

JUNE 2020

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

REPORT | E2A PROJECT



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ACKNOWLEDGEMENTS

The Evidence to Action (E2A) Project gratefully acknowledges the generous support of the U.S. Agency for International Development (USAID) for this report and the work it describes. This first-time parent (FTP) project was a joint activity between E2A and Pathfinder International Burkina Faso, in partnership with the Burkina Faso Ministry of Health. This report was authored by Ginette Hounkanrin, E2A, Senior Youth Advisor, Pathfinder International; Erica Mills, E2A Program Officer–Field Support, Pathfinder International; and Philomene Bambara, Regional Program Manager, Pathfinder International.

The FTP activities and results presented in this report were achieved through the efforts of a large team, including: Pathfinder and E2A staff in project offices, Ouagadougou, and Washington DC; and community health workers, health providers, and young first-time mother (FTM) peer leaders from project communities. Several individuals played a leadership role in the design and implementation of the FTP project: Emmanuel Kabore, RISE-FP and FTP Project Director, Pathfinder International; Augustin Zongo, Burkina Faso Monitoring, Evaluation and Learning Advisor, Pathfinder International; and Philomene Bambara, Regional Program Manager, Pathfinder International.

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On behalf of the project team, E2A thanks the hundreds of young first-time mothers, their partners, and female relatives who participated in the program and shared their experiences, helping to advance programming for young FTPs around the world.

SUGGESTED CITATION

Hounkanrin, Ginette, Erica Mills, and Philomene Bambara. *Addressing the Reproductive, Maternal, and Child Health and Family Planning Needs of Young, First-Time Parents in the Eastern Region of Burkina Faso.* Washington, DC: Evidence to Action Project, April 2020.

ACRONYMS AND ABBREVIATIONS

ANC	Antenatal care
CHW	Community health worker
E2A	Evidence to Action
EMC	Enquête Multisectorielle Continue
FP	Family planning
FTM	First-time mother
FTP	First-time parent
HTSP	Healthy timing and spacing of pregnancy
mCPR	Modern contraceptive prevalence rate
MOH	Ministry of Health
PNC	Postnatal care
RMNCH	Reproductive, maternal, neonatal, and child health

INTRODUCTION

In 2018, Evidence to Action (E2A) Project and Pathfinder International Burkina Faso began implementing a new initiative for young first-time parents (FTPs) in the Fada and Diapaga districts in the Eastern Region of Burkina Faso, in collaboration with the Ministry of Health (MOH). 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 both community- and facility-level interventions with the goal of increasing the use of reproductive, maternal, neonatal, and child health (RMNCH) care—especially antenatal care (ANC) and obstetric and neonatal services—and family planning (FP) uptake among FTPs.

The FTP project generated valuable evidence and insights about working with this vulnerable population and how best to respond to their RMNCH/FP needs. This report presents an overview of the FTP project and the RMNCH/FP-related results in the following sections:

- **Background:** presents an overview of E2A’s global FTP work as well as some background information on the unique needs of FTPs and the reproductive health context in Burkina Faso, and the Eastern (Est) Region specifically
- **Program Description:** describes the key components of the FTP project, both at the facility and community levels
- **Methods:** presents an overview of the main data sources used to inform the results and implementation learnings sections of this report
- **Results:** highlights key results from the FTP project, including areas of progress in addressing the pre- and post-partum health needs of first-time mothers (FTMs), and some persistent barriers that hinder action
- **Implementation Learnings:** presents the key learnings obtained during project implementation about working with FTMs and their key influencers
- **Recommendations:** uses the results and implementation learnings to propose some key conclusions and recommendations to inform future FTP programming in Burkina Faso and globally



BACKGROUND

This FTP work in Burkina Faso, along with similar E2A efforts in Nigeria and Tanzania, is part of an evolving body of work to increase global awareness and evidence on programming for FTPs. E2A's focus on FTPs grew out of efforts to understand the diversity of youth reproductive health experiences and needs. A 2014 review of global data pointed to a large subset of young FTMs who are at increased risk of poor pregnancy, delivery, and child health outcomes, a situation compounded by multiple factors that limit their access to timely health information and services. Despite these vulnerabilities, young FTPs have historically been overlooked by adolescent and youth family planning and reproductive health programs. E2A has prioritized closing this global gap by reaching FTPs in multiple contexts—including the Eastern Region of Burkina Faso—with health and gender interventions and by gathering new evidence on effective programming for this subset of youth.

E2A and Pathfinder International Burkina Faso 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. According to the 2010 Burkina Faso Demographic and Health Survey (DHS), the median age of marriage 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 18.4.¹ In addition to highlighting early marriage and childbearing, these statistics show that sexual debut generally occurs within the context of marriage and that the interval between marriage and first birth is relatively short. Childbearing in the Eastern Region starts earlier than the country as a whole, which has a national median age at first birth of 19.5.² 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%, compared to the national mCPR of 15.3%. Unmet need for family planning in the Eastern Region is also 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 While the 2014 Burkina Faso Multisectorielle Continue (EMC) shows some improvements in early marriage and childbearing, as well as mCPR uptake and unmet need,

1 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.

