally disagree with a social norm, but act in accordance with it out of a desire for social belonging and to

Findings from the review coalesced into six themes of emerging considerations with the potential to strengthen programs, policies and services, as well as to inform research agendas, for FTPs in LMICs.

THEME 1: GENDER AND SOCIAL NORMS

Gender and social norms emerged as a crosscutting theme with relevance for all other emerging themes. Early and rapid repeat pregnancies among FTPs are driven by gendered social norms that pressure first-time mothers (FTMs) to have closely spaced children and limit their decision-making power and agency, including in relation to FP use. The literature highlights that addressing inequitable social and gender norms requires **extending beyond individually focused**

¹ Full details of the methodology and reference list of the desk review is available by request (ASRHteam@savechildren.org)

² A360 Project (PSI), Care International, Evidence to Action Project, Gender and Adolescence: Global Evidence (GAGE) study, Momentum Project (Tulane University), Pathfinder International, Promundo, Tearfund, USAID, Young Lives

avoid social backlash. For example, several FTP programs have observed that health providers may be reluctant to provide FP, especially long-acting reversible contraceptives (LARCs), to FTPs out of fear of backlash from communities.

Working with FTPs' key influencers is widely recognized as an essential strategy to challenge social norms that restrict FTPs' FP use. New data suggests that **generational divides exist between key influencers' and FTPs' norms and attitudes related to fertility and contraceptive use**, which are important for programs to take into consideration. Longitudinal data from the Young Lives study in India revealed that individual attitudes of young couples have shifted away from early childbearing, son preference and having large families. Yet, young married couples are still under sustained pressure from older family and community members to prove their fertility and have male children [5]. Program observations are emerging about **different ways of framing engagement with influencers on social and gender norms**. For example, direct gender equity messaging may work well in some contexts, while, in other contexts it may be more effective to frame FP around concepts that have social traction, such as financial stability and securing a stable future for families.



Photo : Louis Leeson / Save the Children

THEME 2: ASPIRATIONS AND POSITIVE FRAMING

Adolescence is a key period for defining aspirations about education, family formation and livelihoods. Supporting adolescents to formulate positive aspirations is an important soft skill to help navigate life transitions. Recent data from the Young Lives study suggests marriage and even more so, **pregnancy, can drastically alter adolescent girls' aspirations**, which shift from hopes for their own future to hopes for the next generation [7].

Emerging data suggests that a focus on positive aspirations within interventions that work directly with FTPs has the potential to improve FP outcomes, as well as broader psychosocial well-being for FTMs. Findings from studies and programs in LMICs suggest that **having positive educational, economic and/or relational aspirations are associated with adolescent and FTMs' use of modern contraception** [6, 8-12]. There is also an observed association between framing contraception as a tool to help achieve life aspirations and increased contraceptive use among FTMs.

The inclusion of aspirations in sexual and reproductive health (SRH) and FP programming for FTPs requires consideration of the impact of social norms and structural barriers. Recent programs and research highlight that **a disconnect often exists between an adolescent's fertility intentions and her ability or agency to take actions aligned with her intentions**. For example, many married adolescent girls want to delay pregnancy and pursue educational or livelihood goals, yet their aspirations are limited by conflicting social norms that restrict girls' decision-making. In addition, in many contexts, educational sector policies or lack of childcare options prevent young mothers from resuming their studies after having a child. Designing FTP programs with multisectoral outcomes can help to address such barriers. However, results from a 2016 study

“Having persistently low educational aspirations is associated with an increase in early marriage / cohabitation (by 23 pp), whereas a decrease in aspirations (downward aspirations) between ages 12 and 15 is associated with an increase in the probability of early childbearing and early marriage/cohabitation (by 9 pp and 13 pp, respectively).” [6]



highlight **possible trade-offs with a multisectoral approach**. The study showed that a program model focused solely on SRH delivered greater SRH-specific outcomes, but limited effects on other domains; while a multisectoral model generated positive outcomes across several domains, but with slightly smaller effects on SRH outcomes [13].

THEME 3: MARITAL STATUS

The effects of FTPs' marital status on health practices and outcomes **requires a clear understanding of family formation patterns**. Differences are observed in settings where most FTPs are married compared to those where many FTPs are unmarried. The influence of polygamous and monogamous marriage also creates specific considerations in terms of power dynamics and the key influencers who yield power over FP and maternal, newborn and child health (MNCH) decision-making.

