TECHNICAL BRIEF

July 2015

REACHING YOUNG MARRIED WOMEN AND FIRST-TIME PARENTS FOR HEALTHY TIMING AND SPACING OF PREGNANCIES IN BURKINA FASO

Burkina Faso has a high total fertility rate and low contraceptive prevalence rates. Girls and young women marry early, and most sexual activity occurs in the context of marriage. Despite a significant need for timely and accurate sexual and reproductive health (SRH) information and services, there is a dearth of targeted SRH interventions for young married women (YMW) and first-time parents (FTP). Between 2012 and 2015, Pathfinder International worked with the Burkina Faso Ministry of Health and local partners to develop and implement a project that has supported increased contraceptive use among YMW and FTP for healthy timing and spacing of pregnancies (HTSP). Because there is limited evidence about how best to reach this hard-to-reach population, the project implemented an intensive qualitative monitoring and documentation process to respond to this evidence gap. This technical brief discusses key findings from the project and offers lessons for supporting YMW and FTP to access information and contraceptive services that would allow them to practice HTSP in similar contexts.

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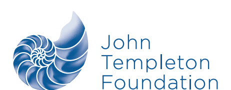


Context

West Africa[i] has disproportionately poor SRH status when compared to the rest of Africa. Illustrative of this, West African countries have some of the lowest contraceptive prevalence rates and highest rates of fertility; child, early, and forced marriage; and maternal mortality in the world (see Table 1).

In Burkina Faso specifically, 51.6 percent of women between the ages of 20 and 24 were married by age 18.[1] As suggested by the median age at first marriage, the median age at first sexual encounter, and the median age at first birth—17.8, 17.7, and 19.5, respectively—sexual activity and reproduction for Burkinabe women predominantly occurs within the context of marriage.[2] Among rural populations, which comprise 73 percent of Burkina Faso's population, marriage and childbearing begin earlier (17.6 years old) than they do in urban areas (19.2 years old).[3] Finally, evidence suggests that birth-to-pregnancy intervals of less than 6 months increase maternal morbidity and mortality risk, and intervals of less than 18 months increase infant, neonatal, and perinatal mortality.[4] However, YMW[ii] in rural Burkina Faso experience shorter birth-to-pregnancy intervals than older married women and women in urban areas.[5,iii] For example, for adolescents between 15 and 19, the median birth-to-pregnancy interval is 28.5 months, whereas for women 20 to 29 years old, it is 34.1 months. In rural areas, the median birth-to-pregnancy interval is 35.2 months, whereas in urban areas, the median birth-to-pregnancy interval is 41.7 months.[6] Because sexual activity and childbearing begin within the context of marriage, and because YMW and FTP[iv] in Burkina Faso are more likely to have closely spaced births, this population is not only an important target group for SRH outreach and services, but also represents an opportunity for the adoption of lifelong positive SRH practices.

TABLE 1: EPIDEMIOLOGICAL CONTEXT

Indicator	Burkina Faso	sub-Saharan Africa	Global
Percent of population 10–24 years old	32%[7]	32%[8]	25%[9]
Contraceptive prevalence rate, all methods	16%[10]	29%[11]	63%[12]
Unmet need for spacing births (women ages 15–49)	17.3%[13]	24.2%[14*]	11.9%[15]
Fertility rate (live births per woman ages 15–49)	5.9[16]	5.1[17]	2.5[18]
Adolescent fertility rate (live births per 1,000 women ages 15–19)	117[19]	101[20]	52[21]
Child marriage (percent of women 20–24 married before age 18)	52%[22]	40%[23]	27%[24]
Maternal mortality ratio	400[25]	510[26]	210[27]

* Percentage of married or in-union women aged 15-49 who want to stop or delay childbearing, but are not using a method of contraception.

Within this context, however, social and cultural norms in Burkina Faso pose barriers to SRH services for YMW, making them more vulnerable to poor SRH outcomes. While some of the barriers YMW face are structural, caused by poorly-equipped facilities, inadequately trained providers, and stock-outs, many of these barriers are rooted in family structures and gender dynamics that socially isolate YMW, and cultural norms that pressure YMW to bear children early. Upon marriage, young Burkinabe women commonly leave their families to live with their husbands' families, at which point they lose established social support networks, as well as decision-making power.[28] Decision-making power for SRH is often determined by financial resources, which is typically held by male partners, and traditional social status, which is held by mothers-in-law. As a result, YMW in Burkina Faso require permission to access care from male partners or mothers-in-law.[29] For example, in 2010, 74.9 percent of women reported that the decision-maker for healthcare was principally the husband.[30] Age also affects decision-making power—YMW report less participation in decision-making (9.6 percent for girls ages 15 to 19) compared to older women (14.2 percent for women ages 45 to 49).[31] Further, almost half of marriages in Burkina Faso are polygamous, which is practiced more frequently in rural than in urban areas, thus, in addition to mothers-in-law, SRH decisions for YMW may also be influenced by co-wives.[32]