2 Ibid.

3 Ibid.

4 Ibid.

5 Ibid.

these broader health concerns persist, and the Eastern Region continues to lag behind the country as a whole.⁶

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. In the Eastern Region and in Burkina Faso generally, childbearing typically occurs within the context of marriage. 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.⁷ Furthermore, even if they have access to reproductive health services, young women and girls often must get permission from their husbands and other household influencers to visit the health center or obtain services.⁸ Unequal power and gender dynamics, along with other factors such as socio-cultural preferences around fertility and health provider bias, can fuel early, rapid, and repeat pregnancies, compromising the health of young women and their newborns. These early or closely spaced pregnancies pose significant risks for young FTMs. Pregnant adolescents are at increased risk for multiple adverse health consequences for both the mother and child. Young women who become pregnant during their teenage years are at an increased risk of developing eclampsia, puerperal endometritis, systemic infections, and maternal death; and children born from adolescent mothers have increased risks of low birth weight and premature birth, which contribute to early neonatal death.^{9,10,11} 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.

⁶ INSD, Rapport du Module Démographie et Santé (MDS) de l'Enquête Multisectorielle Continue (EMC), 2015

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 Ibid.

⁹ Ganchimeg, T., E. Ota, N. Morisaki, M. Laopaiboon, P. Lumbiganon, J. Zhang, B. Yamdamsuren, M. Temmerman, L. Say, and Ö. Tunçalp. 2014. "Pregnancy and Childbirth Outcomes among Adolescent Mothers: A World Health Organization Multicountry Study." *BJOG: An International Journal of Obstetrics & Gynaecology* 121(s1):40-48.

¹⁰ Chen, X.K., S.W. Wen, N. Fleming, K. Demissie, G.G. Rhoads, and M. Walker. 2007. "Teenage Pregnancy and Adverse Birth Outcomes: A Large Population Based Retrospective Cohort Study." *International Journal of Epidemiology* 36(2):368-373.

¹¹ Conde-Agudelo, A., J.M. Belizán, and C. Lammers. 2005. "Maternal-perinatal Morbidity and Mortality Associated with Adolescent Pregnancy in Latin America: Cross-sectional Study." *American Journal of Obstetrics and Gynecology* 192(2):342-349.

ABOUT E2A

The Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls Project (E2A) is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project addresses the reproductive health care needs of girls, women, and underserved communities around the world by increasing support, building evidence, and facilitating the scale-up of best practices that improve family planning services. Awarded in September 2011, this project ends in September 2020. E2A is led by Pathfinder International, in partnership with ExpandNet, IntraHealth International, and PATH.

Overview of E2A's Work with First-Time Parents

First-time parents—defined by E2A as young women under age 25 who are pregnant with or have one child, and their partners—have largely been overlooked in reproductive health (RH) programs for youth. Over the past five years, E2A has undertaken several conceptual and programming efforts that detail the FTP experience and explore how best to respond to their complex needs. Milestones of E2A's FTP work to date include:

A LITERATURE REVIEW: Reaching Young FTPs for the Healthy Spacing of Second and Subsequent Pregnancies (2014), which highlights the lack of programming for this vulnerable population

A TECHNICAL CONSULTATION with 30 health/gender experts to outline components, strategies, and considerations for an integrated package of interventions (2014)

THE DEVELOPMENT OF A CONCEPTUAL FRAMEWORK, which applies a life-course and socio-ecological lens to explore the FTP experience (2017)

THE DEVELOPMENT OF A CONCEPTUAL FRAMEWORK, which applies a lifestage and socio-ecological lens to explore the FTP experience (2017)

NEW PROGRAMS IN BURKINA FASO, NIGERIA & TANZANIA that expand FTP programming with FTMs, male partners, and other influencers to gather evidence on health and gender outcomes (2017–2020)

PROGRAM DESCRIPTION: BURKINA FASO FTP PROJECT

In April 2018, E2A and Pathfinder International Burkina Faso launched the “Supporting Reproductive Health Services for Young First-Time Parents (FTP) in Burkina Faso” project, in collaboration with the MOH. The overall objective of the project was to increase FP uptake and the use of RMNCH care—especially ANC and obstetric and neonatal services—among FTPs.

The project worked at both the facility and community level in two districts, covering a total of 20 health facilities and 57 surrounding villages (12 villages and 4 facilities in Diapaga and 45 villages and 16 facilities in Fada). 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 October 2018 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 post-partum—and address their various needs throughout this period. Interventions focused on increasing utilization of ANC and obstetric and neonatal services, advancing FP, and related gender outcomes. Along with the life-course approach, E2A applied a socio-ecological lens¹² 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.






THREE KEY OBJECTIVES GUIDING THE TECHNICAL STRATEGY

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

¹² To read more about the life-course approach and socio-ecological lens E2A applies to FTP programs, please consult the FTP Framework: e2aproject.org/wp-content/uploads/E2A-FTP-Framework.pdf

To meet these objectives, the Pathfinder team implemented a package of interventions to improve FP- and RMNCH-related knowledge, attitudes, communication, decision making, and use by young FTMs/FTPs. The table below summarizes the interventions included in the FTP project, followed by additional information on participant recruitment, key activities, capacity-building, and data generation.

TABLE 1: BURKINA FASO FTP INTERVENTIONS

	DESCRIPTION
<p>FTM PEER GROUPS</p> 	<p>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.</p>
<p>OUTREACH WITH KEY INFLUENCERS AND COMMUNITIES</p> 	<p>Monthly meetings with FTM peer group members’ male partners, facilitated by CHWs with support from Pathfinder staff. These outreaches used the Pathways to Change game to identify barriers and facilitators. Topics included: men’s and women’s roles, reproductive choices, and ANC.</p> <p>Monthly meetings with FTM per group members’ mothers-in-law, facilitated by CHWs with support from Pathfinder staff, covered the following topics: ANC, safe delivery, and FP.</p>
<p>HOUSEHOLD VISITS</p> 	<p>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.</p>
<p>RADIO BROADCASTING</p> 	<p>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.</p>
<p>SUPPORT FOR HEALTH FACILITIES</p> 	<p>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.</p>

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. This activity was conducted by Pathfinder staff in September 2018, in close coordination with locally based community health workers (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 first 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.