Current data presents **a nuanced picture of the effect of marital status on FTP's contraceptive use**. Evidence from LMICs suggest that marriage generally has a strong negative effect on contraceptive use among adolescents and young women—often due to social pressure for young married women to prove their fertility and have children as soon as possible [5, 7, 14, 15]. Also, health providers have been observed to turn away married FTMs from FP services if they don't have their husband's authorization, while unmarried FTMs are more able to make independent choices about FP use [16, 17]. However, unmarried FTMs may not perceive themselves as 'sexually active' and therefore may choose not to use FP, including PPFP. In 2017, a study in Kenya observed that married young women were more likely than their unmarried counterparts to use PPFP, because marriage exposes young women to more frequent sexual activity [18].

Marital status also has an influence on FTMs' use of antenatal care (ANC) services [19, 20]. Unmarried FTMs may be more likely to delay or forgo accessing ANC services than their married peers due to discrimination within the community or disrespectful treatment by health workers associated with stigma against pregnancy outside of marriage.

In addition to health-seeking behaviors, emerging data also suggests that **social isolation differs based on marital status**. Although married adolescents may initially experience greater social isolation than their unmarried peers, in some settings, a first birth within marriage creates increased social connectedness, since the FTM is considered to have stepped into a more socially accepted role as a confirmed wife and mother [21, 22]. Unmarried FTMs do not benefit from this same positive change in social status.

“The actual experiences of married life differed among our participants; some enjoyed improved standards of living, increased independence, and a greater sense of being cared for and supported. For others, marriage entailed the weakening of social ties to home and constrained physical mobility, so that their well-being in the transition to marital life pivoted critically on the protection, patience and consideration of husbands and in-laws. The most vulnerable young women were those who failed to fulfil their expected marital roles (e.g., housework, bearing the right number and correct sex of children) and who lacked a strong network of social support.” [2, 5]

THEME 4: FATHERHOOD, MASCULINITIES AND GENDER SYNCHRONIZATION

It is well-established that engaging men as supportive partners in SRH and MNCH initiatives has the potential to generate lasting benefits for families, communities and gender equality. This desk review deepened insights into considerations for reaching and engaging FTMs' male partners and the importance of examining masculinities in FTP programming.

There is increasing conceptual agreement that FTP programs should use gender-synchronized approaches that engage both FTMs and their male partners. However, current evidence about the most effective approaches for gender synchronization and its tangible value on SRH outcomes, is still somewhat limited and inconclusive (see text box). In addition, **while many FTP efforts seek to engage male partners, they often overlook their diversity in terms of marital status, age difference with the FTM, level of education and number of children with other women.** These distinctions are important for designing and implementing gender-transformative programs. For example, Pathfinder International's program experience in Burkina Faso revealed that older husbands of FTMs were more reluctant to discuss personal issues in front of their wives during community health worker home visits, whereas younger husbands were more open to discuss FP [25]. Thus, an appropriate strategy for engaging young husbands was couples' counseling, while individual communication was more appropriate for older husbands.

Becoming a father is a crucial milestone and a unique opportunity to explore masculinities and challenge inequitable gender attitudes and norms. Recent literature from LMICs highlights how men, especially young men, feel under pressure to live up to normative expectations of masculinities that define fatherhood [26]. For example, fatherhood is commonly associated with men being able to provide financially for the family. This role is often particularly challenging for young male partners to fulfil, which can affect how or if they assume their role as a father. Program experience suggests that perceptions of masculinity affect male partners' participation in FTP interventions. Men may choose not to participate in interventions perceived to be primarily for women out of fear of being regarded as being 'feminine'. In addition, the provision of tailored information, health and social services to support fathers is often overlooked in FTP programs, which can discourage male partners from participating in program activities.

GENDER SYNCHRONIZATION: EVIDENCE GAPS

Many program models exist for gender synchronization, including couple's counseling, male-only counseling, male-only groups, group discussions with men and their female partners, male health promoters, and integration of SRH/FP with non-health activities for men. Results from some programs and studies suggest that a model in which male and female partners are engaged—both together and separately—is associated with higher contraceptive uptake [4, 23]. However, one study showed that men's participation solely in male-only sessions was associated with greater improvements in gender equitable results than participation in both male-only and couples sessions [24]. Overall, the literature is inconclusive about the relative gains and disadvantages of single-sex and mixed-sex interventions, as well as which types of interventions contribute most effectively to gender-transformative SRH/FP outcomes.



