# Addressing Reproductive, Maternal, and Child Health and Family Planning Needs of Young, First-Time Parents in the Eastern Region of Burkina Faso

**In April 2018, Evidence to Action (E2A) Project and Pathfinder International Burkina Faso launched a new initiative for young first-time parents (FTPs) in the Fada and Diapaga districts in the Eastern Region of Burkina Faso.**

The FTP project "Supporting Reproductive Health Services for Young First-Time Parents in Burkina Faso" focused on women under the age of 25 who are pregnant for the first time or have one child and their husbands. The project included package of community- and facility-level interventions to improve FP- and RMNCH-related knowledge, attitudes, communication, decision making, and use by young first-time mothers (FTMs)/FTPs to achieve the following objectives:

- **Increase FTP access to and utilization of clinical antenatal/ postnatal care (ANC/PNC), delivery services, newborn care, and family planning (FP)**
- **Increase demand among FTPs for RMNCH care, facility-based delivery, healthy timing and spacing of pregnancy (HTSP), and FP**
- **Create a friendly environment for FTP health action among household and community influencers, including health providers**

## MEETING URGENT NEEDS IN THE EASTERN REGION OF BURKINA FASO

E2A and Pathfinder International selected the Fada and Diapaga health districts of the Eastern Region for this new FTP program given the area's high frequency of early marriage and childbearing as well as poor RMNCH and FP outcomes for young mothers. In the Eastern Region of Burkina Faso, sexual debut generally occurs within the context of marriage, and the interval between marriage and first birth is relatively short.[1] According to the 2010 Burkina Faso Demographic and Health Survey (DHS), the median age of marriage

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for women in the Eastern Region is 17.2 years old, the median age at sexual debut is 17.3, and the median age at first birth is 18.4.[2] The Eastern Region also has the highest total fertility rate in the country at 7.5 children per woman. Contraceptive use is low, with a modern contraceptive prevalence rate (mCPR) of 10.8%, and unmet need for family planning is high, at 24.9%.[3] Given early childbearing, it is also important to note that national levels of contraceptive use by younger women are particularly low, with just 5.9% of adolescents aged 15–19 years using a modern contraceptive method.[4] Furthermore, utilization of antenatal care services nationally is poor, with only 33.7% of women receiving at least four antenatal care visits. On average, women are seeking antenatal care late—a particular concern for young FTMs—with only 41.2% of women receiving at least one antenatal care visit within the first four months of pregnancy.[5]

FTMs face unique challenges that limit their reproductive health choices and actions—challenges that are different from other adolescents and different from older married women. Early marriage and the expectation to begin childbearing shortly thereafter can put adolescent girls at a disadvantage by limiting their mobility and isolating them from supportive social networks.[6] Furthermore, even if they have access to reproductive health care, young women and girls must often get permission from their husbands and other household influencers to visit the health center or obtain services.[7] Unequal power and gender dynamics, along with other factors such as sociocultural

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**"Learning helped me a lot in this group. I learned how you can manage your pregnancy to be happy. When you are going to give birth, how you are going to take care of your baby..."**

—FTM peer group member, 18 years old

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preferences around fertility and health provider bias, can fuel early, rapid, and repeat pregnancies, which compromises the health of young women and their newborns. Given the high levels of pregnancy among adolescents and young women in the Eastern Region of Burkina Faso and the particular vulnerabilities of young FTMs, E2A and Pathfinder International Burkina Faso prioritized launching a new project focused on young FTPs.

## BURKINA FASO FTP PROJECT COMPONENTS

The project worked at both the facility and community level in two districts, covering a total of 20 health facilities and 57 surrounding villages. Project activities were implemented by community health workers (CHWs), facility-based supervisors, peer leaders, and Pathfinder project staff, with technical support from E2A/Washington, DC. Preparations for the FTP project began in April 2018, participants were recruited in September 2018, home visits began in October 2018, and the small group discussion sessions with FTMs, husbands, and mothers-in-law were implemented from January to May 2019.

