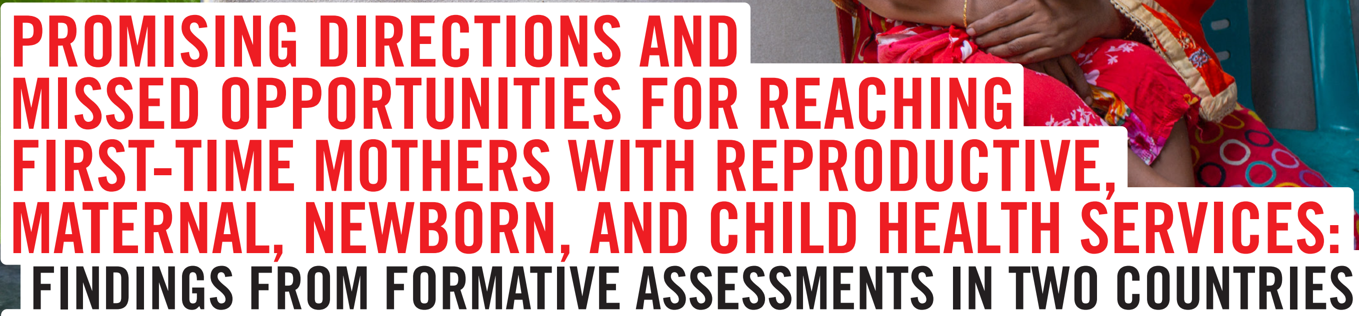

PROMISING DIRECTIONS AND MISSED OPPORTUNITIES FOR REACHING FIRST-TIME MOTHERS WITH REPRODUCTIVE, MATERNAL, NEWBORN, AND CHILD HEALTH SERVICES:

FINDINGS FROM FORMATIVE ASSESSMENTS IN TWO COUNTRIES

Photo: Ellery Lamm / Save the Children

BACKGROUND

Although pregnancy rates among adolescent girls and young women have declined globally,[i] an estimated 12 million adolescents (ages 15-19)[ii] and many more young women (ages 20-24) give birth every year. The transition to becoming a mother for the first time is one of the most significant changes in a young woman's life. Pregnancy and parenthood can be risky for the first-time mothers (FTMs) and their newborns. Adolescent girls who become pregnant are likely to end their education earlier.[iii] Pregnancy and delivery bring an increased risk of maternal death for adolescents,[iv] and impact adolescent girls' lives in many ways. The youngest mothers are confronted with an elevated risk of preterm birth, low birthweight, small size for gestational age, and infant and early childhood mortality; closely spaced pregnancies further heighten these risks.[v] Babies born to adolescent mothers have a 34% higher risk of newborn death and a 26% higher risk of death by age 5.[vi]

Yet this time also represents a window of opportunity: A growing body of evidence suggests that targeted interventions to engage FTMs during this transition can increase use of reproductive, maternal, newborn, and child health (RMNCH) services, including postpartum family planning (PPFP) and catalyze more gender-equitable household practices.[vii viii]

CONNECT PROJECT OVERVIEW

Save the Children leads the Connect project (2019-2024) in Bangladesh and Tanzania, with grant support from the Bill & Melinda Gates Foundation. Connect aims to increase use of PPFP among FTMs aged 15-24, and in Bangladesh, specifically, also aims to improve coverage, timing, and quality of postnatal care (PNC). Connect develops and evaluates scalable "program enhancements", modifications to, or additional activities layered onto, large-scale projects' existing facility- and community-level approaches to address key barriers to FTMs' use of PPFP and PNC in Bangladesh and PPFP in Tanzania. Connect "enhances" two USAID-funded projects reaching FTMs among their target beneficiaries at the facility- and/or community-levels, MaMoni Maternal and Newborn Care Strengthening Project (MNCSP) in Bangladesh and Lishe Endelevu in Tanzania, to maximize their potential to increase FTMs' use of key RMNCH services. Table 1 presents population-based data on younger mothers' RMNCH practices and use of services across the continuum of care in Bangladesh and Tanzania.[1]

[1] For most services, use by younger mothers does not differ significantly from that of adult women; these data are presented to depict the contacts that younger mothers have with the health system during pregnancy and the transition to parenthood.