Photo: Victoria Ziegler / Save the Children

THEME 5: FTP RESPONSIVE HEALTH SERVICE DELIVERY

A first pregnancy is often the first time young women interact with the health system and therefore offers a **unique window of opportunity to provide FTPs an integrated package of care across the spectrum of MNCH, SRH and FP services**. FTPs require carefully phased information and services over a 33-month timeframe—from conception to 2-years postpartum—to optimize healthy timing and spacing of a subsequent birth. Several programs have documented successful experiences of training health professionals and community health agents on FTP responsive FP or MNCH care. However, many of the experiences involved one-off, in-service trainings, which global evidence suggests may have limited impact [27].

The literature highlights several important considerations for designing FTP-responsive integrated health care. First, evidence suggests that while the youngest mothers in LMICs often have comparable rates of accessing some level of ANC as all women

“ANC offers an opportunity to sensitize adolescent mothers about utilisation of maternal health services and promote healthy lifestyles that could potentially improve long-term health outcomes for them and their yet unborn child. For example, family planning counselling could be integrated into ANC, continued as part of PNC and this could potentially have a positive impact on the adolescent’s use of contraception after delivery.” [20]

of reproductive age, **adolescents are more likely than older women to access ANC services late and less frequently** due to financial barriers, insufficient information about pregnancy and ANC, and discrimination by communities and by health workers [19]. Second, in many countries, **PPFP use remains lowest among 15 to 19 year olds** [3]. Third, a 2017 systematic review suggests that—among adolescents in LMIC—ANC and other MNCH service use decreases as parity increases [20]. This highlights that a potentially negative experience by a FTM may discourage her from using services again for the next pregnancy, pointing to the importance of ensuring high-quality and respectful care for FTPs. Fourth, current literature shows that even when FTP programs have increased uptake of contraception, there is **a common preference for short-acting methods** [5, 14, 18, 28, 29]. This preference was often attributable to FTMs' limited knowledge of a full range of modern methods, misconceptions about hormonal contraception, limited availability of LARCs, and providers' biases against offering LARCs to FTMs. Integrated service delivery models that have shown promise for increasing FP and PPFP use among all women of reproductive age, including the group-ANC model, will require adaptations to more effectively reach and serve FTMs.

THEME 6: SCALE-UP CONSIDERATIONS

To date, many FTP programs have been implemented as multi-component interventions at a smaller scale. The desk review revealed factors that hinder scale-up of FTP programs as well as important insights from those that endeavored to scale-up.

Interventions with higher dosage and intensity—that is, **multiple instances of contact with FTPs at multiple life cycle stages, over longer periods of time—are associated with the strongest FP and gender equality results** [4, 30-32]. However, 'high dosage' approaches are often associated with higher costs, which can present challenges for effective scale-up.

Multiple reinforcing interventions that include both demand and supply strategies achieve positive SRH outcomes for FTPs. However, scale-up of such complex interventions is challenging and experts suggest simplifying before bringing them to scale. **Understanding the relative effect of different components in FTP programs can help to guide scale-up planning.** Some projects have found that home visits are associated with contraceptive use among FTPs, particularly when coupled with community-level interventions and quality improvement of facility-based services [4, 33]. Preliminary data from the *Reaching Married Adolescents* project in Niger further suggests that home visits are the most cost-effective intervention for increasing contraceptive use among young married women compared to small groups or a combined approach of the two [34]. However, the same study suggests that small peer groups are more effective for achieving gender transformative outcomes than home visits [35]. Other high-quality evaluations in different settings have shown that the effect of home-based interventions on FTPs' subsequent birth intervals is limited when they are not linked to PPFP counselling and services, and when they do not emphasize goal-setting and an understanding of how contraception can contribute to desired life outcomes. [9].

The literature highlights a **possible trade-off between quality and expansion** that arises when moving from an intensive NGO-implemented approach to one that may reach more people but relies on overburdened government workers or systems [4]. The literature also notes that behavior and norm change interventions, which are central to FTP programming, generally require intensive resources to maintain quality; yet this level of investment may be difficult to sustain at scale [32].