E2A applied a life course approach in designing the components of the FTP intervention in order to reach FTMs spanning the entire FTP lifestage—from pregnancy, through delivery, and up to two years postpartum—and address their various needs throughout this period. Interventions focused on increasing utilization of ANC and obstetric and neonatal services, while advancing FP and related gender outcomes. Along with the life course approach, E2A applied a socioecological lens[8] to examine the experience of young FTMs as they move through the FTP lifestage. FTMs' reproductive health choices are influenced at many levels, including the individual, couple, household, community, and health system. Interventions sought to strengthen the support of household and community members who influence FTMs'/FTPs' health action, including addressing the underlying gender and social norms that influence FP/RMNCH choice and action at every level.

1–5 Institut National de la Statistique et de la Démographie (INSD) et ICF International, 2012. Enquête Démographique et de Santé et à Indicateurs Multiples du Burkina Faso 2010. Calverton, Maryland, USA : INSD et ICF International.

6–7 Anna Engebretsen and Gisele Kabore, Addressing the needs of girls at risk of early marriage and married adolescent girls in Burkina Faso, Population Council, May 2011.

8 To read more about the life course approach and socioecological lens E2A applies to FTP programs, visit e2aproject.org/FTP

# PROGRAMMING WITH A LIFE-COURSE AND SOCIO-ECOLOGICAL LENS

**The FTP Project implemented a package of interventions to improve FP- and RMNCH-related knowledge, attitudes, communication, decision making, and use by young FTMs/FTPs.**

| | DESCRIPTION |
|---|---|
| FTM PEER GROUPS  | Ten small group discussion sessions of FTMs (12–15 members per group), facilitated by peer leaders and supported by CHWs. Topics included: ANC, pregnancy danger signs, HTSP, FP, and men's and women's roles. |
| OUTREACH WITH KEY INFLUENCERS AND COMMUNITIES  | Monthly meetings with FTM peer group members' male partners, facilitated by CHWs with support from Pathfinder staff. Members used Pathways to Change game to identify barriers and facilitators, and covered the following topics: men's and women's roles, reproductive choices, and ANC.<br><br>Monthly meetings with FTM peer group members' mothers-in-law, facilitated by CHWs with support from Pathfinder staff, covering the following topics: ANC, safe delivery, and FP. |
| HOUSEHOLD VISITS  | CHWs conducted household visits with FTM peer group members to provide tailored information and counseling, engage with household influencers, and reinforce messaging conveyed in peer group sessions. These visits were adapted to FTMs' stage of pregnancy or early parenthood. |
| RADIO BROADCASTING  | FP messages disseminated in project-supported areas in partnership with two local radio stations. Topics included: ANC, danger signs during pregnancy, HTSP, FP, and the role of men and women in reproductive health decision making. |
| SUPPORT FOR HEALTH FACILITIES  | Support to 20 health facilities in two districts, including training and mentoring providers on comprehensive and youth-friendly obstetric and neonatal care and a full range of FP options. |

**As with other E2A FTP programs in Nigeria and Tanzania, FTM peer groups and group discussions with key influencers were central activities for the Burkina Faso FTP project.**

## Participant Identification and Recruitment

Prior to the start of the community-based interventions, the project conducted a social mapping exercise to identify FTMs in the project villages. In September 2018, Pathfinder staff conducted this activity in close coordination with locally based CHWs who were known resource persons in the community and trained and paid by the Burkina Faso MOH. The primary purpose of the social mapping exercise was to develop a list of potential program beneficiaries that met the project's recruitment criteria: young women (married or unmarried) residing in the identified project villages under the age of 25 who are pregnant for the first time or have one child under 24 months of age. In most cases, staff and CHWs met with the entire household to inform them of the project and gain support for participation from FTMs, their husbands, and their mothers-in-law. Once the household was informed of the program, the project staff enrolled FTMs individually and collected basic baseline health data. By providing a sense of the potential pool of FTM participants, the mapping exercise helped define the final set of community- and facility-based interventions included in the FTP project.