In total, the social mapping activity identified and enrolled 843 FTMs from 57 villages in the project. To tailor home visits to individual needs and monitor lifestage-specific interventions more effectively, participants were classified into one of three segments based on their status at the time of the mapping exercise: Segment 1: 0–3 months pregnant; Segment 2: 4–9 months pregnant; and Segment 3: has one child under 24 months of age. Each segment had a corresponding package of services to be provided at the health facility and during home visits, as follows:

- **Segment 1:** ANC, counseling on FP, counseling on institutional delivery, and counseling on exclusive breastfeeding
- **Segment 2:** ANC, counseling on FP and HTSP, institutional delivery, counseling on exclusive breastfeeding
- **Segment 3:** Newborn care, immunization, exclusive breastfeeding, FP/HTSP, and nutrition orientation (after six months)

CHW Capacity Building

During start-up, project staff identified 113 CHWs (35 women and 78 men) to support FTP activities in the catchment areas of 20 project-supported health facilities. The nurse in-charge at the health facilities identified the CHWs, who were already working under the MOH, for participation in the project. In August 2018, these CHWs were trained on communication and counseling approaches and how best to reach FTMs and their key influencers. The training used the MOH's official CHW training curriculum, with the addition of FTP-specific materials related to project activities. While CHWs were directly supervised by their facility-based supervisors, Pathfinder staff provided them with monthly coaching and quarterly

joint supportive supervision in collaboration with the nurse in-charges at the facilities. The project provided CHWs with bicycles and animation kits, while the MOH continued to pay their monthly stipends.

CHWs were key implementers of the community-based FTP activities and were responsible for a variety of tasks, including:

- Conducting home visits with FTMs and members of their household
- Participating in the FTM peer group sessions to support the peer leaders, provide health information, and assist with attendance tracking
- Facilitating discussion sessions with husbands and mothers-in-law
- Supporting Pathfinder supervisors during monthly data collection activities

FTM Peer Groups

As with other E2A FTP programs in Nigeria and Tanzania, FTM peer groups were a central activity for the Burkina Faso FTP project. The peer group intervention was implemented in the 57 project-supported villages (12 in Diapaga, 45 in Fada), and 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 (PLs) 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, some of which were adapted from the GREAT project and others which were developed by E2A,¹³ to facilitate the peer group sessions. After the training, peer leaders worked with the CHWs to mobilize the FTMs—who were enrolled in the project through the social mapping exercise—to begin the 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.

13 The Gender Roles, Equality and Transformations (GREAT) project was led by the Institute for Reproductive Health of Georgetown University and implemented by Pathfinder International and Save the Children in Northern Uganda.

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, including antenatal care, pregnancy danger signs, HTSP/post-partum family planning, men’s and women’s roles, and reproductive choice.

Pathfinder staff also conducted monthly meetings with the CHWs and peer leaders to discuss themes, obstacles, and successes experienced during the peer group sessions. In total, 794 FTMs (94% of the 843 FTMs identified through social mapping) participated in at least one peer group session.

TOPICS ADDRESSED IN FTM PEER GROUPS

1. Antenatal care visits and danger signs during pregnancy
2. Healthy timing and spacing of pregnancy
3. Men’s and women’s roles
4. Reproductive health choice
5. Exclusive breastfeeding
6. Contraceptive methods
 - a. Injectable contraceptives
 - b. Combined oral contraceptives
 - c. Intrauterine devices
 - d. Condoms
 - e. Implants
 - f. Lactational Amenorrhea Method

Men’s Groups Discussions

Discussion sessions with the husbands of FTMs were held once per month, for a total of five sessions (January–May 2019). The men were initially invited by the participating FTMs, and all who were interested were able to participate in discussion groups—with an average of 8 men per group. The purpose of these meetings was to raise awareness about young women’s access to critical health services during the FTP lifestage. CHWs, with support from Pathfinder staff, conducted group discussions using MOH counseling tools and Pathfinder’s Pathways to Change game.¹⁴ The game was used to identify barriers and facilitators to adopting key health- and gender-related behaviors that were then discussed as a group. The sessions focused on three key topics: men’s and women’s roles, reproductive choices, and ANC.

Mothers-in-Law Group Discussions

Discussion sessions with the mothers-in-law of FTMs (and other older women who were key influencers of FTM peer group members) were held once per month, for a total of five sessions (January–May 2019). The first invitation to the mothers-in-law was sent through the participating FTMs, and the sessions had on average nine mothers-in-law per group. For these sessions, CHWs—with support from Pathfinder supervisors—used MOH tools to lead discussions on thematic topics around ANC, safe delivery, and

¹⁴ The *Pathways to Change* game is a behavior change tool in the form of a simple game that is designed to identify barriers and facilitators to change and generate discussion and stimulate thinking that can motivate individuals and communities to change.

postpartum family planning with the objective of encouraging mothers-in-law to support young women's access to services.

Household Visits

In their MOH role, CHWs typically conduct home visits with women during pregnancy and the immediate post-partum period. The home visits during pregnancy focused on: encouraging early initiation of ANC and attendance of at least four ANC visits; helping the family prepare for delivery at a health facility; ensuring the pregnant woman is sleeping under a treated mosquito net; and encouraging continued use of prescribed treatments (iron, antiretrovirals, etc.). Home visits during the postpartum period included: assessing the newborn and mother for danger signs; encouraging exclusive breastfeeding and good infant care practices; reminding the mother to go for her postnatal care visit; monitoring the weight and health of the infant; and counseling on FP. During these home visits, they typically provide, among other services, referrals to the health facility for ANC, risk 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 FTM 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 the 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.

