"Because my Husband and I Have Never Had a Baby Before…"[1]

Results and Lessons from Interventions with First-Time Parents in Madagascar, Mozambique, and Nigeria

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Overview

This technical brief presents findings and lessons learned from small-scale interventions implemented by the Maternal and Child Survival Program (MCSP) with first-time parents (FTPs) in three diverse settings. This presentation of cross-country learning is intended to help program implementers design effective interventions for FTPs and to inform future research and learning agendas. This document first describes the three intervention approaches and the data sources from which findings and lessons are drawn. Cross-country findings comprise deepened insights into FTPs and their needs, including the diverse profiles of FTPs and the FTP life course, and factors shaping health care use and non-use, including social norms and health systems factors. Cross-cutting implementation lessons include approaches and challenges in engagement of first-time mothers and their male partners through group-based and home visit approaches, and engagement of community and family. We conclude with recommendations for future program and research investments and also share additional resources for further information.

Background

Becoming a parent for the first time entails a series of major life transitions. FTPs–defined as girls and women between the ages of 15 and 24 who have one child and/or who are pregnant, and their male partners–often navigate a series of major life milestones (sexual debut, first pregnancy, marriage, first birth) in rapid succession, with varied support from family, community, and systems. At the same time that many young women are removed from family, school, and social support networks, they must also navigate caring for their own health while learning to care for a newborn.

Globally, an estimated 13 million adolescents (aged 15-19) give birth each year, accounting for approximately 11% of all births.[i] In sub-Saharan Africa, adolescent pregnancy is associated with adverse health, education, and economic outcomes for mothers and babies. Adolescent girls who become pregnant are likely to end their education earlier than if they had not become pregnant. The evidence on whether the risk of maternal mortality is higher among adolescent mothers is mixed.[ii] Regardless, pregnancy and delivery can be risky for

[1] Quote from a first-time mother in Nigeria.

girls under age 16.[iii] Children of adolescent mothers have a 34% higher risk of death in the neonatal period and a 26% higher risk of death by age 5, compared with children of older mothers.[iv] Particularly among adolescents, rapid repeat pregnancies, defined as less than 24 months after the previous birth, increase risk of preterm birth, low birthweight, small size for gestational age, and infant and early childhood mortality.[v,vi,vii] Yet across many countries, the youngest mothers are most likely to have closely spaced pregnancies.[viii,ix] Use of modern family planning (FP) among sexually active adolescents, including postpartum family planning (PPFP) among young, first-time mothers/couples in sub-Saharan Africa is also very low.[x]

Despite challenges, the FTP life-stage represents a window of opportunity to shape life-long health and other practices for FTPs and their children. Globally, a growing body of evidence suggests that comprehensive programs targeting adolescents and youth during the transition to parenting can increase the use of contraception and other health services, improve the social support FTPs receive, and encourage more gender equitable household practices.[xi,xii]

MCSP's interventions for first-time parents

Between 2015 and 2019, the United States Agency for International Development (USAID)-supported MCSP developed and tested small-scale "proof-of-concept" interventions to increase demand for and access to reproductive and maternal health services among FTPs in three diverse settings: Madagascar, Mozambique, and Nigeria. Table 1 below presents demographic and health service utilization data for the three countries. Each intervention was tailored to the local context and used elements of a socioecological approach recognizing influences at the individual, couple, family, community, and health systems levels. With limited timing and scope, these interventions focused on engaging FTPs as individuals and as couples, and strengthening the health system response, with a modest component engaging influential family and community members. This brief details the approaches, resulting outcomes, and lessons learned from small-scale implementation in three contexts, and uses the socioecological model as an organizing framework. The last page of this brief includes links to program tools, detailed reports, and research and technical briefs.

Table 1: Gaps in health service utilization between the youngest and all mothers

	Source	% beginning childbearing by age 19	Among those with two or more births, % with birth intervals less than 24 months		Among those with a live birth, % with no ANC for their last pregnancy		Among those with a live birth, % with skilled birth attendance at last birth	
			15-19	All WRA	15-19	All WRA	15-19	All WRA
Madagascar	2008-09 DHS	38.9	49	39.7	14.5	12	40.2	43.9
Mozambique	2011 DHS	46.4	34.8	18.8	7.4	9.5	61.3	54.3
Nigeria	2013 DHS	31.5	42.4	32.7	40.9	27.6	25.2	38.1

Activities in Madagascar

MCSP first introduced a focus on FTPs in Madagascar. There, MCSP conducted qualitative formative research using a socioecological approach to explore the factors at the individual, couple, family, community, and health systems levels that shape FTPs' use of RMNH services. Findings showed that even when FTPs value services for the benefit of women's and children's health, they face supply-side barriers to service use, such as poor quality of services, including stock-outs, long wait times, and unwelcoming health providers. Further, FTPs face family pressure to continue traditions of seeking care from traditional birth attendants (TBAs) and traditional healers. Community health workers (CHWs) are trusted sources of information for FTPs and their family members.

In collaboration with the Ministry of Health, MCSP developed and launched the Tanora Mitsinjo Taranaka (Young People Looking after their Legacy; TMT) initiative in two districts of Menabe region to increase FTPs' use of RMNH services. TMT entailed the following activities:

- Individual/couple: 75 CHWs conducted household visits to FTPs using a booklet to provide life-stage-tailored health information. CHWs, supervised by facility-based providers, also encouraged FTPs to access health services by distributing simple, attractive "invitation cards" to encourage use of health services.
- Health system: Facility-based health providers (32) were trained and supported to provide welcoming health care for adolescents and youth in 11 health facilities. Training engaged providers across all health service areas and focused on ensuring welcoming, nonjudgmental care for FTPs. MCSP also supported the design of the National Adolescent Sexual and Reproductive Health Strategic Plan, launched in February 2018, to emphasize a focus on age- and life-stage-tailored approaches.