Purpose of the formative assessment and brief

To inform the design and development of the program enhancements, Connect conducted mixed-methods barrier and facilitator analyses in both countries. These formative assessments aimed to:

- Identify common **touchpoints** where FTMs interact with the health system during pregnancy and the postpartum period.
- Understand **barriers and facilitators** influencing FTMs' use and non-use, as well as delayed initiation and discontinuation, of RMNCH services (antenatal care [ANC], delivery, PNC, immunization, and PPFP).
- Identify **health system responses** to FTMs' RMNCH needs.

This brief synthesizes findings from the barrier and facilitator analyses, highlighting country and global implications for program and research efforts with FTMs.

Table 1: Key RMNCH practices in Bangladesh and Tanzania by mothers ages 15-24 (as a proxy for FTMs ages 15-24)[ix]

	Bangladesh	Tanzania
Made less than 4 antenatal care (ANC) visits during pregnancy	46%	48%
Made first ANC visit by 3 months	32%*	25%
Delivered in a facility	56%*	65%
Received no postnatal check (mothers)	34% (mothers under age 20)[x]	63%
Used a modern family planning (FP) method at 3 months postpartum	37%	12%
Used a modern family planning method at 12 months postpartum	69%	39%
Had a second pregnancy within 24 months	21%	33%
Received 8 basic vaccines by age 2 (babies)	84%	74%

METHODS

Study participants included FTMs, their male partners and older female relatives, and health system actors (see Table 2 below). Participants reacted to hypothetical scenarios using vignettes of an FTM in a setting similar to their own —"Neema" in Tanzania, and "Sharmin" in Bangladesh—and explored the perspectives of Neema/Sharmin, her

Photo: Hanna Adcock / Save the Children

male partner, an older female relative, community health workers (CHWs), and facility-based providers. Questions probed RMNCH service utilization and the factors (barriers and facilitators) determining service use for each type of service. FTM participants created a visual "journey map" depicting the touchpoints Neema or Sharmin may have with the health system, including facility, community, informal, and other private sources, during pregnancy, for delivery, and postpartum. Connect assessed facility readiness to provide PPFP services responsive to FTMs' needs with a quantitative checklist.

Data were collected between March and April 2020. In Bangladesh, data were collected in two upazilas of Noakhali district (Chattogram division) with high rates of poverty and low performance on RMNCH indicators. In Tanzania, two wards of Kongwa district in Dodoma region, notable for high rates of adolescent pregnancy, were sampled.

Table 2: Barrier and facilitator analysis methods and sample

	Bangladesh[2]	Tanzania	Topics explored for each service (ANC, delivery, PNC, immunization, PPFP)
Participant group and method(s)			
First-time mothers stratified by age 15-19 and 20-24	• 4 in-person triad interviews (12 FTMs)* • 8 phone interviews* • Further stratified by facility/home delivery	16 triad interviews (48 FTMs) Further stratified by married/single, and Lishe Endelevu participants/ non-participants	• Touchpoints with the health system • Factors shaping use/non-use, timing, and continuation of service • Decision-making about service use • Sources of information • Experiences, perceived quality, and responsiveness of service delivery points (SDPs)
Male partners	1 Focus group discussion (FGD)*	4 FGDs	• Attitudes and norm-driven practices related to service use • Factors influencing use of care
Older female relatives	Could not be completed	4 FGDs with mothers and grandmothers	
CHWs In Bangladesh, Family Welfare Assistants (FWAs)	• 6 phone in-depth interviews (IDIs)* • 2 FGDs** • 8 in-person IDIs**	4 FGDs	CHW contact, discussion, and provision of information and services with FTMs
Facility-based providers	4 phone IDIs*	7 IDIs (10 providers)	• Treatment of FTMs, including respectful care and provider bias • Barriers to and facilitators of quality care
Facility assessments[3]	4* 10** Total: 14	9	Readiness to provide quality services responsive to FTMs (staffing, commodity availability, service hours)

To contextualize findings within the existing evidence base, Connect also conducted a limited review of grey literature and publications, from 2015 to 2020, that provide insight into the challenges faced by FTMs in the Bangladeshi and Tanzanian contexts.

KEY FINDINGS

FTMs' touchpoints with health system

This section includes highlights of the vignettes used to elicit inputs from FTMs and describes findings from the journey mapping exercises. These qualitative findings aim to explore the experiences of a select group of FTMs in one geographical area of each country and may not reflect the experiences of FTMs across the country. Notably, the journey maps include services that were overall poorly utilized by FTMs, particularly PNC and PPFP; dotted lines depict the pathways reported by few FTMs. The specific barriers and facilitators of FTMs service use (and non-use) are discussed in the section that follows.