Radio Broadcasting

The project—in collaboration with two local radio stations (RTB2 Fada and Radio TIN TUA)—developed and broadcasted messages related to maternal and neonatal health that were aired in three of the project-supported communes: Gourma, Kantchari, and Diabo. Twelve different programs in four languages (French, Gulmancema, Mooré, and Fulfulde) were produced and covered the following topics:

- The importance of ANC and danger signs during pregnancy
- The importance of family planning and birth spacing
- The role of men and women in reproductive health decision making

Support to Health Facilities

In addition to the community component, the FTP project aimed to strengthen the capacity of 20 public sector health facilities (16 in Fada and 4 in Diapaga) to provide comprehensive and youth-friendly antenatal, obstetric, and neonatal services and postpartum family planning services. Of these 20 health facilities, 16 are primary health facilities, three are district hospitals, and one is a regional hospital. A rapid

health facility assessment was conducted from July to August 2018 to determine staffing and FP/RMNCH capacity at implementing health facilities, as well as the availability of required commodities and equipment. Using the results, the project—in collaboration with the MOH—supported the facilities by: (1) training providers on obstetric and neonatal care and the full range of modern contraceptive methods, including long-acting reversible contraception, (2) mentoring trained providers using two mentor-trainers who have been hired as permanent staff, and (3) conducting joint supportive supervision of providers at project-supported facilities in collaboration with the district head nurses.

METHODS

Multiple forms of programmatic data collection and analyses took place over the course of the Burkina Faso FTP project. Two key data sources inform the main health-related findings and implementation learnings presented in this report:

Qualitative Data Collection

E2A and Pathfinder International Burkina Faso 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.

The protocol for this evaluation and other requirements were submitted and presented to the Institutional Ethics Committee of the Centre-Muraz of Bobo-Dioulasso, which approved the study on June 25, 2019. E2A also submitted an application to PATH's research determination committee in the United States, which determined this to be "not research" and therefore not necessitating any additional review (December 2018).

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 were conducted in the study zone. The following tables present the in-depth interviews and focus group discussions conducted:

TABLE 2: NUMBER OF FOCUS GROUP DISCUSSIONS CONDUCTED IN PROJECT VILLAGES

VILLAGE	FOCUS GROUPS			TOTAL
	CHW	Peer Leader	FTP (Seg.1, 2, 3)	
Diabo	1	1	1	3
Tibga	1	1	1	3
Moadá			1	1
Diapangou	1	1	1	3
Tilonti	1	1	1	3
Yamba	1	1	1	3
Nayouri	1	1	1	3
Planned	6	6	6	18
Completed	6	6	7	19

TABLE 3: NUMBER OF IN-DEPTH INTERVIEWS CONDUCTED IN PROJECT VILLAGES

VILLAGES	IN-DEPTH INTERVIEWS						TOTAL
	Husbands	Mothers-in-law	Seg. 3 <i>Accepted FP</i>	Seg. 3 <i>Did Not Adopt FP</i>	Seg. 1 & 2	Pathfinder Staff	
Diabo	1	1		2	1		5
Tibga	2	2		2	3		9
Moadá	2	2		2	1		7
Diapangou	1	1	6				8
Tilonti	1	2	1		2		6
Yamba	2	3			1		6
Nayouri	1	1			2		4
Planned	10	10	6	6	8	3	43
Completed	10	12	7	6	10	3	48

Monthly Monitoring Forms

Two key project monitoring forms informed the results of this report:

- **Registre de Coche**—The Burkina Faso MOH typically issues a health card to all pregnant women which tracks key information, including ANC visits, location of delivery, home visits received (for essential newborn care or for other reasons), FP counseling received, FP accepted, FP method chosen, and CHW referrals received and completed. Facility staff issue and complete these cards as the FTM obtains services, and the FTM retains the card at her home. From October to May, Pathfinder supervisors visited each enrolled FTM, reviewed her MOH health card, and recorded her service utilization information for that month in a project-specific tracking form known as *Registre de Coche*.
- **Peer group attendance forms**—Peer leaders completed this form with the assistance of CHWs at each of the peer group discussion sessions. The form includes a list of names of all FTMs who attended the session, as well as their age and segment.

The completed paper forms were stored at the Fada office. At the end of the project, service utilization and program participation information from these forms was compiled into a database created from the social mapping list. Data were stripped of all identifying information, then cleaned and analyzed. E2A submitted an application for research determination for the secondary analysis of this project monitoring data to PATH’s research determination committee in the United States, which determined the activity to be “not research” and therefore not necessitating any additional review (January 2020).

RESULTS

For E2A, the Burkina Faso FTP project was the first opportunity to work with young FTMs and their key influencers across the lifestage—from those just starting their first pregnancy, through to those who were two years post-partum. As such, the project prioritized gathering new information about FTP health experiences with ANC, HTSP/FP, and exclusive breastfeeding. In addition to monitoring data, the focus group discussions and interviews with program participants and implementers yielded important insights into if and how FTPs were able to take health action. The results presented below highlight key areas where FTMs and their influencers reported progress in addressing their pre- and post-partum health needs, but also point to some of the persistent barriers that hinder action.

SUMMARY OF BURKINA FASO FTP HEALTH-RELATED RESULTS

- 1.** The program attracted and retained FTMs at different stages of their FTP experience and across key demographic characteristics.
- 2.** FTMs reported increased awareness about ANC, including the importance of seeking services early in pregnancy.
- 3.** HTSP/FP knowledge and attitudes improved for young FTMs and their husbands.
- 4.** While FTMs and husbands often have similar views on ideal family size, some FTMs continue to face opposition regarding their stated desired number of children, especially from their mothers-in-law.
- 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.
- 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.
- 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.