Figure 1: A CHW in Madagascar conducts a home visit to a FTM

Photo by Karen Kasmauski, MCSP.

Activities in Mozambique

In Mozambique, MCSP used a similar approach to create a contextually adapted package of adolescent-geared RMNCH services. In lieu of formative research, a process of community consultations exploring the needs of FTPs and the factors that shape health care seeking in Nampula and Sofala Provinces in Mozambique revealed the need to engage male partners, address harmful gender norms, build intracouple communication, and encourage male involvement in family planning and parenting. Using this critical feedback, MCSP adapted Save the Children's *My First Baby* initiative to include male partners, calling the reframed, gender-synchronized package *Our First Baby*.

- **Individual/couple:** Our First Baby includes nine group discussion sessions designed to meet the needs of FTPs and their partners. Each session is conducted by a community health worker *(activista)* trained to lead the implementation and supervised by a Community Development Officer.
- **Health System:** The *activistas* provided referrals to the small group members for services at health facilities. The broader MCSP interventions provided capacity strengthening support to these health facilities to improve the quality of RMNCH services.

Our First Baby Session Topics Mozambique and Nigeria

1. Fertility and pregnancy
2. My pregnancy and antenatal care
3. Caring for yourself during pregnancy
4. Father for the first time!*
5. Birth planning and delivery
6. Newborn care, exclusive breastfeeding, postpartum care*
7. Healthy timing and spacing of pregnancy*
8. Family planning*
9. Sexually transmitted infections, HIV, gender and gender-based violence*

**male partners were invited to join all sessions, but these five were prioritized.*

In Nigeria, Our First Baby was modified to include a savings and loan component in each session.

After a pilot implementation in six districts (three each in Nampula and Sofala), MCSP carefully incorporated key modifications to the program, which included the simplification of the clinical language, lessening of topic redundancy, incorporation of parent (of expectant adolescent) orientation sessions, and adapting the physical size of the teaching materials. MCSP introduced the updated Our First Baby program to an additional three districts in Nampula and five in Sofala while still enrolling new groups in the original six districts. A total of 410 FTPs (271 FTMs and 139 male partners) in the 14 districts completed the program.

Activities in Nigeria

In Nigeria, MCSP adapted and utilized the FTP formative research tools from Madagascar to explore the factors shaping use of health services by FTPs. Findings showed that first-time mothers (FTMs) in Nigeria, particularly the youngest and unmarried, have limited decision-making power because of social norms. FTMs are often socially isolated, particularly when they are unmarried, face strong stigma from family and community, and face significant barriers to health care use because of the costs of accessing facility-based health care and prohibitively high out-of-pocket expenses. The research showed that FTMs could benefit from meaningful engagement of male partners, who, when present, can play a positive and influential role in supporting FTMs during pregnancy and postpartum. To build a sense of social support while also building connections to the health system, MCSP adapted Our First Baby to the Nigerian context (from Mozambique) and tested the adaptation in five health facilities.

- **Individual/couple:** Further, MCSP adapted a mothers' savings and loan component from other MCSP work in Nigeria into the program. In Kogi and Ebonyi, MCSP piloted group sessions facilitated by trained mentors (community members who had also been young parents) to engage FTMs and their male partners. A total of 59 FTMs (20 aged 15-17 years; 39 aged 18-19 years) and 10 male partners participated.

- **Health system:** To strengthen capacity for delivering youth-friendly care, MCSP conducted whole-site orientations for 57 staff in five MCSP-supported facilities, with an emphasis on fostering supportive and nonjudgmental attitudes. Specially developed Age and Life-Stage counseling tools helped health providers to tailor one-on-one counseling for any adolescent client based on their sex, age, and life stage (including pregnant/parenting) to provide sound, practical, and actionable information. To foster a supportive policy environment, MCSP convened biannual national adolescent working group meetings and quarterly state-level adolescent health technical working group meetings in both states.

Data sources

The results and lessons described in this brief were derived from formative research (Madagascar and Nigeria), pre-testing of Our First Baby (Mozambique), reviews of health service data (Madagascar), and project monitoring systems and qualitative end-of-project documentation in all three countries. Specific data sources, described in Table 2, included:

Table 2: Data sources

	Madagascar	Mozambique	Nigeria
Formative work	Formative research *June 2016*	Our First Baby adaptation and pre-testing *September 2016 to January 2017*	Formative research *September 2016 to August 2017*
Monitoring systems	Quarterly learning and reflection meetings with CHWs and health providers explored implementation challenges, learning, and promising practices, helped identify additional training needs and areas for midcourse correction, and identified promising approaches.	Our First Baby facilitators documented participant numbers and facilitation challenges through session log sheets	Our First Baby facilitators documented participant numbers and facilitation challenges through session log sheets