[2] Note: Data collection in Bangladesh occurred over two time periods, with some interviews completed by phone as a result of the COVID-19 pandemic. FGDs with older female relatives could not be conducted. * signifies data collected in April, ** signifies data collected in September 2020.
[3] Findings from the facility assessments were used for programmatic purposes and not presented in this brief.

BANGLADESH

In Bangladesh, Sharmin, age 17, was married last year and moved to live with her husband, Anik, in his family's home. Anik is kind, but he travels overseas for long periods for work, and Sharmin misses her home village and her family. Sharmin spends most of her time at the house with Anik's sisters and his mother. After Anik's last visit home, Sharmin began to feel nauseous. She suspects that she is pregnant. What does Sharmin do?

Figure 1: Bangladeshi FTM's touchpoints with the health system

PREGNANCY

- At a pharmacy, Sharmin purchases a test to confirm her pregnancy.
- After about six months, she visits a health facility close to home for her first ANC visit.
- Sharmin may make four or more ANC visits, concentrated in the last months of pregnancy.

DELIVERY

- Sharmin may deliver in a health facility, or she may deliver with a traditional birth attendant (TBA) at home.

POSTNATAL

- Sharmin must remain at home for 40 days after her baby is born.
- If Sharmin delivers in a facility, she may return for PNC.
- If Sharmin delivers at home, she may receive a follow-up visit from a TBA.
- Sharmin may receive a postnatal visit from a CHW, or she may visit a pharmacy for medication if she or her baby are unwell.

FAMILY PLANNING

- Sharmin may visit a health facility to learn about PPFP to delay her next pregnancy.
- She may receive a home visit from a CHW to discuss or provide FP methods.

IMMUNIZATION

- CHW visits during community immunization campaigns provide reminders.
- Sharmin's baby is likely to make multiple immunization visits. Family members may take the baby for immunizations, and Sharmin stays at home.

1st facility ANC visit

Home birth

TBA or CHW visit

CHW visit

Pharmacy

CHW visit

6 months or later

Subsequent ANC visits

Facility delivery

Facility for immunizations

PNC visit

Facility for FP advice

Pharmacy

Dotted lines represent touchpoints identified by fewer FTMs in Connect's study

TANZANIA

Journey maps showed divergent pathways for care-seeking depending on Tanzanian FTMs' age, marital status, and perception of how her pregnancy will be received by her family, community, and health workers. Factors influencing FTMs' journeys are described in the next section.

In Tanzania, Neema is 17-years-old and lives with her grandmother. She has had a boyfriend, Alvin, for the last few months. Alvin is a few years older, and he lives in the big town that is closest to her village. Neema has been having sex with Alvin when he comes to visit his family, who still lives in her village. Recently, Neema's periods stopped. She guesses that she is pregnant but is embarrassed to tell her grandmother. What does Neema do?

Figure 2: Tanzanian FTM's touchpoints with the health system

PREGNANCY

- In general, Neema seeks care after four months of pregnancy, and makes at least one ANC visit.
  - If younger or unmarried: Neema may hide her pregnancy and not seek care until late.
  - If married: Neema may visit a facility for ANC earlier.
- Neema may be approached by a CHW and referred to ANC services.

DELIVERY

- Regardless of age or marital status, Neema will most likely deliver in a facility.
- If Neema sought care late in pregnancy she may be too late and end up having a home birth.

POSTNATAL

- In general, Neema's use of PNC is likely to be limited, even if she receives information about PNC services.
- A CHW or a TBA may visit Neema after delivery. If Neema's baby is unwell, she may visit a pharmacy.

FAMILY PLANNING

- Neema receives information about PPFP at multiple touchpoints; most often, during immunizations.
- She may visit a facility for PPFP advice or receive a home visit.
- Support for PPFP depends on Neema's age and marital status.
- Although she may receive information about PPFP at multiple touchpoints, Neema is unlikely to adopt a method.

IMMUNIZATION

- Neema may receive a visit from a CHW to encourage immunization visits.
- Neema brings her baby to the facility for immunization services multiple times. Providers may also discuss PPFP during immunization visits.