RESULT 1: The program attracted and retained FTMs at different stages of their FTP experience and across key demographic characteristics.

Monitoring data show that the program attracted FTMs of different ages, education levels, and stages of their FTP experience. Out of the 843 FTMs originally identified through the social mapping exercise, 794 (94%) attended at least one peer group session. Importantly, almost two-thirds of the FTMs (529, 63%) attended at least five out of the ten peer group sessions and had at least one home visit. 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 4 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.¹⁵ This suggests that such characteristics in of themselves did not pose a real barrier to program participation.

TABLE 4: SUMMARY OF KEY CHARACTERISTICS FOR ENROLLED FIRST-TIME MOTHERS AND PROGRAM PARTICIPANTS

		FTMS ENROLLED THROUGH SOCIAL MAPPING (n=843)		FTMS THAT ATTENDED AT LEAST 5 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. This was also consistent with the overall profile of FTMs in the community, again suggesting that young women were able to participate regardless of where they were in their FTP experience.

¹⁵ As almost all FTMs were married, the program did not expect to see any variation in marital status for those participating in the program.

The broad representation of participants also indicates that this type of programming was of interest to both pregnant and post-partum FTMs. Several FTMs spoke of their interest in the program and topics, indicating that peer groups were truly safe spaces for learning and sharing about health issues:

“Between us, there is no shame [laughs]. If you don’t understand, you ask the question. Here, if I don’t understand, whoever understands more can explain it to you . . . and then ask if you have understood carefully.”

—FTM, 21 years old

“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 . . . this is what I really liked in the group.”

—FTM, 18 years old

Monitoring records also tracked attendance at monthly sessions by the key influencers of FTMs—their husbands and their mothers-in-law. In general, 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.

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. In project communities, cultural norms limit FTM interaction outside the household until certain rites are conducted and/or the pregnancy is visible. Given this, many FTMs were unable to travel to facilities for ANC within the first few months of pregnancy, as noted by this participant:

“It is because I did not know that I waited four months. . . I didn’t know that even if it [the pregnancy] doesn’t hurt, you have to go see how it goes. . . It was when my stomach was visible that I had the idea of going to the health center.”

—FTM, 20 years old

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:

“You carry it, but you don't know anything. You don't know if the child is in the womb, if it lives or if it is dead, you don't know. So, it's important that you go to the health center so that the health workers can see the position of the child, because they are the ones who know how to make sure it's good.”

—FTM, 20 years old

“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

CHWs highlighted their own efforts to encourage program participants to utilize ANC services throughout their pregnancies:

“They [FTMs] are reminded that the government has introduced free ANC. We also follow these women through their health records. During our visits, we check that, if we notice that a woman is late, we tell her to do everything possible to keep her next appointment. The mothers-in-law are happy about this because they say that often when they tell their daughters-in-law to go to ANC, they refuse. So, what we're doing is a saving grace.”

—CHW, no age given

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.

“If you adopt family planning, you, the mother, will be healthy and your child will be healthy too. You will be in peace and not in trouble. When I was not yet in the project, I didn't know all this.”

—FTM, 21 years old

“Now people have started to understand. Before, it was not everyone who agreed to talk about it. But nowadays, people understand that it [FP] is not bad in itself. This is really help you take care of your family, to space pregnancies up to the number you want.”

—Husband of FTM, 29 years old

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.

“No [I did not use FP before]. The reason is that I heard some say that if you use [FP], your body will hurt you, your stomach too, and that some are in conflict against their husband because of it. That’s why I didn’t use it. Now [I know] if you [use FP], your child will grow up, be in good health, and you will also be able to do your work as you want. That’s why I went to get family planning.”

—FTM, 18 years old

“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

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.

“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.

“I’ve got a kid. I don’t know how many I’ll have, but four or five children are enough for me. That’s so I can take good care of them. But if it’s more than that—and your husband is poor and you’re poor too—it’s difficult.”

—FTM, 19 years old

“There are too many problems these days. Even feeding oneself has become complicated. If you have a big family and you don’t have enough to feed them, it causes problems. If you yourself can’t feed yourself properly, your children will be in the same situation. If you only manage and you have 10 or 20 children, it is difficult to feed them. It leads to too many problems with their education. Others will be forced to steal and try adventures that will harm them. It is a big problem. But if you only have five or six children, you also know how to take care of them—how to make sure that between the oldest and the youngest there is enough time for them flourish.”

—Husband of FTM, 29 years old

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.

“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

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.

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.

The issue of couple communication about FP emerged during the qualitative endline, and 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.

“For family planning, you as a woman cannot decide on your own that you want to go and adopt a contraceptive method by hiding it from the man. You can tell him and if he is not going to go with you, he can give you his opinion so that you can go to the hospital. You can hide to go and use a method, and it will lead to your repudiation. But if he is giving you his opinion, and you decide to use FP, you don't have to be afraid anymore because it's a choice between you and your husband.”

—FTM peer leader, 19 years old

At the same time, both FTMs and their spouses also noted that previously it was not easy or common for them to talk about FP. They remarked that project activities helped to open the door to communication about FP. Respondents indicated 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

“After she was trained [peer group discussions], she told me that she wanted to do family planning and I agreed. She told me that if she doesn't have the implant, there is a good chance that we will have children close together; it will be difficult for her to take good care of the children. I told her it was a good idea and that she had my permission.”

