Background

In Madagascar, childbearing begins early: 57.3% of women have already become mothers or are pregnant by the age of 19. Rapid repeat pregnancy is frequent among younger mothers: among mothers ages 15–19, the median number of months between births is 25.1, compared to 32.7 among all women.\(^4\) Health consequences of early pregnancy and childbirth in mother and child are well-documented in lower and middle income countries. Early pregnancies increase the risk of maternal mortality; young women under age 20 are twice as likely to die in childbirth as women over 20; and women below age 15 are five times as likely to die in childbirth. Children of adolescent mothers have a 34% higher risk of death in the neonatal period, and a 26% higher risk of death by age five.\(^5\)

There is a clear need for interventions to connect pregnant and parenting young people to health services, ensuring uptake of maternal and newborn care (MNC) and antenatal care (ANC) services as well as healthy timing of a subsequent pregnancy. Yet globally, few models and better practices for reaching first-time parents (FTPs) exist. In Madagascar, USAID’s global Maternal and Child Survival Program (MCSP) is developing and testing an intervention to increase access to and use of essential ANC, MNC, and family planning (FP) services. This intervention will concurrently create enabling environments and strengthen youth assets to allow first-time mothers and fathers, as well as mothers- and fathers-to-be, to realize their sexual and reproductive health (SRH) choices and access services that are responsive to their needs. The first step involved formative research to identify factors at individual, family, and community levels, as well as within health services, that influence FTPs’ access to and use of SRH services. The main research question was: What factors influence FTPs’ intentions to seek and use ANC, MNC, and FP (including postpartum FP) services at relevant times in their reproductive life course?

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\(^2\) Lane, C and Andriamiadana, J. *Assessment of USAID/Madagascar Youth Programming and Recommendations for Future Action to Improve Reproductive Health Outcomes among Malagasy Youth*. USAID May 2012.


\(^4\) Ibid.

Methods
The study, conducted in rural, peri-urban, and urban areas of Menabe and Vakinankaratra Regions, involved focus group discussions and in-depth interviews with a total of 200 young parents, 32 parents and relatives, 12 influential persons, 31 community health workers (CHWs) and eight health providers. The study also involved health facility rapid assessments and compilation of data from ANC, MNC, and FP service registers from the previous six months at six facilities.

Findings
SRH service use by young parents
FTPs’ use of ANC services is limited: only 12% of young mothers received all four ANC visits, well below the national average of 51%. Postpartum FP uptake among FTPs is low: only 16% of young people less than 25 years old began using FP services following first childbirth, with 90% opting for Depo-Provera.

Individual/couple
Many FTPs are neither well-informed nor encouraged to use SRH services. FTPs—as individual women and men and also as couples—are influenced by family (particularly mothers and mothers-in-law) and community opinion-leaders and advisors who either encourage or block them from seeking and using SRH services at critical times during their reproductive life course. Husband/partner and family-level support are important for young women and influence SRH self-care and service choices. Husbands/partners are willing and motivated to help their wives to the extent of their means and capacity, although not always supportive of FP use for different reasons. Educated husbands/partners more often indicated support for their wives going to health centers than those with lower levels of education. See Table 1 for specific information needs identified by FTPs.

Table 1: Information needs identified by first-time parents

<table>
<thead>
<tr>
<th>Family Planning</th>
<th>Pregnancy/ANC</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Young Couples</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the ideal number of children?</td>
<td>When should I have the first ANC visit?</td>
<td>Should I go to the health facility for a prenuptial visit?</td>
</tr>
<tr>
<td>What is FP? How does it work?</td>
<td></td>
<td>Why does my baby need to be weighed?</td>
</tr>
<tr>
<td>What are the advantages of FP?</td>
<td></td>
<td>Why don’t CHWs care for adults?</td>
</tr>
<tr>
<td>What are the side effects of FP?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can we have a child after using FP?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Young Mothers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are side effects of contraceptive methods?</td>
<td>What should I do if my period is late?</td>
<td>Why does my baby refuse to eat?</td>
</tr>
<tr>
<td>Where should I go for health care during pregnancy?</td>
<td></td>
<td></td>
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<tr>
<td><strong>Young Fathers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Which contraceptive methods are not reversible?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there FP methods that involve men?</td>
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<td></td>
</tr>
</tbody>
</table>
Family