CHW visit
1st facility ANC visit
4 months or later
Subsequent ANC visits
Home birth
TBA or CHW visit
Facility delivery
Pharmacy
PNC visit
CHW visit
Facility for FP advice
Facility for immunizations
CHW visit

Dotted lines represent touchpoints identified by fewer FTMs in Connect's study

FACTORS THAT INFLUENCE FIRST-TIME MOTHERS' USE OF SERVICES ACROSS THE CONTINUUM OF CARE

The experiences of FTMs like Sharmin and Neema often differ. Yet across diverse settings, FTMs consistently experience barriers that limit their access to and use of RMNCH services, including PPFP.

This section describes the factors that facilitated or impeded FTMs' use of RMNCH services in Bangladesh and Tanzania. Where applicable, country-specific findings are highlighted. Some findings confirm earlier findings from FTM-focused studies; relevant findings from other sources are referenced throughout this synthesis to provide a full picture of the evidence that informs integrated approaches for FTMs in diverse settings.

Community and social factors

Family involvement, accompaniment, and tradition. As identified in other studies, in both countries, family preference and support were key determinants of service use across the continuum of care. FTMs' male partners and older female relatives (mothers, mothers-in-law, and grandmothers in Tanzania; mothers and mothers-in-law in Bangladesh) played powerful roles in decision-making for all services. The nature of male partner relationships varied in Tanzania (i.e., some are husbands; others are boyfriends). Older female relatives provided information and were often sought for advice, drawn from their own experiences and family traditions.

> "[An FTM] will go to her grandmother, sister, and aunt to get information because they are elder…They understand how to care for a pregnancy." (FTM, Tanzania)

Some FTMs whose families had a tradition of service use felt supported to access services at a facility, often accompanied by a female relative. In both settings, FTMs had limited power to negotiate within the family structure, which limited service use across the continuum of care.

> "There are many families who do not like FTMs or pregnant women seeking care from a doctor or health facility. Many in-laws and parents will often say, 'We never went to a doctor and hospital for ANC or delivery, so what? That didn't stop us from delivering a healthy living child.' Such opinions or family traditions may stop an FTM from seeking formal care." (FTM, Bangladesh)

Notably, while perceived tradition often determined family preferences, these preferences could shift; in Bangladesh, involvement of FTMs' family in counseling during pregnancy facilitated use of ANC as well as later services.

> "When I went to the health center for ANC checkup, the health workers explained to my mother-in-law and husband that my childbirth should be at a facility and not at home. This will reduce the risks associated with childbirth. After hearing this, my mother-in-law and my husband proactively took me to the hospital for delivery." (FTM, Bangladesh)

Reluctance from male partners to permit FTMs to access services outside the home, often stemming from fears of infidelity, limited service use for some FTMs.

> "I experienced with my friend; her husband does not allow her to attend the clinic because he says when she goes there [facility] she can get other men." (FTM, Tanzania)

> "Some men disallow you to go [access PPPF services], they want to keep having children like a chicken." (FTM, Tanzania)

In Bangladesh, many women, including FTMs, have limited freedom to leave the home, stemming from purdah requirements, the Muslim standards for female modesty, which prevented them utilizing formal health services as other studies have found. Religious and social prohibitions to leave the home increase for all mothers during the

postpartum period. These factors hindered FTMs' ability to seek PNC services. Relatedly, concerns about male providers treating a woman in a health facility, a violation of purdah, limited FTMs from seeking care outside the home.

> "My husband says, 'Women should not go out so frequently. Being seen by outsider men too frequently violates a woman's privacy and may deviate her from her faith.' He does not want me to go out too often." (FTM, Bangladesh)

Myths and misinformation. Knowledge gaps around facility-based RMNCH care were prevalent in both countries, as other studies have identified, but the specific misinformation varied. In both settings, many FTMs expressed understanding the importance of seeking care at health facilities by trained providers, but often in general terms. Limited knowledge of the specific benefits of ANC, facility delivery, and PNC among FTMs and their key influencers was an obstacle to seeking timely and appropriate care across the continuum of care.

In Bangladesh, early ANC use was limited by misinformation about the purpose of early care in pregnancy.