	Madagascar	Mozambique	Nigeria
End-of-project documentation	Focus group discussions with 22 FTMs, 46 CHWs, and 11 regional Ministry officers In-depth interviews with 12 male partners, 11 health providers, and 5 national Ministry officers *April to May 2018* Age-disaggregated service data from ANC, delivery, and FP registers in 11 health facilities *May 2016 to April 2018*	Structured interviews with 7 reproductive health *activistas* (facilitators of the small groups), 6 community development officers and district supervisors, 2 national level MCSP staff, 4 health facility/nursing staff, 3 district health officials, and 1 provincial health official *February 2019*	Focus group discussions with 20 FTMs, 10 male partners, 11 facilitators, 21 health facility staff trained in adolescent-responsive health services, and 17 health providers trained in age- and life-stage tailored counseling *July 2018*

The formative research in Madagascar and Nigeria was approved as human subjects research by the Johns Hopkins University School of Public Health's Institutional Review Board and by local institutional review boards (IRBs; the Ethics Committee of the Ministry of Public Health in Madagascar and the state Ministries of Health in Nigeria). All end-of-project studies were approved by the Save the Children Ethics Review Committee. Both the Madagascar and Nigeria end-of-project studies were determined to be non-human subjects research by Johns Hopkins University School of Public Health's IRB. In Madagascar, this end-of-project study received a nonhuman subjects research designation from the Ethics Committee of Madagascar's Ministry of Public Health. In Nigeria, the study received ethical clearance from the Ebonyi and Kogi state Ministries of Health.

Findings

Deepened insights into diverse profiles of FTPs and the FTP life course

The formative work and implementation processes deepened insights into the diverse profiles of FTPs and the myriad challenges they face as they navigate pregnancy and parenthood for the first time. Illustrative quotes in this section come from the formative research in Madagascar and Nigeria.

Findings from the three settings highlighted the series of life changes that occur in quick succession within the FTP life stage. FTMs' reproductive care needs change rapidly from the time that they are sexually active to pregnancy, delivery, postpartum, and parenting; these significant changes can all occur within a year. At the same time, the family and social context for FTMs can also change quickly. FTMs may leave their family home and community and move to their male partner's home and community at the time of marriage or first pregnancy, or young unmarried mothers may be ejected from their family home without another place to go once their pregnancy is revealed. In other cases, pregnant girls have to abandon their schooling once pregnancy is revealed.

Findings also deepen insights into the diversity of profiles of FTPs. Despite common experiences in navigating the transition to parenthood, FTPs are not a homogeneous group and the diversity of their profiles and experiences merit tailored programmatic responses. In the three countries, the formative work revealed that marital status is a key factor that shapes FTMs' experience with pregnancy and parenthood. When pregnancy occurs within the context of marriage or stable partnership, it may cause stress and worry, particularly if unplanned, but is overall a happy and celebrated milestone for FTMs, their male partners, and their families. Pregnancy for an unmarried girl, on the other hand, can bring consequences that may include shame and poor treatment by health facility staff and community members and rejection by family members and/or by her male partner.

The way [families] react to [unmarried adolescent mothers] is uncalled for. Like the one I saw, as soon as the girls got pregnant, their mother chased them out of the home. The girls cannot even get money for feeding, and they sleep in different places. The way they treat them is not good at all. – Older female relative, Nigeria

I feel ashamed to face even my friends. Your peer group is looking at you, seeing you pregnant when you are not supposed to be, when you are in school and you were supposed to finish. I am a student, so this is…very, very bad. I feel pressure from my dad and all of that, so it is quite disappointing. – FTM, aged 15-17, Nigeria

Kinky, perverted, frivolous, rebellious, poorly raised, scatterbrained, a thug. … People talk in a low voice behind your back or say bad things about you [FTPs]. – Male partner, Madagascar

The nature of relationships with male partners varied among and within countries. In Madagascar, though pregnancy did occur outside the context of marriage, family pressure often resulted in the couple marrying once pregnancy was revealed. As a result, few FTMs in the study were unmarried, but participants described conflict within couples because of pressure to marry before they were ready. Frequently, FTPs start life as a couple after an unexpected pregnancy; often, they have had little-to-no communication about health and matters related to sexuality and are unprepared for pregnancy, parenthood, or marriage.

Figure 2: A FTM in Nigeria following delivery

Photo by Karen Kasmauski, MCSP.

Even an insignificant problem can become unbearable for the young couple. A glass that falls and breaks can cause a major argument. – Influential person, Madagascar

I was afraid because I was still in sixth grade; I was pregnant while still in school. My parents were very demanding, very strict. What scared me was how to tell them I was pregnant. They forced the person who got me pregnant to marry me, and we were obviously married. – FTM, aged 15-17, Madagascar

In Nigeria, findings highlighted variations between the (primarily Muslim) context of the northern states and the (primarily Christian) context of states in the south. In the southern states, relationships with male partners were often fluid; many FTMs did not have committed male partners, and others talked of having been abandoned by their male partners.

We were on good terms, but as soon as he impregnated me … he left me and ran away. – FTM, aged 15-17, Nigeria

In the north, where child marriage is common and pregnancy is expected to closely follow marriage, pregnancy more often occurred in the context of marriage and was celebrated. Notably, however, pregnancy outside of marriage in this context was unacceptable, and unmarried mothers faced the greatest stigma and discrimination.