[i] Defined as the countries that compose the Economic Community of West African States (Benin, Burkina Faso, Cabo Verde, Cote d'Ivoire, The Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, Togo). [ii] The WHO defines adolescents as those between the ages of 10 and 19, and young people as those between the ages of 10 and 24 years old (Accessed May 5 2015 at www.who.int/topics/adolescent_health/en/) (Andre Tylee, Dagmar M Haller, Tanya Graham, Rachel Churchill, Lena A Sanci. "Youth-friendly primary care services: how are we doing and what more needs to be done?" *The Lancet,* 2007: 1565-1573.) [iii] To reduce the risk of maternal, perinatal, and infant outcomes, the World Health Organization (WHO) recommends waiting at least 24 months between live birth and attempting the next pregnancy. (Report of a WHO Technical Consultation on Birth Spacing Geneva, Switzerland, 13–15 June 2005. Accessed June 19 2015 at www.who.int/maternal_child_adolescent/documents/birth_spacing.pdf?ua=1) [iv] First-time parents are young married women under age 25, who have one child, and their partners.

Burkina Faso has one of the highest fertility rates in the world. Women's desired number of children, 5.8, suggests a cultural preference for large families. However, differences between the desired number of children between men and women overall, 6.6 and 5.5 respectively, and married men and women specifically, 7.4 and 5.8, suggest women experience pressure to bear children once married.[33] This trend is further reflected in contraceptive prevalence rates, unmet need, and length of intervals between birth and subsequent pregnancy. As seen in Figure 1, YMW report a low contraceptive prevalence rate when compared to their unmarried and sexually active counterparts.

There is international recognition of the adverse SRH landscape in West Africa, and in Burkina Faso specifically. Reflecting a growing local momentum for change, in 2011, Burkina Faso hosted the Ouagadougou Population, Development, and Family Planning in West Africa Conference. There, francophone West African nations congregated to discuss reproductive health (RH) and family planning (FP) needs for the region, and committed to create strategic action plans to strengthen FP programming.[34] Several of these action plans included adolescents and youth as a priority group. As regional leadership grows to address SRH needs, there remains a clear and urgent need for supportive services for YMW and FTP, as well as programs and evidence to support these hard-to-reach and vulnerable populations to access critical services and information.[35]

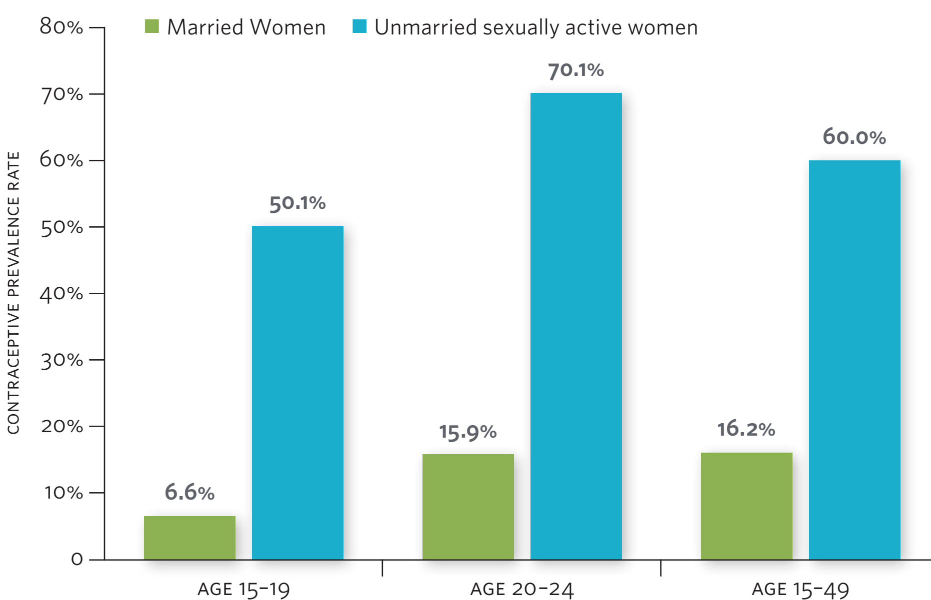
Project Context

Recognizing the need to expand YMW and FTP's access to critical, timely, and appropriate information and services for HTSP, in 2012, Pathfinder's Board of Directors approved the use of private funds to begin operations in the West Africa region. The Addressing the Family Planning Needs of the Young Married Women and First-Time Parents project[v] intended to increase contraceptive use among YMW and FTP in Burkina Faso and Guinea for HTSP, and to contribute to the global knowledge base about how to reach this population.

As the first Pathfinder project in the two countries, the YMW-FTP project was structured to establish operations in its first two years, with intensive implementation taking place in its third and final year. Project staff consisted of the project manager, based in Guinea, and a part-time support staff member, based in Burkina Faso. Owing to implementation impediments and an outbreak of Ebola in 2014, implementation in Guinea was truncated. For this reason, the project re-focused its implementation efforts in Burkina Faso.

To move forward effectively, the project worked with community-based NGOs that have local expertise as well as established infrastructure at project sites. Project management was carried out through regular field visits by the project manager, with technical support from Pathfinder headquarter-based technical and program officers, and through monthly structured group discussions with implementing partners and frontline implementers. This intensive qualitative monitoring and documentation structure—informed by Pathfinder's Implementation Learning approach[vi]—allowed project management to support frontline implementers' collective, routine lesson-sharing and problem-solving while aligning the project's implementation improvement efforts and project management needs with evidence generation.