> "I called my husband on his mobile phone and told him to buy a pregnancy testing kit from the local pharmacy. It requires time and preparation to go to a health facility, but if I can confirm at home just by making a phone call to my husband, why should I go to a health facility?" (FTM, Bangladesh)

In Bangladesh, FTMs noted long-standing cultural beliefs and perceptions that traditional birth attendants (TBAs) had the skills needed to manage any complications. As such, many respondents did not consider delivery at a health facility to be necessary. In contrast, respondents in Tanzania often shared that their families recognized that TBAs are unskilled, and preferred facility delivery. However, misinterpretation of signs of pregnancy was linked to delayed or underutilization of services.

> "Some pregnant women incorrectly count their expected due dates; you find that they get confused then they end up giving birth at home." (FTM, Tanzania)

> "There are others who deliver at home. You know it becomes an emergency, because some mothers tell them to wait until the pregnancy drops, this is what makes them late to the hospital." (Male partner, Tanzania)

Bangladeshi FTMs—particularly FTMs who delivered at home—considered PNC facility visits only necessary if newborns or FTMs were sick.

Photo: Ellery Lamm / Save the Children

> "I would not, normally, go anywhere for PNC checkup. I will go the hospital or seek care, only when I am sick or if my baby, Allah forbid, becomes sick. I don't understand why me, and my baby should go to a hospital, when we are both apparently healthy?!" (FTM, Bangladesh)

In Tanzania, FTMs and their families described misinformation about increased cost implications of PNC for mothers who deliver at home or who never attend ANC, which limited use of PNC services.

Social pressure to closely space pregnancies. According to respondents in both countries, social pressure to grow their families quickly was a key barrier to PPFP uptake by FTMs. In both settings, normative expectations exerted significant pressure on young married FTMs to begin childbearing soon after marriage, along with family preferences for closely spaced pregnancies. Married FTMs were often expected to grow their families quickly, and in Tanzania, a married FTM asking about PPFP might be seen as disrespectful or unfaithful to her husband.

> "I see [an FTM asking about PPFP] as a prostitute, and [spouse of FTM] will be told that his partner is asking about family planning, she is not the right one and there are people who have been with her." (Male partner, Tanzania)

Further, in Bangladesh, FTMs noted that religious beliefs encouraged a closely spaced second pregnancy; in particular, families believe that Allah decides when to send a baby, and will provide for the family.

Fear of judgment. In Tanzania, young FTMs described fear of social repercussions and feelings of embarrassment or apprehension due to family judgment and community stigma, leading them to hide their pregnancy and not seeking timely care or guidance.

> "Fear and keeping [pregnancy] a secret from her parents until her parents discover themselves that this [FTM] is like this [pregnant], [she would] be late to start ANC clinic visits." (FTM, Tanzania)

This barrier was not identified in Bangladesh, where all FTMs in the study were married and first pregnancy was supported by family and community.

Health system factors

Access to and perceived quality of facility services. FTMs' perceptions and experiences of the quality of care provided at facilities played a key role in the decision-making process regarding RMNCH service utilization. In Bangladesh, satisfaction with services was generally high. FTMs who had used services described these as affordable and easily accessible via public transportation, and were generally satisfied with the way they were treated by providers, although with some exceptions in which FTMs described rude providers. Likewise, immunization services were well-liked and described as convenient and easily accessible by Bangladeshi FTMs. However, few reported receiving information about FP when visiting immunization clinics.

Conversely, in Tanzania, FTMs' satisfaction with quality of services at facilities varied. While few FTMs expressed satisfaction with quality of services at facilities, several FTMs cited stock-outs and human resources shortages as impediments to returning to seek care at health facilities. Additional barriers included logistical factors such as perceived cost of services and proximity to healthcare facilities.

> "She [FTM] will go to a health facility because that's where she'll be given appropriate services." (FTM, Tanzania)

> "Poor services: you can go in the morning and queue until 2 or 3pm, and without food, it discourages you." (FTM, Tanzania)

In Tanzania, some FTMs explained that facilities required women to be accompanied by their male partners during ANC visits, or noted that providers indicated that permission from their male partner was required for them to

access other services. Obtaining partner consent required their buy-in on the importance and necessity of the services, particularly in relation to FP use. Consequently, FTMs who were unable to obtain permission and meet these partner attendance requirements delayed or avoided utilizing services.