—Husband of FTM, 29 years old

The following quote provides a good example of how a couple has been able to communicate and share new knowledge to take action:

“Before, I told her to go get a family planning method, and she said ‘no’ – that if you use an FP method you may not be able to give birth afterwards. I said it is not true. . . but she refused. But when the project came and she participated, she accepted. We went [to the facility] and I asked her to choose the method she wants. We asked the nurse to try the implant. If it does not suit, we will change to another method.”

—Husband of FTM, 37 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.

Despite the improved knowledge of and attitudes toward FP by both FTMs and their husbands, significant barriers persist. This includes 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, including conflicting beliefs about ideal family size, as noted above. 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.

In a context where negative views about FP prevail, men may also fear social condemnation for using FP, as this husband remarks:

“If you tell the other men that your wife is on FP, they will treat you as less than nothing—that a man should not allow his wife to use contraceptives. There are people who always say these things.”

—Husband of FTM, 37 years old

Importantly, this same husband made the decision to use FP with his wife and openly discusses their choice with others, suggesting that men/couples are willing to challenge social norms. He explains:

“Each does not live for the other. Everyone sees what he will do to make his life better. If someone asks you for advice, you tell them what you have done to avoid these problems.”

—Husband of FTM, 37 years old

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.

“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

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. This appears to be particularly true when the child is ill, as herbal remedies are often used.

“It wasn't easy, a few days before the child was six months old, the child got sick and I gave him medicine with water and since then I have continued. Also, when the child had stomach aches, I gave him hot water. If she cries, either she has stomachaches, or she is sick.”

—FTM, 24 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

FTP IMPLEMENTATION LEARNINGS

The Burkina Faso project yielded several critical lessons on how to work with FTMs/FTPs and their influencers at different points of their FTP journey to address a range of health outcomes.

The results presented earlier suggest that this type of programming can advance health knowledge, attitudes, communication, and action by FTMs and their husbands. Skillful implementation is needed to ensure that these interventions—with FTMs, their husbands, their mothers-in-law, and other members of their households (such as co-wives)—mutually reinforce positive health behaviors and overcome some of the challenges that FTMs/FTPs face. The project team conducted a review of this project and identified several implementation learnings to inform the next phase of FTP programming in Burkina Faso.

SUMMARY OF LEARNINGS ABOUT BURKINA FASO FTP PROJECT

1. Use of social mapping to identify and recruit participants is a strategic way to reach FTMs/FTPs across the lifestage.
2. Peer group activities were well-received by FTMs, but questions about group configuration and lifestage segmentation emerged.
3. Unlike the FTMs, their husbands were more challenging to engage consistently throughout the program, often due to competing work demands.
4. Mothers-in-law of FTMs were generally engaged in project activities and supportive of their sons and daughters-in-law gaining new information and skills—making them potential allies in advancing FTP health outcomes.
5. CHWs are key implementers for FTP interventions, but their responsibilities must be balanced with other demands on their time and capacities.
6. Given the complex, time-specific health issues that arise during the FTP lifestage, it is challenging to track results at individual and aggregate levels.

LEARNING 1: Use of social mapping to identify and recruit participants is a strategic way to reach FTMs/FTPs across the lifestage.

In many contexts, FTMs can be difficult to identify; they are often isolated within their households and communities, with limited agency to engage with others. In Burkina Faso, there are also cultural norms that restrict knowledge about pregnancies outside the family—especially during a woman’s first pregnancy—which adds to the challenge of finding these young women. The project’s approach of engaging respected,

locally based CHWs to “map” all FTMs in their communities proved to be a strategic and culturally appropriate method of identifying FTMs and inviting their households to participate in the program.

The CHWs were already working in these communities, and their knowledge of specific households and social customs were fundamental to the success of the social mapping approach. 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. Not only was this appropriate, given local customs, but it also helped build household support and participation from the outset of the project.

“If people see that we are writing without having informed them, they will say that we have chosen the ones that we want. That is why we gathered the whole community to pass on the message to them first and then we went into the households and asked for their consent as well. [For] the one who does not consent, we do not write her name”

—Community health worker, 38 years old

The cultural importance of going through the family was noted by the CHWs, although this required additional time and effort:

“There has been a lot of difficulties, because if you want to select someone, you have to go to the person’s family. You have to see their husband first. If you don’t see her husband, you have to see her mother-in-law or father-in-law. Because nowadays, you can’t register someone . . . without [the family] knowing why you came to select her. So, you have to inform the family.”

—Community health worker, 35 years old

It is important to note that by approaching the household as a whole, there may be some obstacles to FTM participation. However, the general participation levels of diverse FTMs in the FTP project (as presented above) suggest that this was not a widespread experience. During focus group discussions, several FTMs reported that the social mapping approach for recruiting participants worked well and was clear and transparent.

“We heard about the project in our village through our [CHW] officials. They informed us that there is a project which wants to select women who are in their first pregnancies or who have given birth for the first time and who do not exceed 25 years. When a project comes to work with women, they contact the CHWs so that they inform women. They [CHWs] said that they will be selected to teach them how to manage their families and their children. So, it was during this period that they came to select the women.”

—FTM, 22 years old

LEARNING 2: Peer group activities were well-received by FTMs, but questions about group configuration and lifestage segmentation emerged.

As noted earlier, the peer group intervention generally had strong participation by diverse FTMs. By design, the FTM peer groups brought together young women who were at different points of the FTP lifestage, including those who were pregnant with their first child (Segments 1 and 2) and those who had already delivered (Segment 3). From a program standpoint, this worked well, as the number of pregnant FTMs in project communities was relatively low. Peer group topics were all relevant to the FTP lifestage (even if individual FTMs had not yet reached that point, i.e., given birth to their first child), and more tailored services were provided through other interventions—namely home visits and facility services.

