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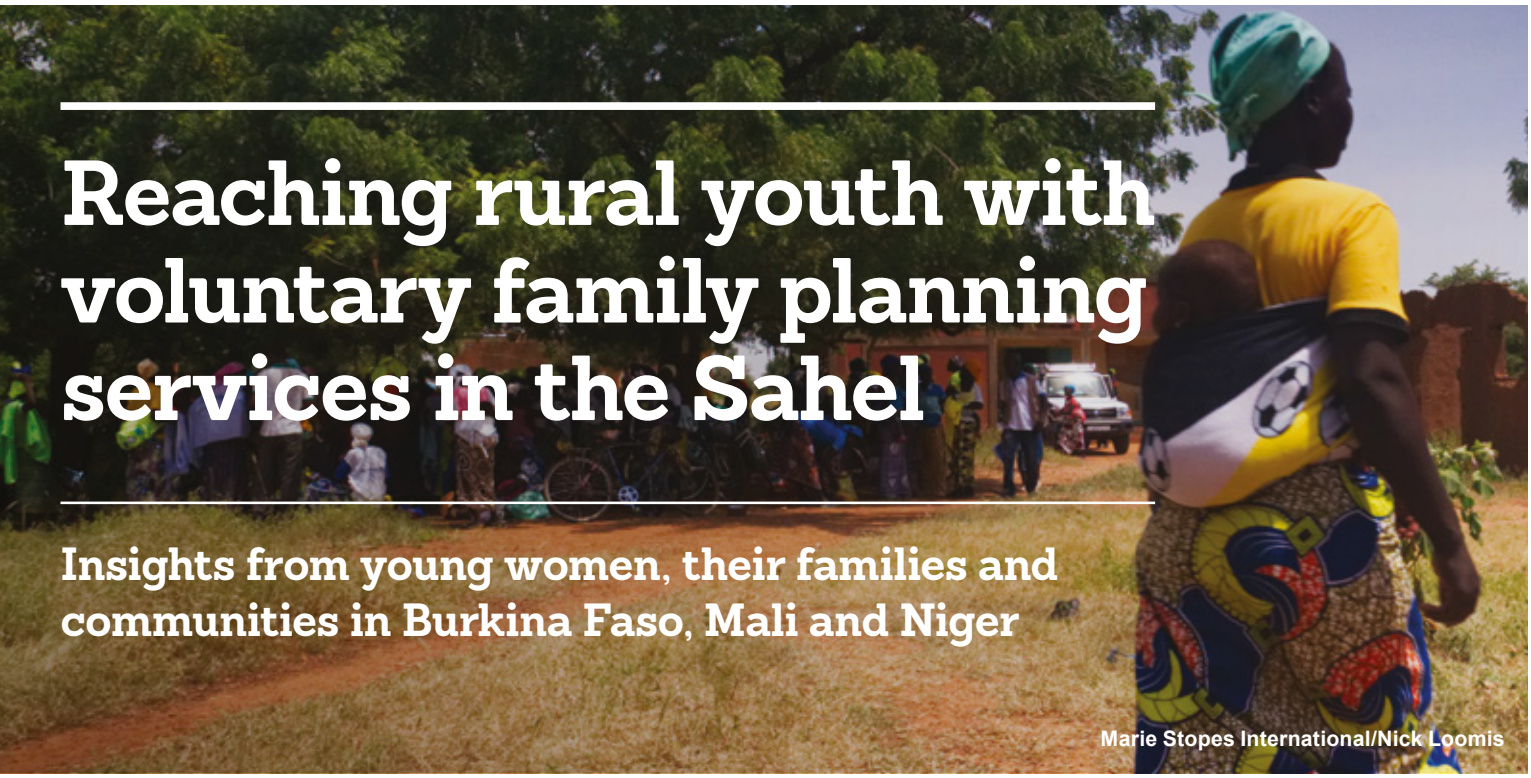
Children by choice, not chance



Reaching rural youth with voluntary family planning services in the Sahel

Insights from young women, their families and communities in Burkina Faso, Mali and Niger

Marie Stopes International/Nick Loomis

Summary

Young people living in the rural Sahelian areas of Mali, Niger, and Burkina Faso make up an important underserved population for voluntary family planning (FP). These areas are experiencing rapid population growth, yet use of modern contraception is low, especially use of more effective voluntary long-acting reversible contraceptives and permanent methods (LAPMs).