FIGURE 1: CONTRACEPTIVE PREVALENCE RATE BY AGE AND MARITAL STATUS, BURKINA FASO[36]



[v] For the purposes of this publication, the project will be referred to as the YMW-FTP project. [vi] Implementation Learning is a process by which implementers can systematically capture and analyze information about how interventions are implemented and apply this learning to improve the quality and effectiveness of ongoing and future implementation. The process is informed by the field of Implementation Science, and draws on integrated knowledge management approaches to embed data generation, analysis, and use within the project lifecycle for the purpose of enabling interventions' iteration and adaptation during the course of implementation, to ensure optimal fit to context amidst dynamic change.

PHOTO: Abdoul Balde

Nikiema Adama, age 23, a young married woman and small group leader, Kantchari, Burkina Faso

YMW-FTP Project Strategy

The YMW-FTP project had two specific goals: (1) to increase access to and use of contraception and other SRH services for YMW and their partners, and (2) to increase community, household, and individual support for YMW and their partners to delay first pregnancy until at least age 18 and space or limit subsequent pregnancies through the use of contraception. Drawing from implementation experience reaching YMW and FTP in India[vii] and Uganda,[viii] Pathfinder developed a strategy that reached all levels of the socio-ecological model—individual, community, and structural—in order to foster changes in behaviors and norms around contraception use and HTSP among YMW and FTP. Pathfinder partnered with two local NGOs—Burkina Council of AIDS Service Organization (BURCASO) and SOS-Jeunesse Défi (SOS-JD)—which have significant experience in SRH programming, ties to the Ministry of Health, networks of community-based health workers, and local knowledge to design and implement the project.

Whereas the project in India, PRACHAR, used home visits—with a few group activities—to reach YMW and FTP, the project in Uganda, GREAT, used small group meetings. The YMW-FTP project implemented both approaches in Burkina Faso. Because the social mobility of YMW and FTP is bound by social and cultural norms as well as the opportunity costs associated with leaving the home, Pathfinder trained animateurs (community health workers under SOS-JD) to reach YMW and FTP at their homes with individualized SRH information, counseling on HTSP and contraception, and couples' communication, as well as to make referrals to health facilities. At the community-level, the project introduced small group discussions with YMW and FTP—led by trained YMW—to complement home visits, as well as community theatre and group discussions with male partners and group discussions with key community leaders to sensitize them to HTSP and contraceptive messaging. The YMW-FTP project was structured to include both home visits and small group discussions to allow implementers to maximally engage YMW and FTP individually as well as in group settings, and to enable greater social cohesion through their mutual learning and shared experiences. Finally, the project worked at a structural level by disseminating national adolescent and youth sexual and reproductive health (AYSRH) standards and integrating youth-friendly services across facilities to ensure an enabling environment for changes at the individual and community levels.

Site selection was based on the following criteria, as indicated in the Burkina Faso 2010 DHS: (1) diversity of YMW and FTP experiences in rural and urban areas, as reflected by varied SRH indicators (2) low contraceptive use but high demand, (3) limited existing services for YMW, (4) and existence of relationships and activities established by partner organizations, providing a foundation for the project to build upon. The project was implemented with equal intensity in two districts: the peri-urban district of Nongremassom, located within Ouagadougou, and the rural Diapaga district, located within the Est Region. See Figure 2 for a depiction of project sites and strategy components.

Individual-level activities: Home visits

YMW often lack autonomy, are more likely to be out of school, and may require permission to seek health care services. The global literature on YMW and FTP, as well as Pathfinder's experience with the PRACHAR project, suggest that home visits are an effective approach to reach this population, which is marginalized due to its limited autonomy and mobility.[37] Animateurs, who are trained community-based health workers working under the supervision of SOS-JD, conducted home visits with YMW and FTP to provide tailored counseling on

[vii] For more information on PRACHAR, visit www.pathfinder.org/our-work/projects/prachar-promoting-change-in-reproductive-behavior-in-bihar-india.html
[viii] For more information on GREAT, visit www.pathfinder.org/our-work/projects/gender-roles-equality-and-transformations-uganda.html

HTSP and contraception, as well as support to navigate the unique contexts of YMW and FTP—while paying special attention to gender and power dynamics experienced at home. Between February and May 2014, 42 animateurs were trained using the national FP and RH curriculum and a curriculum developed by Pathfinder to specifically address the unique needs of YMW and FTP. Training included participatory content to support animateurs and allow them to reflect on their own attitudes and values towards YMW and FTP, fertility, and contraception; to understand HTSP; and to develop counseling skills for YMW and their key influencers, including suggestions for engaging with mothers-in-law.

Because of their local knowledge, SOS-JD and animateurs were able to identify households with YMW for home visits. Each animateur conducted a minimum of six home visits to each participating household. During these home visits, animateurs reached YMW and, when possible, their male partners and other members of the household with counseling on HTSP, contraceptive methods, and support for couples' communication about fertility choices and household decision-making. Animateurs also served as a critical link to youth-friendly health facilities by referring young women—and accompanying them when possible—to health facilities to reduce fear and stigma. Home visits began in June 2014 and ended in June 2015.