Mothers, mothers-in-law, and sisters are present throughout all reproductive life phases and are dedicated to helping the young mother—with the exception of providing FP support (young parents do not receive information about FP from their families until after delivery, if at all). They accompany her to prenatal consultations and closely monitor her health and that of the child to the extent of their knowledge and habits. For delivery, the family comes together to support the young parents financially and to guide them in case of emergencies. Still, the involvement and influence of older female relatives in health-related decisions is not always positive: mothers or mothers-in-law often prefer or demand traditional birth attendants (matrones) for delivery, out of habit or conviction. For similar reasons, there is no support for postnatal visits.

Community

Outside the family, matrones have an important status in the communities, providing counsel and services during the pregnancy, delivery, and postpartum periods. CHWs are also influential from pregnancy through postpartum, as are neighbors who accompany the pregnant woman to the health center to deliver. None of these influential people play significant roles in advising FTPs on FP and healthy timing and spacing of births, with the exception of CHWs if they are trained in this domain.

Adolescent pregnancy and marriage are not condoned; young parents are not well-regarded by the community and their families often blame them for creating a situation that implicates the entire family. At the same time, community and family members feel that it is important to help young people get a good start as their social roles change to child-raising. Finally, FTPs themselves have gendered views that promote traditional male and female roles for prenatal and delivery/postpartum care, but also more gender-egalitarian role-sharing in terms of FP decision-making and support.

Health System

FTPs—both mothers and fathers—have limited SRH knowledge but want services that are comprehensive, affordable, and attractive. Prior service users are convinced of the utility of services, and satisfied with their reception and communication with providers (although less confident of CHW's and mistrustful of the skills of trainees). Health workers classify pregnant women under the age of 18 as “high risk” but do not tailor services or counseling based on age. Cost, particularly for deliveries, is a serious concern, particularly when some services such as postpartum consultations and FP are free in some health facilities. Other factors that determine the use of SRH services by young parents include: the perceived quality of services (including confidentiality and provider discretion), distance to a health facility, previous experience with health services, shame and/or poor treatment by providers, incomplete range of services due to occasional stock-outs of medicines or unavailability of equipment, rumors associated with certain modern FP methods, and insufficient information around available services and their costs.

Programmatic Recommendations

The study results were disseminated nationally to stakeholders, including senior officials from: the Ministries of Health, Youth, Education, Population; the Faculty of Medicine; professional organizations; technical and financial partners working in adolescent SRH; and all equivalent bodies at the regional level in Menabe. These results will inform solutions to increase access to services for young people, and will be used as a practical reference in the development of standards and procedures as part of the 2017–2020 National Strategic Plan for Adolescents Sexual and Reproductive Health, as well as in the improvement of the quality of services.
Activities to engage FTPs should:

- Target influential individuals outside of the health sector—particularly mothers and mothers-in-law, as well as community leaders—to support FTPs in developing a birth plan, accessing ANC and safe delivery services, and planning for the next pregnancy.
- Equip FTPs with critical, life-course-focused SRH information, skills building, and peer support.
- Ensure that health facilities are welcoming to young people in general and to FTPs in particular; consider offering special service days or times for FTPs. Educate providers about the needs and concerns of FTPs so they receive the services they need.

Messages for FTPs should provide information on and spark discussion about:

- Use of existing health services for ANC, MNC, and FP, including when and why to use services.
- Breastfeeding and basic newborn care.
- The ideal number, timing, and spacing of children and the use of FP, including postpartum FP.

In combination with discussions with key stakeholders at the national and regional levels, the findings of this formative research have been used by MCSP to develop an intervention to meet the needs of FTPs. The intervention, which will be piloted in Menabe Region in 2017, will be comprised of activities to: 1) engage FTPs directly, as well as their key influencers such as parents/relatives and community members; and 2) build the capacity of the health system; and 3) create an enabling, positive environment for changes in policy to increase access.