Marie Stopes International (MSI) has been working in the Sahel to improve access to contraceptive services through targeted behavioural and service delivery interventions. Services are offered through fixed-site clinics in urban areas and mobile outreach in rural communities. The latter includes delivery with Sahelian 'resilience zones', areas characterised by vulnerability to economic and environmental shocks

To improve our understanding of how to better reach rural youth in the Sahel with FP information and services, we conducted a qualitative study in 2016 in rural communities in the resilience zones of Burkina Faso, Mali and Niger. We interviewed current youth FP users, non-users, older women, male partners, community leaders, and key informants in the three countries.

The study showed that while many young women in these communities knew about modern contraceptives, dominant cultural norms requiring proof of fertility and large family sizes persisted, and that women's FP decision-making power was limited. Windows of opportunity to raise awareness of FP among youth were identified, including promotion of the educational, economic and health rationales for FP; as well as service delivery strategies that increase confidentiality, such as integration with maternal and child health services. Communication to dispel concerns about the effects of long-acting reversible contraception (LARC) on fertility may also be effective for advocacy and demand generation.

Findings at a glance

Young women in the rural Sahel face multiple barriers to family planning including:

- Persistent social norms around early marriage and high expected fertility
- Lack of young women's autonomy, with control by family and male partners
- Association of contraception with promiscuity, and social stigmatisation
- Perceptions that contraception is a risk to fertility goals and health, especially LARC methods
- Opposing religious beliefs

The following behavioural drivers can act as leverage points to increase access to FP:

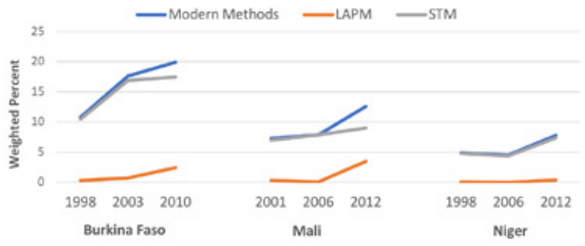
- Increases economic familial prosperity
- Allows girls to finish school
- Good for health and reduces risks from pregnancy at a young age
- Birth spacing is culturally acceptable
- Satisfied users sharing experiences
- There is demand for convenient and confidential services

Background

Rural regions of the Sahel have very high fertility, yet are also some of the most resource-poor settings in the world. Demographic and Health Survey (DHS) data indicates that knowledge of modern contraceptives has been high over the last decade in Burkina Faso, Mali, and Niger. However, average age at first sex, marriage and birth remain between 15 and 17 years old across the three countries, and the ideal number of children is between five and nine children.[1] Among youth aged 15 to 24, the prevalence of short term methods and LAPMs has increased over the past decade, but still remains very low (Figure 1). The prevalence of modern contraception among youth rose from 11% to 20% in Burkina Faso, 7% to 13% in Mali, and 5% to 8% Niger.[1] The prevalence of LAPMs among youth rose from 1% to 3.5% in Burkina Faso and 0.5% to 3.5% in Mali, and remained below 1% in Niger.[1]

MSI began operations in the Sahel in 2009 in Burkina Faso and Mali, followed by Senegal in 2011 and Niger in 2014, aiming to increase FP access and choice for women and men in the region through scaled-up service delivery, with an emphasis on reaching the growing youth population. By the end of 2017 an estimated 895,000 women and men in the Sahel were using a voluntary FP method provided by MSI.[2] MSI provides services in rural areas through mobile outreach, where teams provide voluntary FP counselling and services at networks of rural sites and return to each site every 2-3 months.

Figure 1. Use of modern contraception among youth aged 15 to 24 over past three DHS surveys in Burkina Faso, Mali, and Niger



Study aims

This study aimed to investigate (a) the socio-cultural and service-related influences on youth use of voluntary modern contraception, including LARCs, in the rural Sahel; and (b) the lessons learned from MSI in reaching young clients through its rural outreach programme.