Community-level activities: Small group discussions and engaging key influencers

Many YMW in Burkina Faso are marginalized and are rarely afforded opportunities to develop social capital; gain support from young women with similar life experiences; or discuss SRH, contraception, fertility, couples communication, and decision-making with peers or knowledgeable providers. Working with SOS-JD, the project identified 40 small group leaders to lead community-based discussions and participatory reflections on needs, rights, and challenges of YMW and FTP; challenges YMW face in seeking SRH services; circles of influence around YMW and FTP; healthy couples' communication and decision-making; HTSP; and views and beliefs related to fertility and contraception.

Small group leaders were YMW selected based on leadership skills, literacy in French and ability to speak the community's local language, availability to prepare and conduct small group discussions, and ability to maintain confidentiality. They were trained between February and May 2014 using a three-day SOS-JD curriculum and a two-day supplemental curriculum developed by Pathfinder on community sensitization, AYSRH topics, HTSP, and group facilitation skills. The Pathfinder curriculum included training on the use of activity cards that had been used by Pathfinder and partners for the GREAT project in Northern Uganda and adapted by the small groups in this project. These activity cards proposed group activities, such as true or false games and role-playing, followed by questions to guide discussion.

Because of their familiarity with the project sites, animateurs assisted small group leaders with recruitment for small group participation. Small group leaders accompanied animateurs to households with YMW to explain the project and to establish a time, date, and a place where the YMW felt safe and confident for the first group discussion. Each group leader was responsible for one group of 15 to 18 YMW, and these groups met on a monthly basis. At each meeting, small group leaders engaged participants to decide on future discussion topics and activities, as well as dates and locations, so that YMW and FTP felt ownership over the meetings and so that these meetings were responsive to their needs, interests, and logistical realities.

In addition to working directly with YMW and their male partners, animateurs worked with key influencers and those who primarily made SRH decisions for YMW and their partners, namely mothers-in-law, co-wives, and traditional and religious community

Animatrice Zidouwemba Abiba with young married women in Ouagadougou, Burkina Faso

PHOTO: Abdoul Balde

A supervisor with community actors, Kantchari, Burkina Faso

PHOTO: Abdoul Balde

leaders. Animateurs reached these key gatekeepers, when possible during home visits, with information on HTSP and contraception. Animateurs also worked in the community, reaching husbands at their places of employment or leisure.

To sensitize religious and traditional leaders, animateurs organized individual meetings, community discussions and debates, and community theatre to introduce the importance of HTSP and uptake of contraception to support it.

Structural-level activities: Advancing YFS access

Project activities at the individual and community levels aimed to increase the demand for contraception and SRH services among YMW. Activities at the structural level ensured that increased demand was met by youth-friendly and appropriate SRH and FP services. At project start-up, BURCASO used Pathfinder's youth-friendly service facility assessment tool to conduct an assessment of facilities at project sites to understand how they were meeting the needs of adolescents and youth, especially YMW and FTP. Four primary care facilities were selected for priority implementation. Facilities were selected based on the location of the existing work conducted by SOS-JD and on the needs of the facility—in other words, the facilities most in need of improvements to meet the needs of adolescents and youth. Through BURCASO, the project integrated youth-friendly services into contraceptive service delivery points, including postpartum contraceptive services, at the four selected health facilities through provider trainings, small facility improvements, provision of adolescent contraception counseling cue cards, adolescent-focused IEC material, and dissemination of national AYSRH standards. Finally, BURCASO supported the Ministry of Health officials in conducting supervisory support meetings with health facility providers, including analysis of age-disaggregated service delivery data, on a quarterly basis.

To support national commitments to adolescents and youth in the context of the Ouagadougou Action Plans, Pathfinder, BURCASO, and the Ministry of Health conducted a national workshop to map existing AYSRH services, identify evidence-based practices, and advance commitments to implementing evidence-based practices for AYSRH.

Learning agenda activities: Intensive qualitative monitoring and documentation

Programs designed for mothers or for adolescents and youth tend not to differentiate between young or first-time mothers, young married, and young unmarried women.[38] As a result, little was known before the YMW-FTP project about how best to delay pregnancy and subsequent births among these populations. Recognizing the importance of understanding how to reach YMW and FTP in Burkina Faso's context, Pathfinder and its Evidence to Action (E2A) project collaborated to design and implement an intensive qualitative monitoring and documentation process. Rooted in Pathfinder's Implementation Learning approach, this process was designed to work within the project's resource and time constraints to: 1) foster frontline implementers' own routine and collective reflection, critical thinking, and joint problem-solving to evolve and refine implementation to reach FTP and YMW; 2) bolster project managers' ability to respond rapidly to emerging need in the field; and 3) ensure that the experience of the project contributed to global understanding of how to reach this hard-to-reach population. Thus, at the center of this process were the frontline implementers themselves, who were not only responsible for implementing the project, but also for generating and analyzing its evidence.