> "Even the male partner who got her pregnant can contribute in a certain way to discourage her because he may refuse to escort her to the clinic, and health providers say you should go with your partner when you go to the clinic." (Older female relative of FTM, Tanzania)

Judgmental treatment from health providers. Most FTMs in Bangladesh described warm and welcoming treatment from health providers. However, while some FTMs in Tanzania described receiving respectful care from providers, others spoke about experiencing harsh and judgmental treatment, paralleling the judgment experienced from family and community. When visiting healthcare facilities for ANC services, FTMs – particularly younger and unmarried FTMs – reported encountering discouraging attitudes and poor treatment by providers due to their personal biases, beliefs, or disapproval of adolescent pregnancy, as many other studies have found. Some FTMs identified fear of experiencing prejudice and discrimination by community- and facility-based health workers as a key barrier for accessing ANC services, thus leading to delayed care-seeking. For some FTMs in Tanzania, delayed recognition of pregnancy and resulting late care-seeking in pregnancy resulted in scolding from providers, which further discouraged service use.

> "…even when I go [to the facility] providers have a bad tone, even if I go it is a waste of time. You find other [providers] have a bad tone, you go and ask them something and they answer the way they feel like answering, and scold you." (FTM, Tanzania)

Some Tanzanian providers discussed their willingness to offer FP to unmarried adolescent FTMs to help them avoid "making another mistake," (i.e., a second pregnancy outside the context of marriage) often out of pity.

> "[A health provider] will pity [an unmarried FTM] because she is still young and will suggest to her not to have another baby soon." (Health worker, Tanzania)

While few FTMs described contact with CHWs across the continuum of care in either country, the few Bangladeshi FTMs who had interacted with CHWs described those interactions positively.

> "FWA [the CHW cadre that provides home visits] advised me to take pills, while conducting home visits. I didn't even have to go to facility!" (FTM, Bangladesh)

While some FTMs in Tanzania did have contact with CHWs that they described positively, a few described being shamed or neglected by CHWs, which in turn deterred FTMs from taking up essential health services across the continuum of care.

> "She could speak with her [CHW] on her pregnancy, but not everyone can give appropriate advice. For example, when I got pregnant and went to a CHW to ask for advice, she told me to abort so you can control yourself for the second time." (FTM, Tanzania)

Missed opportunities to encourage continuity of care, especially for PPFP. In both settings, the study identified key breakdowns in continuity of care, and missed opportunities to leverage high-contact touchpoints to encourage increased service use. While nearly all FTMs did make at least one ANC visit in both countries, many Bangladeshi FTMs, and some Tanzanian FTMs, delivered at home, and did not seek PNC services. In Bangladesh, FTMs reported that providers did not share FP information when they accessed other RMNCH services, resulting in missed opportunities for FP integration across the continuum of care. In contrast, many Tanzanian FTMs described receiving FP information during immunization visits, though the information offered to FTMs depended on multiple factors such as FTMs' age and marital status. PPFP uptake was generally low due to pervasive myths and misinformation about FP use, lack of spousal or partner consent, and pressure to continue childbearing.

LIMITATIONS

Given the qualitative nature of the study, findings should not be interpreted as being representative of the general population. Data collection activities were impacted by the COVID-19 pandemic. Specifically, in Bangladesh, the total sample of respondents interviewed was smaller than originally planned. The shift from in-person to telephone-based data collection activities to mitigate COVID-19 risks may have also affected the quality of findings. Even taking into account these limitations, this assessment provides insights into the lived experiences of FTMs in the study's settings and informs efforts to address FTMs' unique needs.

PROGRAMMATIC AND RESEARCH IMPLICATIONS

Findings from the barrier and facilitator analysis suggest considerations for programs and research with FTMs and their male partners, both in the study countries and in other settings. This section discusses insights for programs and research, highlighting country-specific implications where applicable.

Address supply-side barriers to reach FTMs with essential RMNCH services. Across the continuum of care, there are opportunities to leverage FTMs' existing system touchpoints to provide PPFP, and to optimize FTMs' experience with services to encourage continuity of care.