### TOPICS ADDRESSED IN FTM PEER GROUPS

- **Antenatal care visits**
- **Danger signs during pregnancy**
- **Healthy timing and spacing of pregnancy**
- **Men's and women's roles**
- **Reproductive health choice**
- **Exclusive breastfeeding**
- **Contraceptive methods**
  - -Injectable contraceptives
  - -Combined oral contraceptives
  - -Intrauterine devices
  - -Condoms
  - -Implants
  - -Lactational Amenorrhea Method

## FTM Peer Groups

In the 57 project-supported villages (12 in Diapaga, 45 in Fada), a total of 67 peer groups were active over a five-month period (January–May 2019). Peer groups were led by young women peer leaders identified during the social mapping exercise who were FTMs under 25 years old, resided in the local community, and were recommended by CHWs. The project staff trained 132 peer leaders to lead the 67 groups (typically two peer leaders per group). The three-day training focused on Essential Newborn Care/Family Planning and the use of 11 activity cards to facilitate the peer group sessions. The peer leaders were responsible for organizing the groups and facilitating the sessions. At least one CHW attended each session and supported the peer leaders in facilitation, provision of health information, provision of referrals or services to peer group members, and attendance tracking. The peer groups comprised young women from all three segments and had, on average, 12–15 members each. The groups gathered twice a month to discuss a selected topic, using the activity cards as a guide. There were 10 peer group sessions total, covering a range of health- and gender-related topics. Pathfinder staff also conducted monthly meetings with the CHWs and peer leaders to discuss themes, obstacles, and successes experienced during the peer group sessions.

## Discussion Groups with Men and Mothers-in-Law

Separate discussion sessions with husbands and mothers-in-law of FTMs were held once per month, for a total of five sessions (January-May 2019). These key influencers were initially invited by the participating FTMs, and all who were interested were able to participate in the discussion groups. The purpose of these meetings was to raise awareness about and increase support for young women's access to critical health services during the FTP lifestage.

For the husband sessions, CHWs—with support from Pathfinder staff—used MOH counseling tools and Pathfinder's Pathways to Change game to focus on three key topics: men's and women's roles, reproductive choices, and ANC. The game was used to identify barriers and facilitators to adopting key health- and gender-related behaviors that were then discussed as a group. For the mother-in-law sessions, CHWs—with support from Pathfinder supervisors—used MOH tools to lead discussions on thematic topics around ANC, safe delivery, and postpartum family planning. The men's discussion sessions had on average eight participants per group, and the mother-in-law sessions had on average nine participants per group.

## Household Visits

In their MOH role, CHWs typically conduct home visits with women during pregnancy and the immediate postpartum period. During these home visits, they typically provide referrals to the health facility for ANC, risks assessments, FP, and other services as well as community-based refills of some short-term FP methods, such as pills and condoms. For this FTP program, CHWs were encouraged to ensure that all enrolled FTMs received the standard MOH home visits as well as additional visits throughout the FTP lifestage period, based on the needs of the individual FTM. While CHWs had already been trained to provide standard counseling and services for pregnant and postpartum women, CHWs involved in the project received a refresher training focused on providing tailored counseling and services for FTMs/FTPs, so that they are better able to identify and respond to those needs. Through the home visits, CHWs were able to reinforce messages that were raised during peer group discussions. In total, 606 FTMs (72% of the 843 FTMs identified through social mapping) received at least one home visit.

# DELIVERING RESULTS

## METHODOLOGY

**Two key data sources inform the main health-related findings and implementation learnings presented in this report:**

### 1. Qualitative Data Collection

E2A and Pathfinder worked with an independent consultant to conduct qualitative data collection using in-depth interviews and focus group discussions at the end of the FTP program. The key objectives of the qualitative evaluation were: (1) assess adoption of antenatal and postnatal care and family planning practices promoted by community health workers and peer group activities; (2) document the process for implementing an FTP program in Burkina Faso; and (3) understand and explore attitudes, barriers, and facilitators for FTPs in relation to healthy timing and spacing of pregnancy, and FTM peer group participants' use of and access to modern contraceptives. A trained study team collected data at a subset of the project-supported villages. All participants were directly or indirectly involved in the FTP activities and consented to participate in this qualitative evaluation. In total, 19 focus groups—including 30 CHWs, 33 peer leaders, and 54 FTMs—and 48 individual interviews—including 10 husbands, 12 mothers-in-law, 23 FTMs, and 3 Pathfinder staff—were conducted in the study zone.