As part of this approach, the project manager facilitated implementing partners, animateurs, and small group leaders to reflect and analyze their approaches to reach YMW and FTP via regularly scheduled group discussions. Considered specifically were questions of "how" (how to reach YMW and FTP? How to engage them and their key influencers?) and "why" (why did this approach work while this approach did not?). These discussions took place between October 2014 and March 2015, beginning with a broad focus on implementers' processes and techniques, the successes as well as challenges that emerged, and collaborative

FIGURE 2: YMW-FTP PROJECT DESIGN

INDIVIDUAL LEVEL

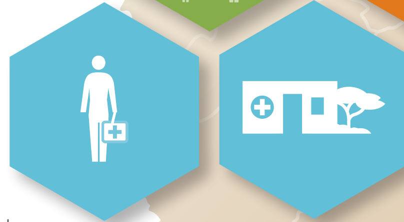
Animateurs conducted home visits with YMW and FTP and, when necessary, referred and accompanied them to health facilities.

COMMUNITY LEVEL

Small group leaders engaged YMW and FTP in discussions with peers. Animateurs met with male partners, community leaders, and other key influencers with information on HTSP and contraception.

STRUCTURAL LEVEL

The project integrated youth-friendly services at four facilities, trained providers, and disseminated national AYSRH standards. BURCASO and the Burkina Faso MOH conducted a national workshop to map existing AYSRH services and advance commitments to implementing evidence-based practices for AYSRH.



NONGREMASSOM

- 20 small group leaders
- 21 animateurs
- 2 health facilities

Ouagadougou

DIAPAGA

- 20 small group leaders
- 21 animateurs
- 2 health facilities

PRACHAR (2001 – 2012)

The PRACHAR project in Bihar, India, was implemented in three phases with funding from the Packard Foundation. PRACHAR sought to use social and behavior change interventions to increase contraceptive use among adolescents and youth for healthy timing and spacing of pregnancies. Using formative research and iterative programming, implementers developed and refined an approach to changing behaviors and norms related to HTSP and contraception among unmarried adolescents and young couples, including FTP, while also building support for these groups among influential family and community members.

Key strategies included training for unmarried adolescents; **home visits for young newlywed couples, FTP, and young couples with more than one child; small group meetings to engage male partners, mothers-in-law, and other key influencers; and community-wide activities to create an enabling environment.** Young women in PRACHAR intervention areas were nearly four times more likely to use contraception than in comparison areas, and contraceptive use among FTP to increase the interval between last live birth and subsequent pregnancy rose from 6 to 25 percent, compared to 4 to 7 percent in the comparison area.

GREAT (2010 – 2017)

The Gender Roles, Equality, and Transformations Project (GREAT) is a USAID-funded project in Northern Uganda, led by Georgetown University's Institute of Reproductive Health and implemented in partnership with Pathfinder and Save the Children. GREAT aims to develop and test a package of evidence-based, scalable, life-stage tailored interventions to transform gender norms, reduce gender-based violence, and promote gender-equitable attitudes and sexual and reproductive health (SRH) among adolescents ages 10 to 19 in post-conflict communities.

The GREAT model employs targeted interventions at the individual, community, and structural levels. At the individual level, **small groups of adolescents** use a toolkit, which includes a community game, radio discussion guides, **activity cards**, and flipbooks. At the community level, the project uses a radio serial drama and capacity-strengthening of community leaders and mobilizers to understand and transform gender norms. To address structural barriers, the project trained village health teams respond to adolescents' unique SRH needs. Results indicate a net improvement of 16 percent in contraceptive use, and a 10 percent increase in self-efficacy related to contraceptive use among newly married and parenting adolescents.

critical thinking to address and leverage learning over time. As key themes and insights emerged about implementation, the project manager refined discussion guides and questions, thereby enabling the focus of discussions and their resulting evidence to evolve as implementers' own thinking and approaches evolved. Concurrent to this evolving learning and practice, the project manager analyzed the qualitative data from these discussions on a month-to-month basis, identifying preliminary hypotheses regarding how to reach the target populations in the project's contexts. Finally, at the close of implementation in April 2015, the full cadre of frontline implementers convened to vet and validate the findings from the culmination of their group discussions. For further detail regarding this approach, please see Figure 3.

Findings

Experience from Pathfinder's previous programs informed the design for this project as well as its goals for evidence generation to address existing knowledge gaps. For example, findings from PRACHAR suggest that approaches should be tailored to specific life stages, concerns, and needs of the target population; implementers should cultivate support and engagement from key gatekeepers, such as mothers-in-law, community leaders, and husbands; and multiple overlapping activities, such as individual meetings and community-based group activities, can strengthen support for messaging.[39] In addition, projects should ensure that there is access to appropriate, youth-friendly health services, particularly for the beneficiaries of interventions, such that demand generation will be met with appropriate supply provision.[40] These findings influenced YMW-FTP project design, and elements from PRACHAR and GREAT were adapted to the Burkina Faso context.

Although these findings pre-dated the project, there was still a dearth of evidence showing the impacts of interventions specifically targeting YMW, FTP, and YMW with multiple children. For this reason, the YMW-FTP project collected: (1) quantitative data from standard monitoring activities conducted throughout the life of the project to determine the effects of the activities on the target populations, and (2) data from the intensive qualitative monitoring approach to understand how and why these activities affected YMW and FTP. The next section discusses findings from the combined quantitative and qualitative monitoring approaches.