There is **limited data on the long-term effects of FTP programs.** The *PRACHAR* project in Bihar, India showed a significant positive effect on contraceptive use among young married women, including FTPs, exposed to the program and among new cohorts of women 4 to 8 years after the program's end [29]. However, no other studies identified in the review looked specifically at the long-term effects of FTP programs.



IMPLICATIONS FOR PROGRAMS AND RESEARCH

Going forward, FTP programs and research endeavors would benefit from considering the findings of this review in the design and implementation of their efforts. In particular, in addition to considering the established “building blocks,” **FTP programs could:**

- Position social and gender norm change efforts as a central component, particularly through interventions at the community-level that transform underlying drivers of inequities. Specific priorities include introducing strategies to address: the intergenerational differences in social and gender norms between FTPs and their key influencers; norms that limit male partners’ participation in programs and use of health services; and norms influencing health providers’ biases related to FTP’s sexuality, fertility and contraceptive use, especially LARCs.
- Include a focus on context-specific aspirations that encourage FTPs to reflect on how contraception may help them achieve their goals. Such efforts should also seek to address structural barriers beyond the health sector through collaboration with education, livelihoods, economic resilience, social protection and social norm change initiatives.
- Strengthen the integration between MNCH and FP service delivery, including PPFP, as well as ensuring continuity of care across community-based and facility-based services.
- Explore scalable service-delivery and programming platforms to sustainably reach FTPs, including: how to offer multiple reinforcing points of contact with FTPs over time through routine reproductive and MNCH services; leveraging existing programs operating at large scale to efficiently reach FTPs; and social and behavior change models that are not reliant on intensive interpersonal approaches.

FTP research and evaluative efforts could explore:

- The nature of girls' aspirations across contexts, including how they evolve across different reproductive life phases, how they align or conflict with those of their male partners, and how they inform reproductive intentions and service use.
- The meaning of fatherhood from the perspective of male partners; and how this affects their involvement in SRH and MNCH decision-making.
- The most effective models of engaging male partners for FTP initiatives.
- The long-term effects of FTP programs on SRH, FP and MNCH practices and outcomes.
- The relative advantage of different intervention components, as well as intensity and dosage of interventions.
- The effects of marital status on FTPs' use of MNCH and FP services in diverse contexts, including different barriers at the household, community and health facility-level

THEMES FOR FURTHER EXPLORATION

In addition to the six major themes presented above, the following topics also emerged through the inductive analysis of literature as areas that warrant future exploration. While limited documentation exists on these themes, they appeared as forthcoming priority areas for FTP initiatives.

HUMANITARIAN SETTINGS

Humanitarian crises may affect the life phase transitions of FTPs—either by precipitating or delaying changes such as marriage or pregnancy, while also limiting access to health, social and protection services. A small number of programs are working with FTPs in humanitarian settings and have flagged the need for further examination of how to ensure safety for accessing health services, how to design safe spaces for FTPs and how to offer mental health programs and services for FTPs.

MIGRATION

Preliminary findings from ongoing programs suggest that migration is an important consideration for FTP programs. Men's migration is often associated with seasonal work, and in some settings, women migrate to marital or natal homes for childbirth. Thus, migration has implications for the timing and technical strategy of FTP interventions, as well as their dosage and intensity. Migration may also affect norms around sexuality, contraceptive use, fertility, and couples' communication in contexts where couples are not in the same geographic location.

MENTAL HEALTH

Poor mental health, including postpartum depression, is associated with early and rapid repeat pregnancies, negative consequences on early childhood development, and substance use/abuse to cope with unintended pregnancies among adolescents. For these reasons, in high-income countries, programs with adolescent mothers often include a focus on emotional and psychosocial resilience and well-being. However, a mental health component is still largely absent from FTP programs in LMICs.

CONCLUSION

Becoming a parent for the first time is a crucial life stage to ensure access to integrated health and social services for young people. Meeting the broad range of FTPs' health and development needs has the potential to generate positive impact for girls, women, their families and communities. This desk review shows that the knowledge base about effective FTP programs and services is growing and is already shining light on emerging themes that have the potential to strengthen programs, policies and services, and ultimately improve outcomes for FTPs in LMICs.

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