Feedback from FTMs was also largely supportive of this approach, as they appreciated being able to share experiences from across the FTP lifestage.

“I want us [pregnant and post-partum FTMs] to stay together, because if we are separated, we could not learn from the other group. So the fact that we were brought together was beneficial for all of us, because we [as pregnant women] learned from what we said and also from women who have already given birth. I have acquired knowledge.”

—FTM, 23 years old

“We were happy, because there was no disagreement between us. We got along well. When we were called for the meeting, we swarmed to participate.”

—FTM, 22 years old

Interestingly, a few FTMs mentioned that it was sometimes challenging to participate in discussions about issues and events they had not yet experienced – for example, talking about using FP, while they themselves were still pregnant. While these voices were in the minority, they do suggest an important alternate way of organizing peer groups for women at a similar point in their FTP journey.

“What they were talking about, I had not yet reached that level. For example, they were already talking about how to take care of a baby, a child, so I saw that it didn't concern me first, because I had not yet given birth. Even how to do contraception, I saw that I had not yet reached that.”

—FTM, 23 years old

One other question that arose during implementation was the value of creating a distinction between Segment 1 (first trimester pregnancy) and Segment 2 (second and third trimester pregnancy) FTMs. The original thinking was to catch FTMs who were in their first trimester in time to complete early ANC, as this was one of the priority areas of the project. Although the social mapping approach successfully identified Segment 1 FTMs, it proved more difficult to execute program interventions within the narrow window of opportunity (typically less than three months before she transitioned into Segment 2). The

logistics of reaching FTMs, promoting ANC, and receiving (and tracking) service utilization were challenging—especially given social norms that restricted disclosure of pregnancy status. Despite considerable efforts by the team, this level of segmentation was too nuanced for the program, given the local context.

LEARNING 3: Unlike the FTMs, their husbands were more challenging to engage consistently throughout in the program, often due to competing work demands.

The project made a deliberate effort to engage husbands and mothers-in-law through group sessions and home visits, given their critical decision-making role on issues related to the health of young mothers and their children. Despite early recruitment and ongoing efforts by CHWs to encourage participation, many husbands did not consistently attend the monthly sessions, and some did not join at all. FTPs reported that competing work demands, including migration/travel for employment, limited participation.

“No, no, my husband didn't even come [to the activity] once. I can inform him that tomorrow the men's meeting will take place, but the next day, he does not come. He goes to the pasture. He is a shepherd.”

—FTM, 19 years old

“I'm a mason and I work at Fada. When they call us for the meeting, usually I'm not there. Often I am in Fada and cannot come. If it happens that I am present [at home], I come.”

—Husband of FTM, 36 years old

For others, gender and social norms (e.g., perception that this kind of activity does not “concern men”) may also have been factors.

“My husband cannot come. When I'm told to inform him, I do, but he doesn't come. He tells me that we have selected women, and therefore, it does not concern men. He sees the other husbands coming, but he refused.”

—FTM, 21 years old

Husbands were also hard to reach during CHW home visits, as they were often away from home. Men reported that they received updates afterward and were generally positive about these visits and their wives' participation.

Given the experience from this first FTP effort, more needs to be done to engage men effectively and strategically, especially since many may be away from home for periods of time. Focusing on key issues that are appealing for men, and restructuring sessions to better accommodate their schedules, may help improve their participation levels.

In general, the men who did participate in activities were positive about the content and issues raised, which gives an important foundation on which to build with future programming.

LEARNING 4: Mothers-in-law of FTMs were generally engaged in project activities and supportive of their sons and daughters-in-law gaining new information and skills—making them potential allies in advancing health FTP outcomes.

While there was still room for improvement with mothers-in-law's participation in group sessions and home visits, they were more relatively engaged—they had stronger attendance rates than the husbands, and their engagement was consistent throughout the project. Many who participated were particularly interested in issues that improved child health, including birth spacing, as it was seen to be critical for the wellbeing of the whole family:

“It is the topic of childcare that I liked the most, because if you take care of your child and he is in good health, you will be happy. You, the mother-in-law, will be happy, the mother will be happy, as well as all the members of the family. If the child has no worries, it is a joy for everyone. I also like the spacing of births [topic], because when you give birth within two years, it is a difficulty. If the first child reaches three or four years of age and then you get pregnant again, you will see that it is good for you. Even the grandmother—if you take care of the first child—you will see that it is good.”

—Mother-in-law of FTM, 47 years old

Views about contraceptive use were more mixed, with some older women voicing concerns about possible issues with future fertility, especially if menstruation was disrupted while on a method. Interestingly, several mothers-in-law who were supportive of FP use did not feel that it was their role to suggest this to their children:

“I’m not going to tell her to use a method to space births. Will that be possible? These are young people—we are ‘old’! Can I tell your wife to use birth spacing methods while you, the husband, are not aware? I couldn’t do it. They are the only ones who can do it. Me, the mother-in-law, cannot tell her to use methods.”

—Mother-in-law of FTM, 57 years old

Given their support for many of the health issues being addressed through the project, these older women were generally in favor of their sons and daughters-in-law participating in activities and being exposed to new ideas and skills:

“We were very happy with the advent of these new things. We have not known these things. Life is how old things pass and give way to new things. Even if we didn’t have that, we have to allow our daughters to take advantage of it—to follow, because we don’t know what will happen in the coming days. Even if she earns nothing materially, it is advice that is valid for life.”

—Mother-in-law of FTM, 55 years old

Participation levels and feedback from the mothers-in-law suggest that they are and could be cultivated further as allies for FTPs, especially in tackling some of deep-seated social norms that may be hindering health action, such as FP use or early ANC.