Project coverage and performance

The YMW-FTP project supported 650 YMW over the course of its year of implementation. There were 40 small groups that held regular meetings and 4,269 participations of YMW and FTP recorded in these meetings. To create an enabling environment for YMW and FTP, animateurs reported 1,923 home visits with mothers-in-law and key influencers and had 171 contacts with religious and traditional leaders to sensitize community members and share accurate SRH and HTSP information. According to data collected during baseline home visits by animateurs, 41[ix] percent of YMW at project sites were using contraception to delay or space pregnancies. During project implementation, animateurs referred 345 YMW to health facilities for contraceptive services. At endline home visits, 81[x] percent of YMW reported using contraception to delay or space pregnancy, suggesting that project activities at the individual, community, and structural levels contributed to the creation of an enabling environment for YMW to seek contraceptive services.

Lessons from systematic implementation analysis: How to reach YMW and FTP

Qualitative analysis sought to understand and capture the processes, techniques, and tacit knowledge of frontline implementers and local partners in reaching YMW and FTP, thus contributing to the global knowledge base.

ENGAGING KEY GATEKEEPERS TO REACH YMW AND FTP

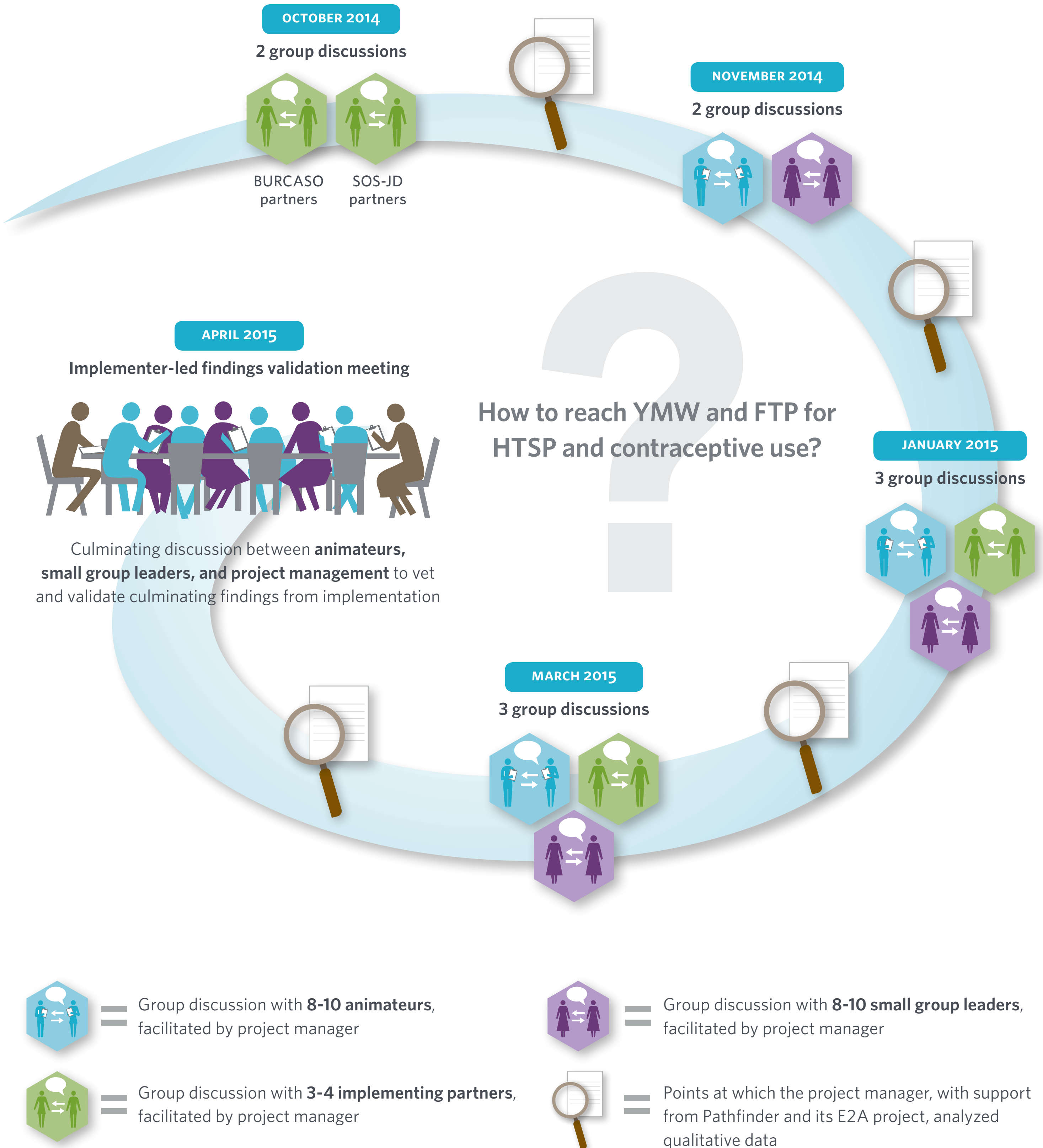
"It is above all a matter of understanding the circle of influence that surrounds YMW and meeting that circle and convincing that circle first before any meeting with YMW."