### 2. Monthly Monitoring Forms

Two key project monitoring forms informed the results of this report. The first was the Register de Coche, which is a project-specific tracking form used to compile service utilization information for each registered FTM using their MOH-issued mother-child health card. This form tracked information on ANC visits, location of delivery, home visits received, FP counseling received, FP accepted, FP method chosen, and CHW referrals received and completed. The second was the peer group attendance form, which peer leaders completed with the assistance of CHWs.

# RESULT 1

**The program attracted and retained FTMs at different stages of their FTP experience and across key demographic characteristics.** Out of the 843 FTMs originally identified through the social mapping exercise, 794 (94%) attended at least one peer group session, and almost two-thirds of the FTMs (529, 63%) attended at least five out of ten peer group sessions and had at least one home visit. Monitoring data show that the program attracted FTMs of different ages, education levels, and stages of their FTP experience. In comparing these 529 to the total potential pool of participants, the program appears to have attracted and retained a good representation of FTMs in these communities, as shown in Table 2 below. The profiles are generally similar when considering demographic characteristics, with the majority being married, of the younger age category (15–19 years), and with no education. This suggests that such characteristics did not pose a real barrier to program participation.

TABLE 1: Summary of Key Characteristics for Enrolled First-Time Mothers and Program Participants

| | | FTMS ENROLLED THROUGH SOCIAL MAPPING (n=843) | | FTMS WHO ATTENDED AT LEAST FIVE SESSIONS AND RECEIVED AT LEAST ONE HOME VISIT (n=529) | |
|---|---|---|---|---|---|
| | | n | % | n | % |
| AGE | 15–19 years | 566* | 67 | 380 | 72 |
| | 20–24 years | 276 | 33 | 149 | 28 |
| EDUCATION | None | 540 | 64 | 356 | 67 |
| | Literate | 55 | 6.5 | 38 | 7 |
| | Primary | 84 | 10 | 50 | 9.5 |
| | Secondary | 164 | 19.5 | 85 | 16 |
| PREGNANCY STATUS AT ENROLLMENT | 0–3 months pregnant | 71 | 8 | 56 | 11 |
| | 4–9 months pregnant | 159 | 19 | 111 | 21 |
| | Has child under 2 years | 613 | 73 | 362 | 68 |

**Includes one FTM who was 14 years old at the start of the intervention*

Importantly, FTMs across all three FTP "segments" (0–3 months pregnant, 4–9 months pregnant, and has one child under 2) participated in the program, with approximately 32% of the 529 peer group members being pregnant and 68% having delivered their first child.

However, participation levels by husbands were somewhat low and inconsistent, with an average of 467 attendees at each of the five monthly sessions. While somewhat higher, participation among mothers-in-law was also not particularly strong, with an average of 530 attendees at each of the five monthly sessions. Given the total number of participating FTMs (n=794), data suggest that many key influencers did not engage in the program.

Photo: Compaore Celestin

## RESULT 2

**FTMs reported increased awareness about ANC, including the importance of seeking services early in pregnancy.** ANC was a priority health issue for the FTP project, especially early ANC attendance. Many FTMs were unable to travel to facilities for ANC within the first few months of pregnancy, given cultural norms that limit FTM interaction outside the household until certain rites are conducted and/or the pregnancy is visible. Peer groups and home visits included information and discussions around early ANC and having a minimum of four ANC visits. Input from FTM peer group members suggest that the program succeeded in improving their knowledge of the health benefits of ANC and the importance of seeking ANC as early as possible.

*"**Regarding [peer group] meetings,** we said that when you get pregnant, you shouldn't even wait for a month before going to the health center. We have to go faster!"* —FTM, 23 years old

## RESULT 3

**HTSP/FP knowledge and attitudes improved for young FTMs and their husbands.** FTMs who participated in the qualitative evaluation indicated that they had improved their understanding of the benefits of HTSP and FP, regardless of whether they have adopted an FP method. Multiple participants also indicated that the program activities improved not only their knowledge about FP, but also their attitudes toward it. Some participants also went on to say that the young women in the peer groups were more likely to use FP than their peers that did not participate in the program.