[Unmarried young parents] will be considered as someone who has no good character and is willing to lead girls astray. In fact, he no longer has value in society. Truly, they have no value in society and shall be considered as someone who has destroyed their reputation and that of their family. – Male partner, Nigeria

Similarly, in Mozambique, pregnancy outside of marriage was described as bringing shame to the family and reflecting poorly on the pregnant girl. Often an unmarried girl would move in with or marry the father of the child, but if the father did not assume responsibility, the girl would remain with, or return to, her family. Importantly, these findings also deepen insight into the diverse profiles of male partners of FTMs. Differences were noted in terms of the nature of relationships with the FTM, as well as their age, education status, and life stage: though many male partners of FTMs are FTPs themselves, others are much older and/or already have one or more children. Though some male partners are able to stay in school, others have to drop out to earn money to care for their new family responsibilities, thus further disadvantaging the couple for future earnings.

Factors shaping health care use and non-use

Through the formative work, we explored social and systems factors that shaped use of health care across the reproductive life course and designed interventions to address these factors to the extent feasible.

Social norms

In the three countries, social norms at each level of the socioecological model shape decisions regarding use of health care.

Figure 3: A young FTM and her baby in Mozambique after delivery

Photo by Kate Holt, MCSP.

Within couples, gender norms play a powerful role; male partners, when present, are often the primary decision-makers on most matters, including healthcare seeking and home health practices. Across the three diverse settings, male partners, when present, have a positive and supportive role. In Madagascar and Nigeria, the formative research showed that it was socially acceptable for male partners to temporarily assume responsibilities for certain household chores traditionally assigned to women during pregnancy and postpartum. Male partners assuming a supportive and helpful role means that FTMs whose male partners are not present or unsupportive are at an even greater disadvantage as they navigate the transition to parenthood.

Female relatives are often perceived as having the expertise in matters related to pregnancy and delivery, and their preferences can outweigh those of male partners. Older female relatives, particularly mothers and mothers-in-law, provide important support during pregnancy and postpartum and often make the final decision about whether and where facility-based care will be sought. In the three countries, their influence on health care use is often negative, as they often preferred that FTMs used the services of traditional birth attendants (TBAs) because of family tradition, trust, and cost factors. Within their extended families, FTMs' decision-making power is limited because they are young, have not completed their education or secured a job, and lack financial resources. This was particularly pronounced in Nigeria, where the cost barriers to accessing care are high; because FTMs rely on influential family members to provide the needed financial resources, they also require their support for use of facility-based care. Norms that give decision-making power to older female relatives and stigmatize FTMs, coupled with service costs, often deterred unmarried FTMs in particular from seeking care during or after pregnancy.

Health system factors

In the formative research in Madagascar and Nigeria, health facility staff attitudes were a primary deterrent to use of health care during and after pregnancy. Staff at health facilities were described as rude, mean, and

disrespectful. FTMs said that they felt staff treated them differently than they did older women. Disrespectful care discouraged FTMs from returning to access health services and in some cases, rumors about unwelcoming services deterred FTMs from accessing care altogether. In contrast, TBAs were described as providing warm, welcoming care.

The day I came to register ... I cried. The woman said, "When you chose to have sex, didn't you know the end result?" Are nurses taught to insult people when they go nursing school? – FTM, aged 15-17, Nigeria

At the health system level, norms intertwine with structural barriers to shape health seeking practices. In Mozambique, unmarried women often avoided seeking care until they could no longer hide their pregnancy, resulting in few ANC visits. Further, particularly in Mozambique, in situations in which the father did not take responsibility for the pregnancy, the FTM faced additional barriers at the health center as providers expect the couple to come together for ANC.

Cross-cutting implementation challenges and lessons

The following sections highlight challenges with and lessons for reaching and engaging FTPs with the aim of increasing knowledge, shifting social norms, and increasing use of health services. Lessons are presented according to the socioecological model, including lessons from engaging FTPs as individuals and couples, and fostering supportive environments at the family, community, and health systems levels. Recruitment and retention of FTMs and their male partners was a key challenge with implications for future programming. Quotes in this section come from end-of-project documentation in the three countries.

Engaging first-time mothers

Lessons from group-based approach

Most respondents in Mozambique and Nigeria said that all nine *Our First Baby (*OFB) sessions were relevant, interesting, provided valued knowledge and skills, and created a space for reflection about gender norms. In Nigeria, FTMs especially appreciated the sessions on fetal development during pregnancy and ANC, FP and sexually transmitted infections (STIs), gender-based violence, and gender. Facilitators in Mozambique similarly noted that all nine OFB sessions were relevant, interesting, and presented new information for FTP. Birth planning, family planning, and newborn care and feeding were frequently mentioned as the most important lessons in Mozambique.

Facilitators in both countries (*activistas* in Mozambique and trained mentors in Nigeria) said that the sessions contributed to positive health-seeking behaviors among FTMs and increased their social capital, noting that the group-based approach helped to build a support system for vulnerable girls.

It was this program that helped to create that kind of bond among first-time mothers. They were able to see that, "Yes, I am not the only one that is a first-time mother." ... It really helped them a lot. – Facilitator, Nigeria

All the adolescents that participated in the pilot are still attending ANC and some have had healthy babies. They bring their babies for [postnatal care] and they receive vaccines – Health technician, Mozambique

In Nigeria, several factors facilitated implementation of the approach. Establishing trust and rapport between the OFB facilitator and participants, as well as fluid communication, were identified as facilitating factors. According to facilitators, ensuring confidentiality within the groups was also key for creating a safe space to participate. Facilitators were central to the success of the approach, and respondents generally agreed that they were effective in their role. In Mozambique, the community-based reproductive health *activistas* who facilitated the groups were already known and trusted in the communities, which helped in mobilizing groups.