—ANIMATEUR, CULMINATING GROUP DISCUSSION, OUAGADOUGOU

Despite the difference in contexts, findings from Burkina Faso confirmed findings from India: to reach YMW and FTP, implementers must first cultivate the engagement and support of key gatekeepers. Mothers-in-law, co-wives, and male partners influence the decision-making process of YMW and FTP. In some instances, these influencers prevent YMW and FTP from using contraception for HTSP because of inaccurate information. For example, animateurs often found that partners had misconceptions about FP: "FP is not accepted because it is interpreted as the refusal to have children, so animateurs/animatrices explain that it is actually the spacing of births." Additionally, animateurs and small group leaders reported mothers-in-law and co-wives directly impeded contact with YMW and FTP until they felt they had been treated with appropriate and due respect. For example, in their culminating group discussions, animateurs explained: "Once I was with the [small group leader], we visited a home to see a young married woman. When I left for the first time, the mother-in-law did not receive us. I came

[ix] Because animateurs—who counseled YMW on contraception—collected this data to inform their counseling approach, there is a potential bias introduced. YMW may have been motivated to respond "yes," when asked if they were using contraception, as that could have been perceived as the desired response in accordance with counseling messages. [x] Ibid.

FIGURE 3: THE YMW-FTP PROJECT INTENSIVE QUALITATIVE MONITORING APPROACH



back a second time with the village [community health worker] to accompany me, and then we were received. After an interview, she allowed us to meet the young married woman."

Mothers-in-law

"I was in conversation with a young married woman without her mother-in-law. When the mother-in-law arrived, she was not happy. We had not yet had chats with mothers-in-law. I ended our conversation and immediately went to report my presence/introduce myself."

—ANIMATEUR, KANTCHARI

Discussions with frontline implementers affirm that mothers-in-law hold significant influence and decision-making power over SRH decisions in the project sites. Illustrative of this, one animateur reported that "though men wear the pants, women choose what pants they wear." Many animateurs felt they were received differently during home visits when they addressed YMW first and when they addressed mothers-in-law first. As a result, frontline implementers recommend that **implementers consider mothers-in-law as a primary target group that should be approached individually at the beginning of outreach interventions. Implementers should take this opportunity to introduce themselves and the project to mothers-in-law before addressing YMW and FTP.** In addition, **animateurs found that mothers-in-law were receptive to messaging tailored to the life stage of the daughter-in-law**. For example, for daughters-in-law with no children, animateurs explained to mothers-in-law the potential for poor child health outcomes related to early pregnancy and frequent deliveries. For daughters-in-law with many children, animateurs explained that large families are expensive as children have costs, such as those for education and health care.

Co-Wives

"As soon as the first co-wife is acknowledged (and she understands why we are targeting YMW), she will encourage the co-wife to participate."

—CULMINATING DISCUSSION GROUP, KANTCHARI

In designing the YMW-FTP project, Pathfinder understood that co-wives would be an important consideration. However, given the dearth of evidence on how to engage YMW and FTP in Burkina Faso and documented strategies to engage co-wives, it was unclear what role co-wives would ultimately play in influencing the decision-making of YMW and FTPs and their partners regarding contraception. Small group discussion leaders and animateurs found variation in the definition of co-wife and in the response of co-wives to the project. First, the definition of "co-wife" extended to sisters-in-law and cousins, in addition to women who shared the same husband. Co-wives in urban settings posed barriers to project participation because they feared that YMW supported by the project and using contraception would become more available to satisfy the sexual needs of the husband. In addition, older co-wives were similar to mothers-in-law with respect to the influence they held. Similar to some experiences with mothers-in-law, animateurs found that they were received differently in homes when they greeted elder co-wives first compared to when they spoke directly with YMW.

Findings suggest that the role and influence of co-wives varied according to urban and rural settings in Burkina Faso, however, older co-wives seemed to consistently hold more influence than younger co-wives. Frontline implementers recommend that **implementers recognize the diverse relationships between co-wives and adapt strategies accordingly**. Specifically for urban areas, where there was less support for the participation of YMW in the project due to jealousy among co-wives, **elder co-wives should be approached individually and courteously to explain the project and its purpose**. Similarly in rural areas, where jealousy was found to be less of a barrier to project participation, elder co-wives may still be approached first, such that they can help facilitate support among younger co-wives. **Finally, including co-wives in small group discussions, and speaking with them separately at home visits to listen to their concerns and needs, reduced barriers to reaching YMW and FTP for project implementers.**

Partners

"There is sometimes a generational conflict, and the husband is irritated to have to discuss with his wife, if there is a large age gap, in the presence of a third party."

—CULMINATING GROUP DISCUSSION, OUAGADOUGOU

Evidence from a range of projects and Pathfinder's own work on YMW and FTP emphasize the importance of engaging the male partners of YMW and FTP.[41] The YMW-FTP project was designed with this in mind, and strategies for engaging men included encounters during home visits as well as community events. However, animateurs found few men were available when they conducted home visits. Additionally, animateurs reported that large age gaps between spouses contributed to an unequal power dynamic that made it difficult for the young woman to express herself openly. Men who were significantly older than their wives did not feel comfortable discussing personal matters in front of a third party.