Men who participated in the program also reported having improved knowledge of and attitudes toward FP use. Male respondents indicated that they now understood the benefits of FP for birth spacing, and that their attitudes toward FP and their involvement in contraceptive decision making had also improved.

**"My opinion has changed because, before I joined the project, I didn't know what family planning was.** Now that I have joined the project, I have been shown. If you choose a planning method that goes well with your body, [you] will be able to carry out your activities without worries. Your child will be healthy, and so will you."

—FTM, 19 years old

**"She will be able to rest; she will be in good health and also, she will be free to do the work she wants to do.** She will always be cheerful, and this will rejuvenate her. The children will be able to grow up serenely. When you look at the pre-project and the post-project, it is not the same thing anymore. I say this because there are a lot of illiterate people here who don't know a lot of things. Before there were too many problems in the homes. The women used to give birth very close together, but now I think they are waiting for more time."

—Husband of FTM, 20 years old

## RESULT 4

**While FTMs and husbands often have similar views on ideal family size, some FTMs continue to face opposition to their stated desired number of children, especially from their mothers-in-law.** While the range for ideal family size indicated by respondents of the qualitative study was broad—generally three to six children—the responses indicated similar ranges for FTMs and their husbands. Furthermore, FTMs and their husbands indicated similar rationale behind determining their preferred family size. Although some respondents indicated that the number of children is determined by "God's will," many noted practical and financial reasons to limit childbearing. In contrast to FTMs and their husbands, some mothers-in-law of FTMs indicated a preference for larger families and leaving the number of children up to God's will.

This difference of opinion about family size suggests possible tension within the household about HTSP and FP use, particularly as cultural norms require the young FTM or couple to defer to elders on this matter. While the project did engage mothers-in-law on the topic of HTSP/FP, feedback from participants indicates that additional efforts are needed to align attitudes and build household support.

**"If it's 10 it's good. We want a lot of children. We want them to work.** Some will go to school, and some will stay home and give me water to drink if I am thirsty. During the rainy season, they will also grow crops for me. It is God who limits births. You know that you have to give birth until menopause."

—Mother-in-law of FTM, 65 years old

## RESULT 5

**Some FTMs and husbands noted improvements in couple communication about HTSP and FP, which then facilitated the decision to use a modern contraceptive method.** Both FTMs and their husbands noted the importance of being able to talk about FP and avoid future disagreements. FTMs particularly remarked on the need to discuss and gather a husband's opinion about FP use before adopting contraception. Previously, FTMs and their spouses noted that it had not been common or easy for them to talk about FP, but that project activities helped to open the door to communication about FP. They particularly mentioned that participation by both members of the couple in project activities facilitated couple communication.

**"No! We hadn't talked about it. We didn't understand everything.** It [husband session] gave us a chance to get to know the subject better and discuss it with our wives. We're going to sit down and discuss it. Each one will say how many children they wish to have. Everyone knows that life has become complicated and before making a choice everyone must be aware of this fact. It is therefore necessary to agree."

—Husband of FTM, 26 years old

## RESULT 6

**Despite some improvement in HTSP/FP knowledge, attitudes, and communication, significant barriers persist, including spousal refusal, rumors about contraceptive side effects, the cost of FP services, and certain social norms.** Barriers to FP reported by both FTMs and their husbands include basic issues of access and costs related to obtaining a method and managing any side effects. Participants also noted several barriers rooted in fundamental social, religious, and gender issues. While communication about FP has improved for some, others noted that it can still be a struggle for FTMs to raise this topic with their husbands. Some men remain resistant to FP, in part due to religious beliefs and customs; as one husband of an FTM notes, "Tradition does not tolerate these things." Without spousal consent, FTMs largely cannot take the step of using FP. Additionally, the cultural belief that women should not use contraception when their husbands are away from home is a barrier, especially given the high numbers of men who migrate or travel for work.

**"I gave birth a month after he traveled.** If your husband [isn't] at home and you want to do this [contraception], won't the family stop it? But if your husband is at home you can use."

—FTM, 19 years old

## RESULT 7

**Participants reported increased knowledge related to exclusive breastfeeding, but the practice is still difficult to implement due to traditional infant care practices and resistance from mothers-in-law.** Input from program participants shows that many have good knowledge about exclusive breastfeeding and its benefits. Some of the participants were also able to successfully implement this practice.