The direct contact between the activista and adolescent is very helpful as it breaks the cultural barriers that prevent adolescents from breaking the silence when they are pregnant – Supervisor, DHO, Mozambique

In both countries, facilitators said they were most at ease leading sessions on topics that either they themselves had knowledge and experience of, or that participants had knowledge of; however, sessions with content on FP in particular generated many questions that facilitators were not fully prepared to answer. In Mozambique, *activistas* are a lower level of health cadre and struggled with some of the technical content in the facilitator's guide and flipbook. Some facilitators in Nigeria mitigated this challenge by inviting health providers to co-facilitate the more technical or sensitive discussions.

Recruitment of first-time mothers: challenges and lessons learned

Notably, some facilitators in Nigeria and Mozambique said that stigma against unmarried adolescent mothers may have limited participation. Further, in Mozambique, family and community members feared that FTPs were being recruited for punishment for becoming pregnant.

The ladies believed that when somebody has done what is unethical and unsocial to the communities—by getting pregnant before time—they will receive negative talk from the community. – Facilitator, Nigeria

We have so many young adolescents who are pregnant and in hideouts, because they feel they could not walk in the streets. So one of the challenges we had was identifying them, since they could not even come out. – Facilitator, Nigeria

In recruitment of FTMs, programs need to foster equitable participation through special attention to the needs of the most vulnerable (i.e., the youngest and unmarried mothers). Implementers must also take care to communicate the benefits of participation and to mitigate concerns about FTMs being punished or further stigmatized through participation. Mitigating this challenge will also require addressing community- and family-level factors, including shame and judgment of young and unmarried mothers.

Multisectoral innovation highlight

In the formative research in Nigeria, participants emphasized that costs of accessing services were a primary barrier to use. To mitigate this barrier, MCSP tested the feasibility of incorporating a mothers' savings and loan program into the Our First Baby sessions, building on previous MCSP innovations in Nigeria and in other settings. Individual groups determined the amount of money that would be contributed by each participant, with amounts ranging from 50 to 100 naira (15 to 30 US cents) per meeting.

Participants and facilitators noted that this element motivated participants to continue to attend sessions and also fostered a sense of cohesion among groups. Facilitators and FTMs spoke of using funds for emergency and social needs (i.e., child needs).

The mothers' saving [group] really helped us a lot. It was easy for a pregnant woman to get the money to use in the hospital. – FTM

That they got pregnant at that adolescent age is not the end of life. So with that [loan] they can still find a way to send themselves back to school and also to attend to their children's needs. – Facilitator

Lessons from home visit approach

Reactions of FTPs in Madagascar indicated that TMT's reliance on CHWs to conduct home visits was well received. FTPs remarked that CHWs are trusted community members, known for their efforts to engage mothers and children. They appreciated having the CHWs' focus expanded to include young parents, who previously were frequently overlooked in household visits because CHWs lacked dedicated materials and were not comfortable working with FTPs.

CHWs reported that the TMT training equipped them with skills and confidence to engage FTPs and helped build trust and earn respect in the community.

My experience is that TMT has freed me from my shyness. It has become a reflex for me to approach any girl with a baby on her arm. I give her advice that seems relevant to her. — CHW, Madagascar

Engaging male partners

Experiences across countries confirmed that male partners hold significant decision-making power within the couple and that their engagement is critical. Male partners said they most appreciated sessions that gave clear guidance on how they could support their partners and care for their babies, explaining that this information helped them to see how they could be good fathers. Regardless of the intervention approach (home visits versus group sessions), framing the intervention around what men can do to be "good fathers,", rather than simply supporting their wives/partners, was important for ensuring that messages resonated with male partners.

Engaging male partners in group-based approaches

Among male partners who participated in OFB sessions in Nigeria, the primary motivation to participate was a desire to become better fathers and to improve their ability to ensure the wellbeing of their family. Male participants said they highly valued sessions that provided answers for questions/concerns related to FTMs' experiences (e.g., body changes during pregnancy), that corrected misunderstandings (e.g., pregnancy nutrition), and/or that provided new information to help make healthy choices and achieve their aspirations.

As a man, it broadens my knowledge in the sense that I know how to help my wife if she has another pregnancy. How to take good care of her and how to contribute to her wellbeing. ... The joy of a man is seeing your family being happy. – Male partner, Nigeria

Health facility staff and health officials in Mozambique also said the inclusion of male partners in the OFB sessions was important to helping the young couple learn together how to support each other through the pregnancy and how to better care for the new baby.

They liked knowing that husbands can help take care of babies and even change diapers, play with them, even inside [the] belly…also like to know the importance of going to PNC with her husband. – Activista, Mozambique

Engaging male partners through home visits

In Madagascar, CHWs also reached male partners through home visits. Respondents spoke positively about the information they learned, particularly the importance of facility-based delivery. Some providers reported noticing an increase in the numbers of male partners accompanying FTMs for ANC or delivery services. The providers who noted this trend were supportive of male partners at the facility and said that TMT helped them to more confidently engage male partners. Providers explained that their discussions focused on young men's responsibilities to their families in acting as supportive partners. Other providers noted that some male partners came alone to the health facility to inquire about matters related to their family's health, though this remained a relatively rare occurrence.

An outcome that surprised me was to see the young couples who come to the service. One couple was still very young, but the boy knew the date of the last menses of his partner. I do not know if this is the effect of the CHW's encouragement, but they are always present every month for ANC. Every time he asks, "Is the baby moving well?" I made him listen to the baby's heartbeat, and he was very happy. He said, "He is very vigorous!" – Health provider, Madagascar

Figure 4: A young father in Madagascar

Photo by Karen Kasmauski, MCSP.