Findings from group discussions revealed different approaches that frontline implementers applied to engage partners in urban areas, partners in rural areas, and partners significantly older than the YMW. To engage partners in urban areas, the most common

and effective strategy was to **obtain the partner's mobile phone number so that the time and date of home visits could be arranged in advance**. To engage partners in rural areas, **animateurs reached them in the household before work, while they were at work in the fields, or at weekly gatherings in the community**. In response to the age gap, frontline implementers **recommend speaking to older husbands and YMW separately so that each feels comfortable expressing him or herself openly, while couples who are close in age responded well to couples' counseling.**

As suggested by animateurs' findings, messages that focused on the risks of early pregnancy were most effective for YMW with no children; messages on HTSP were most effective for FTP; and messages that emphasized the costs of providing for large families were most effective for YMW with several children who were more receptive to learning about FP.

ADAPTING TECHNIQUES TO REACH YMW AND FTP IN RURAL VERSUS URBAN SITES

Significant differences exist between urban and rural settings, such as higher rates of polygamy, and tendencies towards earlier marriage and childbearing in rural areas, making it necessary to tailor approaches to a specific setting. Animateurs and small group leaders observed differences in attitudes and behaviors between project components at urban and rural sites. Mothers-in-law at urban sites were more exposed to information on FP; however, they did not always have accurate information. Additionally, frontline implementers report differences in messaging best used to engage urban versus rural mothers-in-law. Although HTSP messages were used uniformly with mothers-in-law at both sites, analysis of implementers' tacit insights into engaging these important stakeholders across sites provides useful information: **Urban mothers-in-law responded more significantly to messages that included discussion of the workload burden distributed throughout the household as a result of daughter-in-law's early or closely spaced births, while rural mothers-in-law appeared to respond to messages oriented toward basic information about the concepts of HTSP—likely reflecting the relative nascence of birth-limiting and -spacing concepts in rural contexts.**

In addition, animateurs found that some YMW under 14 from rural areas slept in mothers-in-law residences until old enough to bear children, and would not speak to frontline implementers without the presence of the mother-in-law.

VARYING STRATEGIES TO ENGAGE YMW WITH NO CHILDREN, FTP, AND YMW WITH MORE THAN ONE CHILD

Evidence from the PRACHAR project in India suggested the importance of tailoring project strategies and content to YMW with no children and YMW and their partners with children. Project experience in Burkina Faso reinforced this finding. Structured discussions with frontline implementers revealed varied experiences and needs among YMW and FTP. As suggested by animateurs' findings, **messages that focused on the risks of early pregnancy were most effective for YMW with no children; messages on HTSP were most effective for FTP; and messages that emphasized the costs of providing for large families were most effective for YMW with several children who were more receptive to learning about FP.**

Next steps

As evidence suggests, there is significant need among YMW and FTP in Burkina Faso for SRH services. The YMW-FTP project findings suggest that elements from previous Pathfinder programming (specifically PRACHAR and GREAT) can be successfully adapted to varied SRH contexts to reach those in need. Further, the project findings confirm that implementers must engage and understand the social context around YMW and FTP, aligning their approaches specifically to the setting (rural or urban), and designing approaches to fit the relationship dynamics of YMW and FTP to those with most significant power to influence them. Additionally, and importantly, the findings demonstrate the value of a systematic qualitative monitoring approach to engage frontline implementers as experts in some of the key questions our industry is now increasingly being prompted to ask—beyond effectiveness, how do interventions work?

While the Burkinabe Ministry of Health and its neighboring regional leaders increasingly pursue AYSRH programmatic agendas, there is a need for evidence that answers this question: how can we reach these marginalized and vulnerable segments of the youth population in their diverse SRH contexts? Rather than rely solely on quantitative monitoring indicators, the YMW-FTP project designed an approach that engaged all levels of project implementers as experts and analysts of implementation. Together, these learning and project management structures enabled the implementation team to unpack how to support YMW and FTP in Burkina Faso to practice HTSP and use contraceptives—turning otherwise tacit knowledge into

evidence for both internal project and larger global learning. This design empowered frontline implementers to become the creators and users of data, bolstered project management approaches by ensuring meaningful and frequent critical thinking between the project's frontline and its leadership, and proved an effective means of enabling this project to contribute to our industry's knowledge base. Project findings respond to current evidence gaps in global knowledge of YMW and FTP, despite the project's human and financial resource constraints.

All too often, projects similar to the YMW-FTP project are limited in their capacity to contribute to global knowledge and discussions, even in cases in which they are at the fore of new and important questions about how to reach the hardest-to-reach populations. The project's approach embedded iterative question-asking into the management structure to foster collaborative learning and knowledge sharing as part of implementation, and enabled these findings—a finding in and of itself. Systematic approaches to learning from implementation of interventions can offer our global SRH community critical insight into how to direct and refine our future efforts. The YMW-FTP project experience suggests this approach to implementation merits wider application.

ENDNOTES

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COVER: Ouali Tenilaba, young married woman age 17, Burkina Faso PHOTO: Abdoul Balde