LEARNING 5: CHWs are key implementers for FTP interventions, but their responsibilities must be balanced with other demands on their time and capacities.

Throughout the FTP project, CHWs were the constant, on-the-ground resource person for all participants. They led or played a key role in multiple activities, from the social mapping exercise to supporting peer groups. This particularly included home visits, where the project has extended the number of visits conducted in the post-partum period. At the same time, CHWs were also responsible for conducting their routine MOH work, along with other health projects collaborating with the MOH in these communities (e.g., on malaria, on hygiene, etc.). Although the FTP project team worked closely with the MOH to coordinate plans, the FTP activities did raise some workload concerns for CHWs. CHWs were sometimes unable to complete planned activities, which was discouraging for the FTPs involved. For the project team, this provided an important learning and provided an opportunity to revisit how FTP interventions are structured and paced to ensure CHWs are not overburdened.

LEARNING 6: Given the complex, time-specific health issues that arise during the FTP lifestage, it is challenging to track results at individual and aggregate levels.

As noted earlier, this project provided E2A’s first opportunity to address health issues across the FTP lifestage—from the first ANC visit, through delivery at a facility, to the uptake of family planning. As such, the project made deliberate efforts to track key health indicators for the 843 individual FTMs identified during social mapping, using MOH health cards as the primary source of information.

Despite these efforts, the project had difficulty tracking this information. The high number of FTMs involved—each at a different point (or segment) in the FTP lifestage—made systematic tracking, especially with limited resources, a challenge. Many health issues are also time-specific (e.g., timing of the four ANC visits) and need to be tracked in real time to be accurate and to ensure that any gaps (e.g., delay in seeking ANC) are addressed quickly. In the absence of a health information system that effectively enables

monitoring and follow-up of individual clients at the community level, alternative approaches are needed to capture health results as FTMs move through the lifestage. This includes results that are not recorded by a facility provider, such as exclusive breastfeeding. For the project team, the data tracking challenges stimulated new thinking about how best to capture meaningful data on health outcomes for FTPs. One possibility is to use a baseline/endline approach that would clearly define and capture the specific health indicators for each FTM, based on where she is in the FTP lifestage.

EMERGING RECOMMENDATIONS

The Burkina Faso FTP project generated a wealth of new experience and evidence on both the “how to” of programming for young FTMs and their key influencers, and the potential health impact that can be achieved through such efforts. Looking across the implementation results and learnings from this project, several broader conclusions and recommendations emerge to inform and advance future programs for this important youth population in Burkina Faso and across the globe.

RECOMMENDATION 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 lifstage.

The Burkina Faso FTP project experience demonstrated that community-based interventions that use a lifstage and socio-ecological approach 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 (husbands and mothers-in-law), build their understanding of the different health issues that arise over the FTP lifstage, encourage appropriate health behaviors and health-seeking, and address some of the barriers that may hinder health action. In general, the participation levels and feedback indicate that FTP activities were well-received and that some positive shifts in knowledge, attitudes, and behaviors were happening as a result. While challenges continue—especially related to key issues like early ANC and FP uptake, which are tied to deeply held beliefs—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.

RECOMMENDATION 2: Consider if and how diversity within FTPs—by demographic or lifstage characteristics—should be incorporated into the program response.

E2A programs in different contexts have highlighted the diversity of FTPs—by age, by partnership/marital status, by education, etc. For the most part, demographic variations have not necessitated any special programmatic considerations; diverse FTPs have generally participated in and benefited from being part of the same intervention package. However, the Burkina Faso FTP experience provided some important insights into the programmatic implications of segmenting FTPs by their particular point in the lifstage, especially whether pregnant or post-partum. 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. Furthermore, 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 FTM 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.

RECOMMENDATION 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. This experience of this project highlighted three health areas where influencers are particularly important: (1) seeking ANC early in a pregnancy; (2) practicing exclusive breastfeeding; and (3) using modern contraceptive methods to achieve HTSP. All involve cultural and/or gender norms—from customs around sharing news about pregnancies, to traditional feeding practices, to norms around family size and control—and require influencer support for positive health actions to take place. Repackaging influencer engagement to focus on these topics and related social/gender norms may streamline project demands on their time and may also be more appealing/relevant. This could include couples sessions that allow for joint exploration of these health issues.

RECOMMENDATION 4: Structure and pace interventions to ensure local capacity to implement them.

In general, the FTP project reinforced the need for multiple interventions that work together to advance health outcomes for FTPs and their children. At the same time, carrying out complex activities with participants who are at different points in the FTP lifestage is challenging for the implementation team. While some activities can be planned in advance and at a fixed time (e.g., peer group sessions), others need to be tailored to the specific needs and availability of the FTPs (e.g., home visits planned at specific times during pregnancy and post-partum period). Streamlining (as per Recommendations 2 and 3) and mapping out activities will ideally help manage workloads and troubleshoot potential challenges. Using an approach like the social mapping that this project conducted also helps to identify and anticipate the needs of program participants, again facilitating planning by local implementers.

RECOMMENDATION 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. Some outcomes have a wider window (e.g., FP use any time post-partum), while others only have a narrow timeframe for action (e.g., ANC within first trimester). Tracking this, especially when working with hundreds of FTPs all 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. This project showed that paper-based systems built on the MOH MIS may not be sufficient to track and assess health outcomes of interest for FTPs in a timely manner. With literacy limitations among CHWs and FTPs themselves, there are also constraints for self-tracking. Creative monitoring approaches are needed, or alternatively, baseline/endlines that can capture results tailored to each FTP.



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