Recruitment of male partners: challenges and lessons learned

Recruiting male partners for participation in group-based sessions was difficult in Mozambique and Nigeria. In Mozambique, facilitators stressed the benefits of male participation to overcome initial resistance. While

some groups had low numbers of male partners, those that did participate mostly remained in the group for all nine sessions. In Nigeria, participation of male partners, even in a small number of sessions, proved challenging; facilitators tested different approaches (sending letters home with FTMs to invite their male partners, calling via phone, and contacting male partners in person) and ultimately found that phone calls to male partners to be the most effective and efficient option. Still, participation of male partners remained generally low because of disinterest, lack of financial incentives, perceptions of the groups as "women's domain," and high proportions of FTMs that were single or whose male partner lived elsewhere. Further, when male partners did join sessions, some said they felt isolated and embarrassed.

I feel not that happy, because as a young man, when you sit together with them [young women], some will say, "Oh, this is a small guy." So, you will be ashamed of yourself. – Male partner, Nigeria

Respondents noted that unmarried male partners may have feared being stigmatized for being "irresponsible," thereby limiting their participation. Some of the unmarried male partners who participated in the sessions, however, noted that they appreciated coming together with peers in similar situations.

The challenge for the guys is they think we want to have them embarrassed … because some of them got their spouse pregnant out of wedlock so they feel shy. – Facilitator, Nigeria

For me, I really enjoy the group because I thought that [pregnancy] is the end for me. I thought I'm the only one to make that kind of mistake. But when this group came, I met other people that this thing is happening to. That means I'm not the only one. – Male partner, Nigeria

In both countries, FTMs whose partners joined OFB sessions were generally happy with the approach. Bringing male partners together with their wives and other FTMs was perceived to create solidarity between young men and women. Notably, however, while many FTMs in Nigeria appreciated having their male partners join the sessions, the presence of male partners could be uncomfortable or isolating for young single mothers.

In fact, [engaging male partners in the sessions] was very, very challenging, and it even made those who could not come with their husbands and boyfriends unhappy. Some of them felt jealous even, because they were unable to come with their husbands. Let's remember that not all our mothers are married. – Facilitator, Nigeria

Community and family

As noted, the interventions did not include a significant community or household engagement component. Given the nature of family influence (largely mothers and mothers-in-law) over FTPs' practices, this remains a critical component for strengthening in future programs. In some communities in Mozambique, groups invited the parents of the FTP to attend the sessions as well and said it was a beneficial aspect of the program to involve the whole family. In one community that did not invite the parents, the community development officer noted that the participants would have liked their parents to be there to learn alongside them. Initial outreach in some of the communities raised concerns that participating in the groups would be used as a way to get the young women and men into trouble, as punishment for being pregnant.

Similarly, stakeholders in Madagascar, from the national to the district levels, raised concerns that attention to and activities targeting young parents could incentivize early childbearing. In Mozambique, including local leaders in the mobilization efforts, having a CHW who was trusted among the community as the group facilitator helped reduce these fears and increase group participation. In Nigeria, married FTMs also noted this as an area for strengthening in future programs, suggesting including sessions for their parents or in-laws to also join to help reduce pressure placed on young married couples to have many children.

In Madagascar, some CHWs did meet with community leaders and held community-level activities. They also noted that some parents of FTPs remained uncomfortable with discussion of matters related to sexuality, yet they appreciated having CHWs play that role.

At first, I was afraid parents would get angry at me for talking to their children, but no, on the contrary, it's the parents themselves who send their girls to me. – CHW, Madagascar

In general, however, though CHWs are an excellent resource for reaching FTPs and their families through home visits, their ability to organize community activities was limited in Madagascar as it exceeds their mandate.

Health system

Responsive health services

In Madagascar and Nigeria, health workers described changes to their ability to provide welcoming, non-judgmental services to FTMs and said that this increased clients' satisfaction with services. Respondents were keen to mention how they had become more attuned to youth needs in clinical settings; in particular, they described positive changes in how staff received adolescent patients, notably in interpersonal skills—listening, privacy, a nonjudgmental approach, and friendliness.

All our staff committed to making our center more attractive. We now hold twice-weekly information sessions to clients and their companions in order to promote our service every Monday and Friday. This helped us have our lost clients to come back to our facility because of better services. – Health provider, Madagascar

She opened up and told [me] about her problem, saying that she doesn't know what is happening to her. And we took her through the counseling and everything she needed to know. She left happy. She has been referring her friends to come around. – Health provider, Nigeria

Health system linkages

Madagascar highlights

72% of the 1,430 invitation cards distributed by CHWs were returned to health facilities for services.

Community-based distribution of short-acting FP methods increased from an average of 35 clients ages 10–24 to 76 clients per CHW.

In Madagascar, the TMT invitation cards were widely used and positively received by CHWs, health workers, and young beneficiaries. FTPs said they were impressed by the provision of the simple but attractive card to formally invite them to visit the health facility. Further, CHWs appreciated being able to monitor the outcomes of their discussions with FTPs by seeing how many cards were returned to the health facility, and health providers found the approach useful in monitoring the activities of CHWs.

It was the CHW who convinced me to come to the hospital. I was only 16 when I was first pregnant, and the risks of complications are high at this age. I liked the way I was treated at the hospital, and the midwife answered all questions. – FTM, Madagascar

Notably, although not part of the formal TMT model, accompaniment by CHWs to the health facility powerfully motivated FTPs to use services. CHWs explained that they appreciated this trust and did not raise concerns about the additional demand on their time.