(1) Church K, Thompson G, Porter C, Ky-Zerbo O, Camara M, Brown H, Nakoulma F, Haddou M, Mack N. Reaching rural youth with family planning services in the Sahel: a mixed methods study to understand reproductive behaviour and the programme response in Burkina Faso, Mali and Niger. Paper presented at the International Population Conference, Cape Town, 2017.

Methods

The study took place in six rural communities served by MSI's outreach teams in Burkina Faso (in Pièla and Pissila), Mali (in Dougabougou and Mahina), and Niger (in Goubé and Balleyara). 100 in-depth interviews and 4 focus groups were conducted with community members, including young users of MSI FP services (18-24); young women who had never used FP; male partners; older women; community leaders; and key informants (MSI staff). Structured observations were also carried out during community mobilisation and service delivery activities. Interviews were conducted in local languages, translated into and analysed in French by a team from FHI 360. Data were collected from August – October 2016.

Findings: Social, religious and gender norms pose barriers for use of FP among youth

Social pressures promoting early marriage and birth were intertwined with religious beliefs that deemed children as divine gifts. Pressure to conceive was compounded by fears of infertility, and the role of contraception in potentially causing it. This increased pressure to prove fertility before using family planning, acting as a strong barrier to FP use for nulliparous girls. Childless couples were often suspected to be infertile and could suffer social marginalisation as a consequence.

Gender norms also strongly influenced reproductive behaviours and decision-making across all three countries studied. There was a clear absence of youth female autonomy: instead their decisions and behaviour were influenced by others, most notably the husband, as well as parents, in-laws, and other community members. Some male partners supported FP use by their young wives, but primarily for birth spacing. Once fertility was established, the most common objection to the use of FP was the perception that women use FP to protect themselves in extra-marital affairs.

Older women would also seek to influence the sexual behaviour of their female family members. Early marriage was promoted as a principal way to achieve this, as contraceptive use among youth not living with a partner was associated with promiscuity.

The close-knit nature of the rural communities contributed to the challenges faced by youth in accessing services discreetly.

> ***"They never go because any young girl who goes and sees a doctor in order to tell him that she needs family planning, means that she wants to indulge in prostitution. That's very simple. She must be either a prostitute if we have to call her that, or a married woman, of course, with the consent of her husband."***
>
> ***(Community leader, Niger)***

Cultural and economic shifts offer opportunities to increase FP access among youth

Findings suggested that cultural and economic shifts may be occurring which allow space for consideration of contraceptive use by adolescents. These were notably present in Burkina Faso and Mali, and less so in Niger, where desired fertility remains extremely high.

Girls' education offered a window to delay either marriage or childbearing post-marriage. Contraceptive users emphasised the importance of finishing school before having children, with contraception considered in Mali a way to ensure that girls have a "good future". Female focus groups also revealed that girls could be allowed or even encouraged to use contraception before marriage to avoid unintended pre-marital pregnancy, especially for those pursuing their education.

Lack of money (noted primarily in Burkina Faso), and the need for a young woman, man, or couple to have the financial capacity to assume the responsibilities of a child (all countries) were also reported as reasons why young people choose to use contraception.

> ***"Here, these women are satisfied with the services of Marie Stopes because family planning protects them against unwanted pregnancies and allows them to study. Some [older] parents bring their child in order to avoid a possible pregnancy."***
>
> ***(Community leader, Mali)***

FP has health benefits…but suffers misconceptions

And while overall there was limited cultural acceptance of delaying first birth (only one community leader recognized the need for girls to achieve physical maturity before child-bearing), birth spacing was widely advocated for by two thirds of the sample, to allow women to 'rest' between births, and was clearly contrasted with pre-marital contraception.

Risks to health were recognized by some girls themselves, however, and a few interviewed in both Burkina Faso and Niger talked about the fragility of their bodies and the physical dangers of having children too young. Others in the sample, however, emphasized health risks associated with contraceptive use, not only the fear of infertility, but also the unknown mechanisms of action of both implants and IUDs.