- Optimize all contacts with FTMs to reduce missed opportunities for integration. In each country, most FTMs did have some contact with the health system, with ANC and immunization services the best-attended in both countries, and pharmacies often utilized in Bangladesh. Yet few FTMs reported receiving information about other services along the continuum of care. Efforts to increase service utilization among FTMs should identify high-contact touchpoints, including those outside the formal health system, to provide integrated services where feasible, facility referrals, and timely information about the purpose of each service, focusing on underutilized and misunderstood services.
- Address gaps in respectful care among facility- and community-based providers. While most FTMs in Bangladesh felt they were treated respectfully, for some Tanzanian FTMs, harsh, judgmental provider treatment discouraged continued service use, a key barrier noted in prior studies. Warm, supportive treatment from providers facilitated service use. Respectful care efforts with both facility- and community-based providers, inclusive of attention to the needs of adolescents and youth, including FTMs, are needed as part of a broader adolescent-responsive health system approach. FTMs' health needs extend across the continuum of care, and siloed approaches, such as separate spaces or isolated youth-friendly service provider trainings, are unlikely to address the breadth of FTMs' needs or to be sustainable.
- Prioritize CHW visits to target FTMs. In both countries, FTMs' contacts with CHWs were infrequent and inconsistent. When CHW contacts did occur, they were often positively received. Efforts to prioritize CHW visits to target FTMs are needed to reduce missed opportunities and to engage family in decision-making. To support outreach to FTMs, CHW training and supervision needs to include specific emphasis on engaging this population. In district-level review meetings, age- and parity-disaggregated data on the populations reached by CHWs through home visits or other community activities should be reviewed to better understand equity gaps.

Address underlying barriers to use of RMNCH services. Efforts are needed to address social barriers that inhibit FTMs' timely use of RMNCH services, and encourage continuity of care.

- Foster social norms that support FTMs' service use, encourage community support for FTMs, and increase FTMs' decision-making power. In both countries, social norms limited FTMs' decision-making power and drove pressure to become pregnant right after marriage and to grow families quickly, echoing findings from other settings. In Tanzania, norms drove stigma from community and peers and judgment from providers, and in Bangladesh, contributed to restrictions on FTMs' movement following delivery. Efforts must identify normative barriers to FTMs' use of services to inform tailored responses that empower FTMs to make and act on their own decisions. Where peers are influential, program efforts could explore identifying satisfied FTMs who have used—and continue to use—RMNCH services, as well as their supportive families and their male partners, to share testimonials about positive experiences and perceived benefits.

- Engage family as key gatekeepers to service use. Connect's study confirms prior studies in its finding that family are often the primary decision-makers about service use, and suggests that engaging family in counseling and decision-making has positive impacts on service use by FTMs. In any context where family preferences impede FTMs' service access, an effective programmatic response must identify which family members most influence FTMs' decisions about RMNCH service use. Effective social and behavioral change (SBC) efforts are needed to engage key family members in community- and facility-level counseling; diffuse accurate information about health services; address specific concerns of decision-makers; and foster social and gender norms that support healthy practices such as FTMs' use of RMNCH services, including PPFP for birth spacing.
- Identify and address specific misinformation that discourages use of services. While specific misinformation differed in the two settings, knowledge gaps contributed to delayed care-seeking or prevented FTMs from using services altogether. In any setting, FTM efforts must identify and address specific knowledge barriers through SBC, mHealth, and/or provider-led counseling to provide information about the purpose of each service along the continuum of care, focusing on underutilized and misunderstood services (e.g., PNC in Bangladesh).
- Address gaps in policy from the facility to the national levels. In Tanzania, some facilities or individual providers required mothers seeking ANC to be accompanied by a male partner. While this contradicts national policy, it presented a barrier for unmarried FTMs and those whose male partners are unavailable or unsupportive. Programs must identify where official policy may impede service use, such as requirements for spousal consent or accompaniment—and also monitor and address requirements outside of formal policies enforced by individual providers or facilities.

CONCLUSION

The formative assessment identified FTMs' touchpoints with the health system for RMNCH services across the continuum of care, and key insights into factors shaping FTMs' use of services. In Bangladesh and Tanzania, there were missed opportunities to leverage FTMs' use of higher-frequency touchpoints, particularly ANC and immunization, to encourage continuity of care, and to integrate PPFP. Given that PNC use was reportedly very limited among FTMs, particularly those who had delivered at home in both settings, preference and tradition around the place of delivery are a key driver of breakdowns in continuity of care. Individual, familial, and socio-cultural factors contribute to facilitating or hindering FTMs' decision-making and ability to enact care-seeking preferences. The findings underscore the need to both take advantage of windows of opportunity and address household, community, and health facility barriers that inhibit FTMs' uptake and utilization of RMNCH care.