One day, so I was busy working sitting at my desk, there was a knock on the door, and a young mother came in suddenly, smiling. She said to me, "Come and accompany me to the midwife because today it's my appointment for my [contraceptive] injection!" I was so touched by so much trust and friendship, and I got up, and I accompanied her to the hospital in a rickshaw. – CHW, Madagascar

Health providers as change agents beyond the health facility

In Madagascar and Nigeria, an unexpected outcome was health providers acting as agents of change outside of their professional roles. In Madagascar, CHWs reported using the TMT booklet to discuss matters related to sexuality and health with young people in their own families and communities.

As we say "I before you," I started by educating my family and the children of my sisters and brothers, and I gave them the booklet. As a result, discussion about sex between parents and their children becomes possible.
– CHW, Madagascar

In Nigeria, facility-based health providers applied the knowledge and skills gained from the training beyond the health facility setting. For example, in addition to using the Age and Life-Stage tools as intended, respondents shared some unintended applications of the tools, including using the tools while informally discussing matters related to health with adolescents at home.

Even at home, there are some mothers now that approach me. They are bringing adolescents for me to talk to. They may not like to come to the facility; it means I will use [the tools] in the house.
– Health facility staff, Nigeria

I learned that you should be a friend with them. I am organizing a kind of training for teenagers in my neighborhood. Be a friend with them so that they can open up to you.
– Health facility staff, Nigeria

Figure 5: A FTM and her extended family at a health facility in Madagascar

Photo: Karen Kasmauski, MCSP.

In both countries, these health professionals leveraged the nascent skills and knowledge from FTP-related training and support with their position of influence in their family and community to influence health-related behaviors more broadly than their professional duties mandated. As parents, relatives, caretakers and more, health facility staff are influencers of youth. This was confirmed by a participant in Madagascar:

My aunt and sister-in-law are CHWs, and they have made me aware of birth spacing and practicing FP.
– FTM, Madagascar

Lingering challenges with health systems components

In the three settings, service and transport costs remained barriers to use of all services. Stock-outs of essential commodities and supplies remained problematic, limiting uptake of FP services, in particular, and contributing to negative views about the quality of available health care.

In Madagascar, though TMT made progress in building capacity of health system actors to better address the needs of FTPs, factors within and beyond the health sector require further efforts to facilitate FTPs' access to health services. In many communities, insecurity, often in the form of banditry on the roads, discourages families from traveling to seek health services, particularly for delivery when labor begins at night.

When I talk to mothers, young mothers, and their families about the importance and benefits of coming to the hospital for their health, they often say things like, "We are afraid and ashamed of our poverty, especially since the woman welcomes you badly when you do not have enough money for prescriptions," or "We are afraid to go out at night because of insecurity."
– Health provider, Madagascar

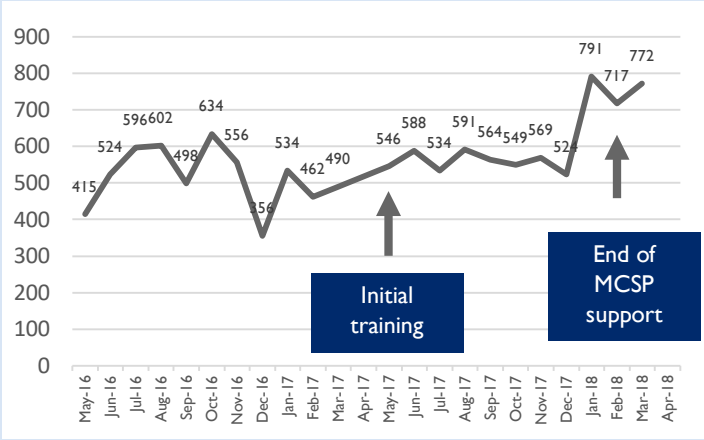
Health workers noted that social stigma continues to impede FTMs in accessing care.

Most of the time the problem we are facing with [adolescent mothers] is just that some of them don't like to stay too long in the facility. Because coming to the antenatal [care visit], some may be thinking, "I don't know who knows me, who may just say, 'Ahhh! Why are you here?' " – Health facility staff, Nigeria

Results highlight:
Uptake of services in Madagascar

In Madagascar, health worker and CHW reports of increased use of ANC were confirmed by service data (Chart 1). Monthly ANC visits by adolescents and youth ages 10–24 in the 11 facilities increased from 415 in May 2016 at baseline to 772 in April 2018. This increase continued after MCSP's direct support for activities had ended, perhaps motivated by attention and discussions during end-of-project documentation. Some providers remarked that use of ANC increased to the point that an unintended consequence was longer wait times. Some reorganized their duties to cope with this increase in client flow by holding separate service times that prioritized FTPs.

Chart 1. Total number of monthly antenatal care visits for adolescents and youth ages 10–24 in the 11 supported facilities in Madagascar



However, use of facility-based delivery and FP services by young people did not consistently increase. Respondents cited local insecurity, costs, and other access barriers as prohibitive to using delivery services, and pervasive stock-outs as limiting use of delivery services and FP uptake at health facilities.

Recommendations

From design, implementation, and documentation of dedicated FTP initiatives in three unique settings, MCSP identified key recommendations for program design and evidence gaps for further exploration.