However, many of the FTMs noted that exclusive breastfeeding was difficult to implement in their day-to-day lives. Cultural norms related to infant feeding and resistance from mothers-in-law were mentioned as critical barriers to maintaining exclusive breastfeeding.

**"I was able to do it. It allowed him to grow up fast.** Because if you start giving a child food, he can't grow up fast. So, after the six months when I started giving him porridge there I saw that it's good for him. If you give your child breast milk first, it will give him more intelligence. Even if you enroll him in school, it will help him."

—FTM, 23 years old

**"They say not to give water,** whereas if the child is sick and you don't have the means to take him to a health center and you turn to herbal teas, you are obliged to purge him and give him the decoction to drink."

—FTM, 19 years old

# EMERGING RECOMMENDATIONS

*Looking across the results presented above as well as the learnings communicated by the implementation team (which can be found in the full report), several broader conclusions and recommendations emerge to inform and advance future programs for this important youth population in Burkina Faso and across the globe.*

**1. Invest in community-based interventions that apply a socio-ecological approach to provide health information, address related gender issues, and build local support for FTPs across the lifestage.** The Burkina Faso FTP project demonstrated that such interventions can advance multiple health issues for FTPs. Given the local context, it was particularly important to address all aspects of the FTP universe—especially engaging household gatekeepers who control access to information/services and uphold social/cultural norms. In doing so, the program was able to reach diverse young FTMs and their influencers, build their understanding of the different health issues that arise over the FTP lifestage, encourage appropriate health behaviors and health-seeking, and address some of the barriers that may hinder health action. The results emerging from this project provide a good foundation to continue investing in this youth population, especially given the high levels of early childbearing, and the various social factors and influencers that affect their behavior.

**2. Consider if and how diversity within FTPs—by demographic or lifestage characteristics—should be incorporated into the program response.** The Burkina Faso FTP experience provided some important insights into the programmatic implications of segmenting FTPs by their particular point in the lifestage. While combining FTMs generally worked well, it may be important in some contexts to have separate activities that are specifically tailored for pregnant FTMs and for post-partum FTMs. This experience also revealed that segmentation can sometimes be too nuanced to execute effectively, as was found with challenges reaching and addressing the particular needs of FTMs early in their pregnancy. It is important for projects to understand the local context and have input from program participants and implementers to determine where different FTMs/FTPs may require different interventions.

**3. Focus engagement with key influencers on strategic health gaps/concerns, especially those that touch on deeply held cultural and gender norms.** While the project was able to engage husbands and mothers-in-law, their participation levels were not always strong and consistent. This was particularly true with the men, who were sometimes away from home due to work demands. Given this challenge, along with their pivotal role in health decision making, the most strategic approach would be to prioritize topics for influencer engagement. Repackaging influencer engagement to focus on key topics that involve cultural and/or gender norms and require influencer support for positive health action to take place—such as early ANC, exclusive breastfeeding, and HTSP/FP—and related social/gender norms may streamline project demands on their time and may also be more appealing/relevant.

**4. Structure and pace interventions to ensure local capacity to implement them.** The FTP project reinforced the need for multiple interventions that work together to advance health outcomes for FTPs and their children. However, carrying out complex activities with participants who are at different points in the FTP lifestage was challenging for the implementation team. Streamlining (as per Recommendations 2 and 3) and mapping out activities would, ideally, help manage workloads and troubleshoot potential challenges. Using an approach like the social mapping that this project conducted also helped to identify and anticipate the needs of program participants, again facilitating planning by local implementers.

**5. Invest in real-time data tracking and/or clear baseline/endline data collection to capture FTP health outcomes throughout the lifestage.** The FTP lifestage encompasses a wide range of health indicators that require a specific health behavior/action and particular moment in time. Tracking this, especially when working with hundreds of FTPs at different points in their FTP journey, is a challenge, but one that must be addressed to understand what results are emerging and where additional efforts are needed. Given limitations with paper-based systems built on the MOH MIS and literacy issues among CHWs and FTPs themselves, creative monitoring approaches are needed, or, alternatively, baseline/endlines that can capture results tailored to each FTP.

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