Photo: Ellery Lamm / Save the Children

REFERENCES

[i] Ganchimeg T., Ota, E., Morisaki, N., Laopaiboon, M., Lumbiganon, P., Zhang, J., Yamdamsuren, B., Temmerman, M., Say, L., Tuncalp, O., Vogel, J.P., Souza, J.P., Mori, R., on behalf of the WHO Multicountry Survey on Maternal Newborn Health Research Network. (2014). Pregnancy and childbirth outcomes among adolescent mothers: a World Health Organization multicountry study. BJOG 121(Suppl. 1):40–48.
[ii] ibid
[iii] Birungi, H, Undie C, MacKenzie I, Katahoire A, Obare F, & Machawira, P. 2015. Education sector response to early and unintended pregnancy: A review of country experiences in sub-Saharan Africa, STEP UP Research Report. Nairobi: Population Council.
[iv] Nove, A., Matthews, Z., Neal, S., Camacho, A. (2014). Maternal mortality in adolescents compared with women of other ages: evidence from 144 countries, The Lancet Global Health, 2(3):e155–e164.
[v] Ganchimeg, T., Ota, E., Morisaki, N., Laopaiboon, M., Lumbiganon, P., Zhang, J., Yamdamsuren, B., Temmerman, M., Say, L., Tuncalp, O., Vogel, J.P., Souza, J.P., Mori, R., on behalf of the WHO Multicountry Survey on Maternal Newborn Health Research Network. (2014). Pregnancy and childbirth outcomes among adolescent mothers: a World Health Organization multicountry study. BJOG 121(Suppl. 1):40–48.
[vi] Kamal, S. M. M. (2015). What Is the Association Between Maternal Age and Neonatal Mortality? An Analysis of the 2007 Bangladesh Demographic and Health Survey. Asia Pacific Journal of Public Health, 27(2), NP1106–NP1117. https://doi.org/10.1177/1010539511428949
[vii] Subramanian, L., Simon, C., & Daniel, E.E. (2018). Increasing contraceptive use among young married couples in Bihar, India: Evidence from a decade of implementation of the PRACHAR project. Global Health: Science Practice, 6(2):328 LP-342.
[viii] Sarkar, A., Chandra-Mouli, V., Jain, K., Behera, J., Mishra, S.K., & Mehra, S. (2015). Community based reproductive health interventions for young married couples in resource-constrained settings: a systematic review. BMC Public Health, 15(1):1037. doi:10.1186/s12889-015-2352-7
[ix] All data from secondary analyses of Bangladesh Demographic and Health Survey (DHS) (2014) and Tanzania DHS (2015-16) provided by Track20, except for those noted with *, which are from secondary analyses of the Bangladesh 2019 Multiple Indicator Cluster Surveys (MICS) provided by Track20.
[x] Bangladesh Bureau of Statistics (BBS) and UNICEF Bangladesh. (2019). Progotir Pathey, Bangladesh Multiple Indicator Cluster Survey 2019, Survey Findings Report. Dhaka, Bangladesh: Bangladesh Bureau of Statistics (BBS).
[xi] FHI 360. (2020). USAID Tulonge Afya. Social Norms Exploration on Family Planning and Reproductive Health: Summary Findings Report. Dar es Salaam: FHI 360.
[xii] A. S. M. Shahabuddin et al., What influences adolescent girls' decision-making regarding contraceptive methods use and childbearing? A qualitative exploratory study in Rangpur District, Bangladesh. PLoS One, vol. 11, no. 6, pp. 1–15, 2016, doi: 10.1371/journal.pone.0157664.
[xiii] Molitoris, J. (2018), Heterogeneous Effects of Birth Spacing on Neonatal Mortality Risks in Bangladesh.Studies in Family Planning49, (1), 3–21. doi: 10.1111/sifp.12048.
[xiv] Chebet, J. J., McMahon, S. A., Greenspan, J. A., Mosha, I. H., Callaghan-Koru, J. A., Killewo, J., ... & Winch, P. J. (2015). "Every method seems to have its problems"-Perspectives on side effects of hormonal contraceptives in Morogoro Region, Tanzania. BMC Women's Health, 15(1), 1-12. doi: 10.1186/s12905-015-0255-5.
[xv] Cogburn, M.D. (2020).Homebirth fines and health cards in rural Tanzania: On the push for numbers in maternal health.Social Science & Medicine, 254,112508.

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