Consider the full range of health needs of FTPs and their children

A reproductive life course focus was strategic for addressing concerns about family health and fostering connections to the health system early in pregnancy. Programs should use a broad RMNH lens that considers FTPs' (and their babies') needs from pregnancy through delivery and postpartum, as well as linkages to child health, immunization, and basic infant nutrition. Because FTPs transition through this life stage very quickly, and their health care needs evolve rapidly, fragmented approaches that focus on one service miss opportunities to meet the broader needs of mothers and babies.

Tailor programs to reflect the heterogeneity of FTPs

MCSP's formative work and program experiences affirm the importance of understanding the diverse profiles of first-time mothers, their relationships with male partners, and relationship dynamics with household and community influencers. Programs need to invest in careful, intentional understanding of the diverse needs of FTPs in the local context and mitigate discomfort for young single mothers (and/or unmarried FTMs).

Refine approaches for recruiting and engaging first-time mothers and male partners

Findings suggest a need to refine strategies for recruitment and particularly for encouraging participation of male partners. Programs should ensure that approaches appeal to men's interest, such as framing content and communication about activities within communities to speak to the aspirations of male partners to be good fathers (rather than about how men can support their partners). While providing a collective space for FTMs and male partners to learn and discuss together was important, programs may need to explore the feasibility of dedicated sessions for male partners to align with men's interest and provide male partners a space to navigate complex challenges and emotions around fatherhood.

Balance demand creation and systems strengthening components

Though community group-based activities and household visits led by CHWs helped address knowledge, attitudes, behaviors, and some norms that discourage FTPs from visiting health facilities, systems barriers (e.g., costs, stock-outs, and transportation) limited continued use of services for some FTPs. A multifaceted approach involving both transformation of norms at the community level and strengthening of health systems is important for fully addressing barriers that limit continued use of health services by FTPs–it is not one versus the other.

Explore innovative approaches to addressing health worker behaviors

Health care workers' treatment of unmarried and young parents may be driven by underlying social norms that reflect those of the community around them. Health workers are community members themselves, and their norms are shaped by influencers in their families and communities. To address health workers' negative treatment of FTMs, particularly those who are not married, programs must identify the social norms that shape their behavior as well as those who influence them. Programs should seek to build on health workers' clear role as agents of change outside of their professional responsibilities. This approach could serve dual purposes of leveraging the respect and trust placed in health workers and encouraging health workers to further reflect on their own practices.

Leverage existing platforms to reach FTPs at scale

Each of these interventions was implemented as a dedicated proof-of-concept at a small scale. The interventions tested are, by design, complex, multicomponent approaches that, while effective in engaging the multiple levels of influence that shape FTPs' health practices, may prove inherently challenging to scale. An area for exploration would be to assess the feasibility of implementing these components through existing large-scale health or other development initiatives that may already reach FTPs and their household influencers at scale. Further investments in data on program outcomes in terms of health service use are needed to inform scale-up. Further, lack of health management information system (HMIS) data disaggregated by age and service complicates efforts to understand patterns of health service use among FTPs as compared with older women. Investments in nuanced data, such as through electronic registers, would facilitate timely and evidence-based decision-making from the facility to the national levels.

Go beyond the health sector to address the full range of FTPs' needs

FTPs, particularly FTMs, in these three diverse settings have limited use of health services and use unhealthy practices because they lack influence over their own decisions and because of cost barriers. Much of FTPs' powerlessness stems from lack of education and financial resources compounded by social norms restricting decision-making power. Connecting FTPs with education and livelihood opportunities, in conjunction with broader social norms shifting efforts, could help mitigate cost barriers and provide leverage in negotiating decision-making with partners and family. Programs may need to consider exploring creative, non-traditional partnerships with local organizations to help connect FTPs to local resources, to continue their education, and to enter job training. Further, advocacy efforts are needed for policies that enable FTMs to stay in or return to school once the baby is born and for policies that reduce health care costs for FTMs.

Conclusions

Becoming a parent for the first time marks a critical stage of multiple life transitions occurring rapidly, and not always in the same order. This represents a critical window of opportunity to influence lifelong health practices. MCSP's formative work and resulting program interventions with FTPs in three diverse settings generated valuable insights into considerations for future research and programs. These implementation experiences and documentation highlight the need to balance FTP outreach with continued efforts include male partners/spouses and family members, address social and gender norms, and strengthen the overall health system. Though MCSP's efforts expand the evidence base, our work was limited by the scale of the interventions in the three countries and by the limited availability of outcome-level data.

For more information about the FTP formative research, interventions, and results, access MCSP's resources here:

Program and research tools

- Adolescent Age and Life-Stage Assessment and Counseling tools
- Factors Impacting Use of Health Services by First-Time Young Parents: A Formative Research Toolkit
- Our First Baby Facilitator's Guide and Flip Book

Research findings

- Factors Influencing Use of Health Services by First-Time Young Parents: Findings from Formative Research in Six States in Nigeria
- Formative Research to Identify Factors that Impact the Use of Sexual and Reproductive Health Services by First-Time/Young Parents in Two Regions of Madagascar
- Six state-specific briefs of formative research findings from Nigeria

Implementation lessons and results

- Lessons Learned from an Integrated Approach for Reaching First-time Young Parents in Nigeria
- Our First Baby: Engaging First-Time Mothers and Their Partners in Mozambique
- Tanora Mitsinjo Taranaka–Lessons Learned from an Integrated Approach to Increase Use of Health Services by First-Time Young Parents in Madagascar

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