Sister supporters

Although male partners were the gatekeepers of family planning use, both young and some older women supported clandestine use if their husbands did not agree for them to use it. Friends, sisters, aunts, mothers, neighbours, and acquaintances, could also act as promoters of FP use – many MSI clients reported sharing their experiences, providing a source of support and information for new FP users.

Strengths and opportunities for service delivery to youth in the Sahel

The main strengths of MSI service delivery were speed (short wait times) and quality, which young women desired, especially if seeking FP clandestinely. Key informants and clients also discussed the confidentiality of MSI services, emphasising the efforts made to maximize FP service provision access by coordinating FP services with vaccinations and antenatal consultations at community health centres. This integrated approach enabled clandestine service use for women seeking FP for birth spacing and unmarried/ nulliparous women blending in to the crowd.

> ***"As a result of [MSI] choosing Thursdays [for the FP service], which is our vaccination day, a lot of women can take advantage of that and also those who don't come for vaccination can blend into the crowd to come and benefit from the [FP] services."***
>
> ***(Key informant, Mali)***

MSI key informants in all three countries recommended improvements and enhancements to sensitisation strategies, including: targeting particular audiences; focusing on cultural messages to shift norms and behaviours (including around promiscuity and family planning); and expanding geographical coverage and frequency of outreach services (to greater than once a month).

Key informants in all three countries agreed that offering voluntary LARCs, in addition to short term methods, was responsive to the needs of the youth population. The need to ensure and increase access to LARC removal services was emphasized in Burkina Faso and Niger, to ensure this did not become a barrier to uptake. Some community leaders thought that only MSI agents could insert and remove long-acting methods. Women in the focus groups noted that this would cause danger for women who opt for LARCs because in the event of a problem requiring removal, the basic social and health structures in rural areas have neither the technical base nor the qualified staff to do so.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Conclusions

While sexual activity and FP use before marriage and first birth is still generally socially unacceptable and highly stigmatized in the rural Sahelian areas of Burkina Faso, Niger, and Mali, there are windows of opportunity that can be considered in a programming response for youth. Behavioural drivers that can be harnessed included the social and economic impetus to allow younger girls to complete school, including when married or unmarried; working with female community members to support girls to avoid ostracism through pre-marital unintended pregnancy; and capitalising on the acceptance of the health rationale for delaying or spacing pregnancy. Messages around managing family size for economic and health benefits may also be effective, except in Niger where desire for large families persists.

Given the patriarchal nature of Sahelian societies, male partners and community leaders as well as older women, are important potential advocates for leveraging behavioural change, and this study indicated cultural acceptance of FP amongst these groups, at least for birth spacing, which can be leveraged in programming responses.

Misperceptions about voluntary LARCs—most notably their role in causing infertility—suggest the need for greater sensitisation on this topic at the community level. In addition, access to LARC removal was of concern to many and might be addressed through collaboration with public health facilities and greater dissemination of information on where removal may be performed.

Service and programming responses must also be considered moving forward. Issues such as the frequency of outreach visits by the mobile teams, waiting times, and confidentiality concerns, can all have negative ramifications on youth access to services. The successful integration of FP with infant health services may be an important way to promote confidentiality, and MSI needs to carefully balance this with the need to advertise and make obvious its presence and availability.

Acknowledgements

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Recommendations:

Improve FP acceptability and access:

- Promote messages on the economic benefits of girls completing education and avoiding pre-marital unintended pregnancy
- Promote benefits of smaller family size commensurate with one's financial means
- Normalize discussion of sexuality and use of voluntary FP among young people, dispel negative perceptions about user lifestyles, create advocates
- Address strong concerns around LAPMs and infertility through high quality counselling and sensitisation, and by ensuring counselling on full method mix
- Support women's groups and networks to promote voluntary FP, including to youth.

Recommendations:

Improve service delivery:

- Increase frequency of scheduled service days and increase geographic coverage
- Increase confidentiality (for example ensure waiting rooms, integrate services with infant and child health)
- Increase locations that provide LARC removal options
- Work with community health centres to integrate voluntary FP services with infant health services.

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